Smart Medicine SF

Smart Medicine SF is part of an increasing number of fee for service practices. Our practice concentrates on patient care under a low overhead model that seeks to eliminate the costly and time consuming process of medical billing. This allows us to pass on our savings to our patients in the form of timely unhurried medical visits with increased access to our doctors.

At the end of each visit we will provide you with a medical superbill with all the necessary codes that insurance carriers require to process your claim. These codes include the ICD-10, which is numerical code representing the diagnosis. Also included will be the procedural codes for the type of visit called CPT codes. We also provide you with a reimbursement request for your convenience. This form maybe used to submit our superbill to your insurance carrier.

Our Medical office does not guarantee any form of reimbursement from your insurance company. Your insurance carrier may not reimburse the full amount of for services provided by our office. All patients of Smart Medicine SF are fully responsible for payments of our services due at the time our services are performed. Payment is made by credit card, Health Savings account, Flex spending account, or cash.

We would like to make the process as simple as possible. If there is any feedback either positive or negative you would like to convey, please call us at 415-586-7633 or email us at info@smartmedsf.com

Sincerely,
Vinh Ngo MD
Medical Director
Smart Medicine SF

Smart Medicine

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

Address: _____ **Day Phone:** _____

City: _____ **State** _____ **Zip:** _____

Clinic/Hospital/Health Care Provider –

(**Who** has the information you want released?) **Please list the specific Hospital and/or clinic.**

NAME: _____

Address: _____ **Day Phone:** _____

City: _____ **State** _____ **Zip:** _____

Receiving Party

(**Where** do you want the information sent? **Who** may have the information?)

NAME: _____ **Attention to:** _____

Address: _____ **Day Phone:** _____

City: _____ **State** _____ **Zip:** _____

Fax Number : _____

Information to be Released

(**What** do you want sent or released? Check the appropriate box.)

Routine Record Sets **(indicate date(s) of service** _____**)**
- Clinic (office visit, lab, radiology, medicines, immunizations)
- Hospital (history and physical, discharge summary, operative report, consultations, emergency, laboratory, radiology)
- Billing Records
- Copies of Films/Images
- Community Pharmacy Charges
- Any and all records (includes ALL types of record listed below. If you want to include images and billing records, check those boxes.)

Only records types checked below:

Discharge summary/note	Radiology reports	Emergency record(s)	Medication records
History & physical exam	Rehab records (PT/OT/ST)	Immunization/allergy record	Chemical dependency/
Operative report	Laboratory reports	Pathology reports	Substance abuse records
Consultations	Progress notes/clinic notes	Mental health records	Pathology slides/blocks

Other records specify record type(s) _____

OPTIONAL Limits - Disclose only records related to following:
Date(s) of service/:_____ injury or illness: _____

Release Instructions

(**How** and **When** do you want the information?)

Date information is needed: _____ **(NOTE: PLEASE ALLOW 7-10 DAYS FOR PROCESSING)**

Release Method / Format requested: (check one)
Paper **CD/DVD** **View my Record** **Fax (patient care only)** **Verbal**

Continuing Care Information released by Nursing Station/Department (verbal and paper) **Yes** **No**

Purpose of Release

(**Why** is it needed?)

Continuing care
Insurance application
Insurance payment/claim
Other _____
Transfer of care
Personal use or review
Litigation/legal
Social security appeal
Social security disability determination

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____
This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The SMART MEDICINE SF Notice of Privacy Practice describes how to cancel (revoke) this authorization.
SMART MEDICINE SF will not restrict my treatment if I choose not to sign this authorization.
A photocopy/fax of this authorization will be treated in the same way as an original.
SMART MEDICINE SF records may include records that it received from other organizations.
Your signature indicates that you have read and understand this form, and authorize release of your information as described above.
authorization, you release SMART MEDICINE SF from any and all liability resulting from a redisclosure by the recipient.

Patient/Legal Guardian Signature _____ Date _____ Authority to act on behalf of patient (attach document) _____

Phone: (415) 598-7633 Fax: (415) 495-7633 info@smartmedsf.com www.smartmedsf.com 468 Tehama St. Suite #A San Francisco, CA 94103