Internal Medicine, Emilia E. Murray, MD, PA.
1172 Goodlette Road, # 202. Naples, FL 34102

OFFICE FINANCIAL POLICY

We at Internal Medicine are committed to providing you with the best possible care. If you have insurance, we will be happy to submit your medical claims on your behalf; however, you must realize that your insurance is a contract between YOU and your INSURANCE COMPANY. Any co-pay and/or deductible is expected at time of service. If you do not have insurance, payment is required at the time services rendered.

The insurance card and information provided to our office must be valid and current. If, for any reason, your insurance changes or you receive a new card is your responsibility to update the office with the new information. If payment is not received from your insurance company within 90 days, you will owe for the visit in full and it is your responsibility to follow up with your insurance company. Any balance NOT paid after 90 days may be referred to a collection agency. There will be $ 35.00 charge for return checks.

We do our absolute best to accommodate any patient needing immediate care, therefore require a 24-hour cancellation notice. If a cancellation notice is not given there will be a
$ 75.00 NO SHOW FEE for any missed Physical appointment.

Dr. Murray owns the records she creates, or orders and the State of Florida allows Doctors to charge for the copying of Medical Records at $1.00 per page. Therefore, there will be a charge for the copying of any medical records request.

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Patient`s Signature **Date**

FOR MEDICAID PATIENTS ONLY

We are not participating provider of Florida Medicaid program. All Medicaid patients will be treated as self-pay patients. Neither do we take Medicaid as a secondary to Medicare; therefore, the same policy applies.

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Patient`s Signature **Date**

PLEASE SIGN FOR INSURANCE AND/OR MEDICARE ASSIGMENT

I hereby authorize and assign payment of all medical benefits on my behalf to INTERNAL MEDICINE, EMILIA MURRAY, MD, PA., for any services furnished to me. I also authorize to release of any medical information held by INTERNAL MEDICINE, EMILIA MURRAY, MD, PA., to the health care financing administration and its agents, to process my claims

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Patient`s Signature **Date**

HIPPA CONSENT FORM

I hereby acknowledge that I have reviewed and had an opportunity to ask questions concerning INTERNAL MEDICINE, EMILIA MURRAY, MD, PA`s notice of privacy practices.

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Patient`s Signature **Date**

INTERNET MEDICAL RECORDS STORAGE

I, the undersigned, hereby authorize medical office of INTERNAL MEDICINE, EMILIA MURRAY, MD, PA., including nut not limited to Dr. Murray, her staff and her agents, to store medical and required related information about me on a secure server. Communication of this medical sensitive and related non-medical data will be done with encrypted transfer over a secure cable line internet.

Through this authorization, I am hereby irrevocably releasing the medical offices on INTERNAL MEDICINE, EMILIA MURRAY, MD, PA., including but not limited to Dr. Murray, her staff and her agents from any and all liability for any damages or costs, or both, relating to or arising out the storage of my medical records in this matter.

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Patient`s Signature **Date**