

Patient Name: _____

Date of Birth: _____

Authorization and Payment Terms

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, and prescriptions. I also authorize payment of medical benefits to the physician.

In order to avoid any misunderstanding regarding our payment policies, please review our Financial Policy below. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected at the time of service.

➤ **We accept payment via cash, check, debit cards, Master Card, Visa, Discover or American Express.**

Your signature below authorizes the release of your medical information and payment as listed above, and signifies your willingness to comply with our financial policy (attached). Please present your insurance card(s) and a photo ID to the receptionist. These will be copied and placed in your medical record for identification purposes and for protection of your Private Health Information.

By law, we are only permitted to discuss your diagnosis and treatment with you (the patient). In the event that a spouse, family member, or close friend may need this information, please list their name in the space provided below.

Name: _____ Relationship: _____

By listing the individual above, you have given us permission to discuss your medical history and treatment with this person. We cannot disclose any of your private health information to anyone who is not listed on this form.

Financial Policy and Notice of Privacy Practices

We ask that you read and sign the following form to acknowledge your financial responsibility for the medical services provided here as well as our policy on the protection of your private health information. We would be happy to provide further clarification if necessary.

Medicare Patients: We bill Medicare directly for you. However, you are responsible for charges applied to your deductible, any co-insurance, or charges not covered by Medicare. **We do not bill supplemental insurance carriers.** Therefore, if your secondary insurance does not crossover with Medicare, you are responsible for that portion of your charges at the time of service (normally 20% of the covered charges).

Participating Insurance: We are a provider for a variety of commercial insurance carriers and we bill them as a courtesy to you. Prior to your visit, you will be informed whether or not we are a provider for your insurance plan. We accept payment for covered services from these insurance plans in accordance with our contracts. You are responsible for co-insurance and deductible amounts as well as payment for services that are not covered by insurance at the time of service.

Non-participating Insurance: If we are not a provider for your insurance you are responsible for payment of all charges at the time of service. We will provide you with a receipt for reimbursement.

Uninsured: All charges are to be paid in full at the time of service. It is your responsibility to know and understand the guidelines of your insurance plan. You should attempt to seek medical care with physicians participating in your plan when possible. Insurance may not cover all fees. To be fully aware of your benefit limitations, please read your insurance policy thoroughly or talk with your insurance representative. Please note that you may be billed separately for laboratory analysis if we are required by your insurance to send specimens to an external laboratory.

Refund Policy: We do not offer refunds for medical and cosmetic procedures.

Notice of Privacy Practices: We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements. We may use and disclose medical information about you for one or more of the following reasons; medical treatment, payment, internal operations, appointment reminders, others involved in your care, as required by law, to avert a serious threat to health or safety, organ and tissue donation, public health risks, worker's compensation, government activities, lawsuits and disputes, law enforcement, coroner or medical examinations.

You have the right to inspect and copy the medical information that we maintain. To inspect a copy of your medical record, you must submit your request in writing. In some cases there may be a fee associated with your request. A complete copy of our Notice of Privacy Practices is available for you in our lobby. I understand that I have financial responsibility for payment of medical services provided and hereby assume payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

I have read and understand this financial policy and notice of privacy practices and agree to accept responsibility as described.

Printed Name

Signature of Patient/Responsible Party

Date