Dear Patient,

Please complete the first page, as well as read, sign, and date the following pages.

Please do not hesitate to ask us any questions.

Thank you,

Arsenio Medical, P.C.
**PATIENT INFORMATION FORM**

- **SEX:** M  F  
  - **BIRTHDATE:** _____/_____/_______
  - **Apartment #**
  - **MARITAL STATUS:** M  S  D  W

- **ADDRESS**
  - **CITY, STATE**
  - **ZIP CODE**

- **HOME PHONE**
  - **WORK PHONE**
  - **CELL PHONE:** _______________________________
  - **EMERGENCY PHONE:** ____________________________

- **EMAIL:** _____________________________________

- **REferred BY:** _____________________________________________

**RESPONSIBLE PARTY (POLICY HOLDER)**

- **PERSON RESPONSIBLE**
  - **SS#**
- **ADDRESS**
  - **PHONE**

- **CITY, STATE**
  - **ZIP CODE**

- **RELATIONSHIP TO PT:** Self  Spouse  Child  Other _____________

**PRIMARY INSURANCE COMPANY**

- **NAME OF COMPANY**
  - **POLICY #**
  - **COPAY AMT**
  - **Group #**
  - **Sequence #**

- **ADDRESS TO SEND CLAIMS**
  - **TO THE POLICY HOLDER:** Self  Spouse  Child  Other _____________

- **CITY, STATE**
  - **ZIP CODE**

- **POLICY HOLDER**
  - **POLICY HOLDER’S DOB**
  - **SS#**

**SECONDARY INSURANCE COMPANY**

- **NAME OF COMPANY**
  - **POLICY #**
  - **COPAY AMT**
  - **Group #**
  - **Sequence #**

- **ADDRESS TO SEND CLAIMS**
  - **TO THE POLICY HOLDER:** Self  Spouse  Child  Other _____________

- **CITY, STATE**
  - **ZIP CODE**

- **POLICY HOLDER**
  - **POLICY HOLDER’S DOB**
  - **SS#**

**RELEASE OF INFORMATION**

I AUTHORIZE the release of any information necessary to process insurance claims. I also AUTHORIZE payment of benefits to the physician or supplier for services rendered. I also AUTHORIZE my provider to file a complaint on my behalf.

Signature  Date

**MEDICARE PATIENTS**

I AUTHORIZE any holder of medical or other information about me to release to THE SOCIAL SECURITY ADMINISTRATION and HEALTH CARE FINANCING ADMINISTRATION or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this AUTHORIZATION to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is MANDATORY to notify the health care provider of any other party who may be responsible for paying for my treatment.

Signature  Date
PATIENT RESPONSIBILITY TO CHANGE PCP TO ARSENIO MEDICAL

I, ________________________________ AGREE TO CHANGE MY PRIMARY
(PATIENT NAME)
CARE PHYSICIAN WITH MY INSURANCE COMPANY TO A PHYSICIAN OF
THE ARSENIO MEDICAL PRACTICE WITHIN 24 HOURS OF MY INITIAL VISIT.

I UNDERSTAND THAT THE BILL WILL BE MY RESPONSIBILITY IF I DO NOT
COMPLY WITH THE ABOVE.

X______________________________________________
(PATIENT SIGNATURE) (DATE)
CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND
HEALTH CARE OPERATIONS

I, __________________________________, hereby authorize Arsenio Medical, P.C. to use and/or
disclose my health information which specifically identifies me or which can reasonably be used to
identify me to carry out my treatment, payment and health care operations. I understand that while this
consent is voluntary, if I refuse to sign this consent, Arsenio Medical, P.C. can refuse to treat me.

I have been informed that Arsenio Medical, P.C. has prepared a notice (“Notice”), which more fully
describes the uses and disclosures that can be made of my individually identifiable health information
for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Arsenio Medical, P.C., in writing,
but if I revoke my consent, such revocation will not affect any actions that Arsenio Medical, P.C. took
before receiving my revocation.

I understand that Arsenio Medical, P.C. has reserved the right to change his/her privacy practices and
that I can obtain such changed notice upon request.

I understand that I have the right to request that Arsenio Medical, P.C. restricts how my individually
identifiable health information is used and/or disclosed to carry out treatment, payment or health
operations. I understand that Arsenio Medical, P.C. does not have to agree to such restrictions, but that
once such restrictions are agreed to, Arsenio Medical, P.C. must adhere to such restrictions.

I also understand that should my insurance company send payment to me, I will forward the payment to
Arsenio Medical, P.C. within 48 hours. I agree that if I fail to send the payment to the Provider and
they are forced to proceed with the collections process; I will be responsible for any cost incurred by the
office to retrieve their monies. In the event patient receives any check, draft or other payment
subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any
violations of this agreement will, at provider’s election, terminate patient charge privileges with
provider and bring any balance owed by patient to provider immediately due and payable.

_____________________________________________  __________________
Signature of patient or patient’s representative  Date
(Form MUST be completed before signing).

_____________________________________________
Printed name of patient or patient’s representative

_____________________________________________
Relationship to the patient
Financial Agreement

We, the staff at Arsenio Medical P.C. thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

We believe your understanding of our patients’ financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office manager. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa and in-state checks). A $25.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Insurance
Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information.

It is the patient’s responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and
customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier

**Miscellaneous Forms, Additional Information, and Authorizations**

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities there will be an administrative fee, not to exceed $35.00, for the additional information.

**Missed Appointments**

We require notice of cancellations 24 hours in advance for specialist appointments. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $30.00 but not to exceed half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

**Medical Records Fees**

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries. We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

**Timeliness of Appointments**

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: __________________________

Date: ___________________________________________________________________
24 Hour Cancellation & “No Show” Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Arsenio Medical P. C., reserves the right to charge a fee of $30.00 for all missed appointments (“no shows”) and appointments which, absent of a compelling reason, are not cancelled with a 24-hour advance notice.

“No show” fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____________________________  _______________________
Printed Name                                           Date

_____________________________
Signature