SMART CHOICE
PRIMARY CARE + URGENT CARE

www.SmartChoiceNow.com
4235 Sunbeam Road • Jacksonville, Florida 32257
(904) 322-8555 • Fax: (904) 322-8578

Wissam M. Shaya, M.D.

Insurance and Authorization Information

I consent to any medical, diagnostic, therapeutic, or minor surgical procedure rendered to the patient under the supervision of the physicians. I hereby recognize the practice of medicine and surgery is not an exact science and I acknowledge that no one has made any representation, guarantee, or warranty to me regarding the results to be achieved by any treatments or examination that I (or the patient) will receive as a result of services. I authorize release of my patient records, including alcohol and drug abuse records protected under the regulations of code 42 of federal regulations, part 2 if any; psychological services, if any; social services records, if any, to my insurance company(s) for the purpose of payment of bills to my health care provider for continuity of care. I authorize and request my insurance company to pay directly to the provider the amount due for medical care. In addition, I understand that I will be responsible for any amounts that are not covered by insurance.

I understand that if any employee or physician of **SCPUC**, sustain a subcutaneous (through the skin), mucous membrane (through the mouth or eye), or open wound exposure to my blood or other bodily fluids, I may be tested for the Human Immunodeficiency Virus (HIV) which causes Acquired Immune Deficiency Syndrome (AIDS).

I hereby certify that the contents of this form are understood by me. Paragraphs or lines that I choose not to pertain to me, if any, were stricken and initialed by me, before I signed:

I attest that the information that I have provided on this form is complete to the best of my knowledge.

Patient Name (Please Print):_____

Patient Signature:_____

Responsible Party Name (where appropriate):_____

Responsible Party Signature:_____

* U.S. government required statistical data necessary for all healthcare entities to attain "Meaningful Use" of Electronic Health Records.
Please return this document to the **SCPUC** reception desk upon completion

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Office Visit Charges Notice of Responsibility at Time of Service

Patient Name: _____ Doctor: _____

Patient DOB: _____ Today's Date: _____

Office Visit Responsibility at Time of Service:

1) For All Patients:

   Because of the changes associated with the Affordable Care Act, beginning in 2014, most patients will be responsible for significant portions of their healthcare costs as out of pocket expenses. As a consequence, **SCPUC** has determined that it is necessary to collect deductibles, co-pays, and co-insurances at the time of service for any patient seeing a healthcare provider for which such patient expenses are customary. Please be aware that when calculating such expenses, we err on the side of caution on your behalf, so balances will be calculated for patients with deductibles and co-insurance for only the office visit portion of the charges and not for any in office labs or procedures.

2) For HMO Patients Only:

   Normally my HMO insurance requires that I be assigned to a Primary Care Physician (PCP) prior to my insurance coverage being engaged for office visit coverage at a PCP's office. If I have chosen to postpone my assignment to one of the SCPUC medical practitioners as my PCP until after I complete my initial office visit I accept responsibility for any and all charges associated with my office visit in the event that I decide not to assign a **SCPUC** physician as my PCP office.

I, _____, have read this patient information sheet and acknowledge that the requirement of this form and my acceptance of responsibility for office visit charges is standard practice for my insurance in cases such as this.

_____ _____

Patient Signature Date

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Agreement of Responsibility:

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of services. I understand that I am responsible for charges not covered by my insurance company.

Consent to Treat:

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in her/his judgement.

Release of Information / Assignment of Benefits:

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. I hereby authorize **SCPUC**, its agents, employees and affiliates to have access to my complete medical records for the purpose of performing its management functions as they deem necessary.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to **SCPUC**, for any services furnished to me by that physician/supplier. I authorize the holder of the medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

A Medigap Authorization is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medical Supplemental policy is a health insurance policy or other health plan offered by a private company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This agreement is in effect until revoked in writing by the patient / legal guardian.

Name:_____ Date:_____

Signature (Patient / Legal Guardian):_____

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