OB-GYN SPECIALISTS OF SOUTH MIAMI
OBSTETRICS AND GYNECOLOGY

Appt. Date:
Appt. time:

PATIENT INFORMATION

Patient Number:	**Gender:**	**Date of Birth:**	
Last Name:		**Age:**	**Marital Status:**
First Name:	**Initial:**	**Social Security #:**	
Address:		**Home Phone:**	
City, State, Zip:		**Work Phone:**	
Email Address:		**Cell Phone:**	
Employer:			

RESPONSIBLE PARTY

Account #	**Patient Relationship to Guarantor:**		
Last Name:		**Gender:**	
First Name:		**Date of Birth:**	
Address:		**Home Phone:**	
City, State, Zip:		**Work Phone:**	
Employer:		**Cell Phone:**	

INSURANCE INFORMATION

Primary Insurance:		**Policy/Subscriber:**	
Address:		**Date of Birth:**	
City, State, Zip:		**Insured Policy ID:**	
Plan Phone:		**Group Number:**	
Effective Dates:		**Patient Relationship to Subscriber:**	
Secondary Insurance:		**Policy/Subscriber:**	
Address:		**Date of Birth:**	
City, State, Zip:		**Insured Policy ID:**	
Plan Phone:		**Group Number:**	
Effective Dates:		**Patient Relationship to Subscriber:**	

MISCELLANEOUS INFORMATION	**EMERGENCY CONTACT INFORMATION**
What is the best telephone number to contact you?	**Emergency Contact:** **Patient relationship to Contact:**
I authorize JIMENEZ AND SIMAN MD LLC to leave a message containing detailed medical information at the number listed above.	**Contact Home Phone:** **Contact Work Phone:** **Contact Cell Phone:**
Signature:	

OB-GYN SPECIALISTS OF SOUTH MIAMI
OBSTETRICS AND GYNECOLOGY

Acct #: **Patient Name:** **Date of Birth:**

KNOWN ALLERGIES	

KNOWN MEDICATIONS	

What is your preferred Pharmacy's Phone number:	**Who referred you to us? Please circle one:** **Friend Relative Physician Existing Patient** **Insurance Other (Please specify)** _____

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

INSURANCE AUTHORIZATION AND ASSIGNMENT. I hereby authorize «PracticeName» to furnish information to my Insurance Carrier concerning illness and treatments and hereby assign «PracticeName» payments for medical services rendered to myself or dependents. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**

Signature x_____ **Date:** _____

Notice of Privacy Acknowledgement

- I acknowledge that the Notice of Privacy Practices is available.
  (If you would like a copy of the Privacy Practices, please request one at the front desk)
- I acknowledge that due to the current HIPPA laws my doctor is required to obtain a written consent to disclose any Private Health Information in the presence of anyone other than myself.

Please check the corresponding line:

_____ **I ALLOW** JIMENEZ AND SIMAN MD LLC to discuss details of my medical records/financial records with

_____ (Please print name of authorized family member or friend)

Relation (of authorized person) to patient _____

_____ **I DO NOT ALLOW** JIMENEZ AND SIMAN MD LLC to discuss details of my medical records/financial records with anyone else but me.

_____ Patient's Name

_____
Patient's Signature

_____
Date

OB-GYN Specialists of South Miami

CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to JIMENEZ AND SIMAN MD LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of
(print name) ____ , age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by JIMENEZ AND SIMAN MD LLC and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, television, radio, digital, internet, or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that JIMENEZ AND SIMAN MD LLC are the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, they have the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by television, radio, newspapers, magazines, newsletters, brochures, Internet, intranet, or in other media once released.

JIMENEZ AND SIMAN MD LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above named person or for participation in said productions. I agree to hold , its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone: _____

Email address: _____

Signature: _____ Date: _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable time frame. I also understand that this file may have been copied without permission, and I agree not to hold JIMENEZ AND SIMAN MD LLC responsible for instances of these violations.

Signature: _____ Date: _____

Notice of Privacy Practices
JIMENEZ AND SIMAN MD LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

Please sign the accompanying "Acknowledgement" form

7000 S W 62 AVE, SUITE 200
MIAMI, FL 33143

Office: 305-662-9320
Fax:305-669-2111

Attn: DORIS MARTINEZ

2013

Aviso De Prácticas De Privacidad
JIMENEZ AND SIMAN MD LLC

ESTE AVISO DESCRIBE CÓMO LA INFORMACIÓN MÉDICA SOBRE USTED PUEDE USAR Y DIVULGADA Y CÓMO USTED PUEDE OBTENER ACCESO A ESTA INFORMACIÓN. POR FAVOR, LÉALA CON ATENCIÓN.

Cómo podemos usar y divulgar su información médica: Se describe como sigue es las maneras en que podemos usar y divulgar información de salud que le identifica a usted (información de salud). Excepto para los siguientes propósitos, vamos a utilizar y divulgar su información médica sólo con su permiso por escrito. Usted puede revocar tal autorización en cualquier momento por escrito a nuestra práctica.

Tratamiento:
Podemos usar y divulgar su información médica para su tratamiento y para proporcionarle los servicios de salud relacionados con el tratamiento. Por ejemplo, podemos divulgar información médica a doctores, enfermeras, técnicos y otro personal, incluyendo personas fuera de nuestra oficina, que participan en su atención médica y necesitan la información para proporcionarle atención médica.

Pago:
Podemos usar y divulgar su información médica para que nosotros u otros podemos facturar y recibir pago de usted, una compañía de seguros o un tercero para el tratamiento y los servicios que recibió. Por ejemplo, podemos dar su información de plan de salud para que pagarán por su tratamiento.

Operaciones de atención médicos:
Podemos utilizar y divulgar información médica para fines de atención médica de la operación. Estos usos y divulgaciones son necesarios para asegurarse de que todos nuestros pacientes reciban atención de calidad y para operar y administrar nuestra oficina. Por ejemplo, podemos utilizar y divulgar información para asegurarse de que el cuidado médico que recibe es de la más alta calidad. También podemos compartir información con otras entidades que tienen una relación con usted (por ejemplo, su plan de salud) para sus actividades de atención médica de la operación.

Recordatorios de citas, salud y alternativas de tratamiento, beneficios y servicios relacionados. Podemos utilizar y divulgar información médica para contactarle y recordarle que usted tiene una cita con nosotros. También podemos usar y divulgar información médica para informarle sobre alternativas de tratamiento o beneficios relacionados con la salud y servicios que puedan ser de su interés.

Individuos involucrados en su cuidado o el pago de su atención. Cuando sea apropiado, podemos compartir información médica con una persona que participa en su atención médica o el pago de su atención, como su familia o un amigo cercano. También podemos notificar a su familia sobre su ubicación o condición general o divulgar dicha información a una entidad en un esfuerzo de alivio de desastre.

Investigación. Bajo ciertas circunstancias, podemos usar y divulgar información médica para la investigación. Por ejemplo, un proyecto de investigación puede involucrar comparar la salud de los pacientes que recibieron un tratamiento a aquellos que recibieron otro, para la misma condición. Antes de que usemos o divulguemos información médica para la investigación, el proyecto pasará por un proceso de aprobación especial. Incluso sin autorización especial, podemos permitir los investigadores registros para ayudarles a identificar a los pacientes que pueden incluirse en su proyecto de investigación o para otros propósitos similares, siempre y cuando no retire ni tomar una copia de cualquier información de salud.

Las actividades de recaudación de fondos. Podemos utilizar o divulgar su información médica protegida, según sea necesario, para poder ubicarte para actividades de recaudación de fondos. Usted tiene el derecho de optar por no recibir comunicaciones de recaudación de fondos. (Opcional) Si no quieres recibir estos materiales, por favor envíe una solicitud por escrito al oficial de privacidad.

SITUACIONES ESPECIALES:

Requeridas por la ley. Divulgaremos información de salud cuando así lo requiere la ley internacional, federal, estatal o local.

Para evitar una amenaza grave para la salud o seguridad. Podemos usar y divulgar su información médica cuando sea necesario para prevenir una amenaza grave a su salud y seguridad o la salud y seguridad del público u otra persona. Revelaciones, sin embargo, se hará sólo a alguien que puede ayudar a prevenir la amenaza.

Asociados de negocios. Podemos divulgar información médica a nuestros asociados de negocios que realizan funciones en nuestro nombre o nos proporcionan servicios si la información es necesaria para dichas funciones o servicios. Por ejemplo, podemos utilizar otra compañía para realizar la facturación de servicios en nuestro nombre. Todos nuestros asociados de negocios están obligados a proteger la privacidad de su información y no se les permite usar o divulgar cualquier información que como se especifica en el contrato.

Violación de datos con fines de notificación. Podemos utilizar su información de contacto para proporcionar avisos requeridos legalmente de adquisición no autorizada, el acceso o la divulgación de su información médica. Podemos enviar aviso directamente a usted o notificar al patrocinador de su plan a través del cual recibe cobertura.

Donación de órganos y tejido. Si usted es un donante de órganos, podemos utilizar o divulgar información de salud a organizaciones que manejan la adquisición de órganos u otras entidades que participan en licitaciones; banca o transporte de órganos, ojos o tejidos para facilitar de órganos, ojos o tejidos donación; y trasplante.

Militares y veteranos. Si usted es un miembro de las fuerzas armadas, podemos divulgar información médica según lo requerido por las autoridades de comando militar. También podemos divulgar información médica a la autoridad militar extranjera correspondiente si eres un miembro de un ejército extranjero.

Compensación. Podemos divulgar información de salud para la compensación de trabajadores o programas similares. Estos programas proporcionan beneficios por accidente de trabajo o enfermedad.

Salud pública riesgos. Podemos divulgar información médica para actividades de salud pública. Estas actividades generalmente incluyen revelaciones para prevenir o controlar enfermedades, lesiones o incapacidades; nacimientos de informe y muertes; abuso de informe o negligencia; reacciones de informe a medicamentos o problemas con productos; notificar a las personas retiradas de productos que pueden estar usando; una persona que han estado expuesta a una enfermedad o puede estar en riesgo de contraer o propagar una enfermedad o condición; y la autoridad de gobierno apropiada si creemos que un paciente ha sido víctima de abuso, negligencia o violencia doméstica. Solamente haremos esta divulgación si usted está de acuerdo o cuando lo requiera o autorice la ley.

SUS DERECHOS:

Usted tiene los siguientes derechos con respecto a la información médica que tenemos sobre usted:

Acceso a registros electrónicos. La tecnología de la información de salud para la salud económica y clínica. Ley de alta tecnología permite a las personas para pedir copias *electrónicas* de su PHI contenida en registros electrónicos de salud o solicitar por escrito o electrónicamente otra persona reciba una copia electrónica de estos registros. Las reglas finales de ómnibus amplían el derecho de una persona para acceder a los registros electrónicos o dirigir que ser enviado a otra persona para incluir no sólo registros electrónicos de salud sino también todos los registros en uno o más conjuntos de registros designados. Si la persona solicita una copia electrónica, deben ser proporcionados en el formato solicitado o en un formato de acuerdo mutuo. Entidades cubiertas pueden cobrar a individuos por el costo de cualquier medio electrónico (como una unidad flash USB) utilizado para proporcionar una copia de la PHI de la electrónica.

Derecho a inspeccionar y copiar. Usted tiene el derecho de inspeccionar y copiar información de salud que pueden utilizarse para tomar decisiones sobre su cuidado o el pago de su atención. Esto incluye registros médicos y de facturación, excepto las notas de psicoterapia. Para inspeccionar y copiar esta información de salud, debe hacer su petición, por escrito.

Derecho a enmendar. Si usted cree que la información de salud que tenemos es incorrecta o incompleta, puede pedirnos que enmendemos la información. Usted tiene el derecho de pedir una enmienda mientras la información se mantiene por o para nuestra oficina. Para solicitar una enmienda, usted debe hacer su petición, por escrito.

Derecho a una contabilidad de accesos. Usted tiene el derecho de solicitar una lista de ciertas revelaciones que hicimos de información médica para fines que no sean de tratamiento, pago y operaciones de atención médica o que proporcionaste autorización por escrito. Para solicitar una contabilidad de accesos, usted debe hacer su petición, por escrito.

Derecho a solicitar restricciones. Usted tiene el derecho a solicitar una restricción o limitación en la información médica que utilizamos o revelamos para tratamiento, pago u operaciones de atención médica. Usted también tiene derecho a solicitar un límite en la información de salud que divulguemos a alguien involucrado en su cuidado o el pago de su atención, como un familiar o amigo. Por ejemplo, usted puede pedir que no compartamos información sobre un determinado diagnóstico o tratamiento con su cónyuge. Para solicitar una restricción, usted debe hacer su petición, por escrito.

No estamos obligados a aceptar su petición. Si estamos de acuerdo, cumpliremos con su petición a menos que la información es necesaria para proporcionarle tratamiento de emergencia.

Derecho a la comunicación mediante solicitud confidencial. Usted tiene el derecho a solicitar que nos comuniquemos con usted acerca de asuntos médicos de una cierta manera o en cierto lugar. Por ejemplo, usted puede solicitar que sólo te contactamos por correo o en el trabajo. Para solicitar comunicación confidencial, usted debe hacer su petición, por escrito. Su petición debe especificar cómo o dónde desea ser contactado. Acomodamos las peticiones razonables.

Derecho a una copia impresa de esta notificación. Usted tiene el derecho a una copia impresa de esta notificación. Usted puede pedirnos que le dará una copia de este aviso en cualquier momento.

CAMBIOS A ESTE AVISO:

Nos reservamos el derecho de cambiar este aviso a la nueva notificación se aplica a la información de salud que ya tenemos así como cualquier información que recibamos en el futuro. Publicaremos una copia de nuestra notificación actual en nuestra oficina. La notificación contendrá la fecha de vigencia en la primera página, en la esquina superior derecha.

QUEJAS:

Si usted cree que sus derechos de privacidad han sido violados, puede presentar una queja con nuestra oficina o con el Secretario del Departamento de salud y servicios humanos. Todas las quejas deben hacerse por escrito.

Usted no será penalizado por presentar una queja.

Por favor firmar el "Reconocimiento"

7000 S W 62 AVE SUITE 200
MIAMI, FLA 33143

Office: 305-662-9320
Fax:305-669-2111

Atención: Compliance Contact

PATIENT NAME : _____ **DOB:** _____

RELEASE OF INFORMATION / ENTREGA DE INFORMATION

I authorize the release of any medical information necessary to process a claim.
Yo autorizo la entrega de cualquier informacion medica necesaria para poder procesar un reclamo.

SIGNATURE: _____ **DATE:** _____
Firma Fecha

I authorize payment of medical benefits to myself or the named provider of professional serves rendered.
Yo autorizo el pago de servicios/beneficios medicos a mi o al proveedor professional de los servicios.

SIGNATURE : _____ **DATE:** _____
Firma Fecha

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

RECIBO DEL AVISO DE LAS PRACTICAS DE PRIVACIDAD FORMA ESCRITA DE RECONOCIMIENTO

I have read and understood the notice of privacy practices. I am aware that if I want a copy of the Privacy Practices, one will be provided to me at my request.
He leido y comprendido el aviso de practicas de privacidad. Soy consciente de que si quiero una copia de las practicas de privacidad, se le proporcionara a mi en mi solicitud.

SIGNATURE : _____ **DATE:** _____
Firma Fecha

FINANCIAL POLICY

Thank you for choosing **JIMENEZ AND SIMAN M.D.,LLC** as your health care provider. We are committed to building a successful physician-patient relationship. The following is a statement of our Financial Policy. Our office will be happy to answer any questions or concerns you may have.

PAYMENT IS DUE AT THE TIME OF SERVICE
ALL COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT

WE ACCEPT: CASH, CHECK, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. We are in network with most major insurance carriers. However, it is the patient's responsibility to verify that we are a participating provider of the insurance plan. It is the patient's responsibility to know and understand the requirements of their insurance plan. As part of the contract with your insurance company, all co-payments, co-insurances and deductibles must be paid at time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

HMO/REFERRALS: It is the patient's responsibility to obtain a referral form from your primary care physician if your insurance carrier requires it for your visits. If you arrive without a referral for your visit and are required to bring one, your appointment will be rescheduled.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for payment of services rendered.

MISSED APPOINTMENTS: Unless cancelled 24 hours in advance, there is a $25.00 fee for missed appointments. Please help us serve you better by keeping scheduled appointments.

NONCOVERED SERVICES: Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

RETURNED CHECKS: Any check returned for non-sufficient funds will be subject to bank fees (the amount the bank charges the practice) along with a $50.00 NSF fee from the office.

COLLECTION POLICY: Should your account become past due, the patient/debtor assumes all costs of collection, including but not limited to, collection agency fees, court costs, interest and legal fees. All unpaid accounts will be reported to the credit bureau.

FORMS: There is a flat fee of $15.00 for each set of forms the office completes on your behalf.

I HAVE READ AND FULLY UNDERSTAND the Financial Policy and all my questions regarding this policy have been answered. I hereby agree to render payment in accordance with the terms and conditions set forth.

Patient Name: _____ Date: _____

Patient/Responsible Party Signature: _____