Morris Medical Center, P.A.

Dareld R. Morris II, D.O. 6800 Porto Fino Cir. Fort Myers, FL 33912 Daniel S. Rowe Jr., M.D.
Phone (239) 418-0775

Thank you for choosing our practice to assist in your healthcare needs. We appreciate the confidence you and your personal physician have placed in us. Please read the following instructions and information and let us know immediately if you have any questions.

INSURANCE: Please bring your insurance cards so we can copy them for your chart. We will file your primary insurance claim for you. If your insurance requires prior authorization, please ensure it is taken care of before the day of your appointment as you cannot be seen without it and your appointment will have to be rescheduled.

PAYMENT: It is the policy of this office to advise patients that they are responsible for all bills incurred. Please be prepared to pay any copay or coinsurance amounts due at the time of service.
We accept cash, and most major credit cards. **Personal checks are only accepted if 1. You have been a patient at Morris Medical Center, for 1 year or more, 2. Your bank and the address on your check must be local.**

Financial Policy

We are committed to providing you with the best possible care. In order to achieve these goals we need your assistance and understanding of our payment policy.

Payment for services is due at the time services are rendered.

Returned checks and account balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize that: Your insurance is a contract between you and your insurance company. We are not party to that contract.

We must emphasize that, as medical physicians, our relationship is with you, not your insurance company. All charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do a rise, we encourage you to contact us promptly for assistance in the management of your account.

If you any questions about the above information, PLEASE do not hesitate to ask us. We are here to help you.

Responsible Party (**print name**):_____

Responsible Party (**signature**):_____

Date: _____

Relationship to patient: Self Spouse Parent

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PATIENT INFORMATION

Last Name:_____First Name:_____SEX: M F

If patient is a minor, name of parent or guardian accompanying patient:_____

Relationship to patient:_____Phone # (if different): _____

Address:_____

City:_____State:_____Zip Code: _____

Home Phone:_____Cell:_____Email: _____

Date of Birth:_____SS#:_____married single divorced widowed (circle one)

Referred by:_____Phone:_____Location:_____ Family

Doctor:_____Phone:_____Location: _____

INSURANCE

Date of accident: (If applicable):_____**Type of Accident**: _____

Please briefly describe the accident. If necessary, you may use the back of this page. Please also note whether you were in the course of employment at the time. _____

Primary Insurance Name: _____Adj.:_____ Auto Health W/C (circle one)

Phone #: _____ _____Group #:_____ Ext.: _____

Claim or ID #: _____ _____

Subscriber: _____ Relationship: Subscriber _____

Subscriber Date of Birth: _____ Social Security #:_____ _____

Insurance Name: Phone #: _____Adj.:_____ Auto Health W/C (circle one)

Claim or ID #:_____ _____ Ext.:_____

Subscriber: _____ Group #: Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Tertiary Insurance Name: _____ Auto Health W/C (circle one)

Phone #: _____ Group #: _____

Claim or ID #: _____ Relationship: _____

Subscriber: _____ Subscriber Social Security _____

Subscriber Date of Birth: _____ _____

Attorney Name: _____

Are we authorized to release your medical information to the listed emergency contact? Yes or No

SIGNATURE: _____**Date:**_____

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MEDICARE AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical provider(s) services to the medical provider(s) furnishing the services and authorize such medical provider(s) to submit a claim to Medicare for payment.

SIGNATURE_____ DATE_____
PATIENT'S SIGNATURE (OR PARENT IF MINOR)

AUTHORIZATION TO RELEASE INFORMATION

I authorize any holder of medical or other information about me to release same to the insurance carrier for the purpose of payment of services.

I hereby authorize payment directly to my medical provider for all medical care benefits otherwise payable to me; this is not to be construed as an assignment of benefits unless the medical provider has a contractual agreement with the insurance company. I understand that I am responsible for any insurance deductibles and coinsurance, and I am financially responsible for my medical bills regardless of insurance coverage.

SIGNATURE_____ DATE_____
PATIENT'S SIGNATURE (OR PARENT IF MINOR)

NOTE: You will be charged a **NO SHOW FEE of $25.00** for failure to notify our office in advance of any appointment cancellation. This charge will be your responsibility as insurance does not cover this fee.

For, and in consideration of, services rendered to the above named patient, I/we jointly and severally promise to pay to MORRIS MEDICAL CENTER, P.A. (dba FORT MYERS SPINE & JOINT CENTER) all its charges for services rendered to and for the above named patient. I/we understand MORRIS MEDICAL CENTER, P.A. may elect to accept or not to accept assignment of insurance benefits as it deems advisable. Any other arrangements made by me (insurance company, lawyers, etc.) does not involve MORRIS MEDICAL CENTER, P.A. and does not change my (our) responsibility to pay for services.

I have read and understand all of the above.

_____ _____
(PATIENT) (GUARANTOR)

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CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name:_____ Date of Birth: _____

Please Check One of the Following:

_____ I REQUEST THAT ALL OF MY PROTECTED HEALTH INFORMATION BE DISCLOSED ONLY TO ME AND NO OTHER FRIENDS OR FAMILY.

OR

_____ I GIVE MY PERMISSION TO THE EMPLOYEES OF Morris Medical Center, P.A. TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY MEMBERS OR FRIENDS.

NAME:_____ RELATION: _____

NAME:_____ RELATION: _____

NAME:_____ RELATION: _____

NAME:_____ RELATION: _____

WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to better serve you, Morris Medical Center, P.A would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is our policy to call you at any phone number you provide to us. Please let us know what type of message we may leave on your answering machine/voicemail by answering the following questions by circling **YES** or **NO**.

When we contact you by calling you at any telephone number you have provided us:

May we leave a detailed message on your answering machine/voicemail? **YES** or **NO**

If no, we will leave a message with just enough information for you to call us back.

*****Please Note: We will ALWAYS leave a detailed message on your answering machine/voicemail or with anyone who answers your telephone when we are contacting you to remind you of an appointment at our office.*****

I understand I may revoke or change this consent at any time by filling out another consent form to replace this one.

_____ _____
Patient/Guardian/or Legal Representative Signature Date

_____ _____
Printed Name if not signed by Patient Relationship

Internal Use Only: Please post the above information in the patient's off-bill comments.

Date Received:_____ Posted By: _____

DATE REVOKED/CHANGED_____
If revoked/changed see new consent form

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Notice of Privacy Practices

Effective April 14, 2003, all medical practices must follow certain guidelines as it pertains to the "Protected Health Information" (PHI) of their patients. PHI is defined as information about the patient, including demographic information, that may identify the patient, and relates to the patient's past, present, or future physical or mental condition and related health care services.

This short form has been created to provide you an overview explaining how we will handle your PHI and actions you can take if you feel we have not handled your PHI properly. A more detailed explanation of this Notice of Privacy Practices is available on our website at www.swfna.com.

How we handle your Protected Health Information:
We will ask each patient to sign consent from allowing our office to use your PHI for three purposes only. Those purposes are for medical treatment, information required for payment of services rendered, and for conducting our operational activities. No other use of your PHI will occur without your written consent, unless it is to comply with state and federal laws.

Patient Signature _____ Date _____

Employee/Staff Signature _____ Date _____