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.

Arsenio Medical, P.C.

PATIENT INFORMATION FORM

***PLEASE COMPLETE ENTIRE FORM**

____
PATIENTS NAME (Last, First, MI)

SEX: M F

BIRTHDATE: ______/______/________

______________________________ Apartment #__________
ADDRESS

MARITAL STATUS: M S D W

____
CITY, STATE ZIP CODE

____
SOCIAL SECURITY #

______________ ______________
HOME PHONE WORK PHONE

EMERGENCY CONTACT PERSON: ____________________________

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

____
ADDRESS TO SEND CLAIMS

Group #______________________________ Sequence #______________

PATIENT RELATIONSHIP
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

____
ADDRESS TO SEND CLAIMS

Group #______________________________ Sequence #________________

PATIENT RELATIONSHIP
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