Bluepoint
MEDICAL ASSOCIATES
www.BluepointMed.com

14631 Lee Highway
Suite 413
703.385.8222
CENTREVILLE

2080 Old Bridge Road
Suite 101
703.385.8222
LAKERIDGE

Assignment of Benefits/Patient Financial Agreement

INSURANCE

I hereby authorize Bluepoint Medical Associates to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or, in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). A copy of the authorization may be used in place of the original.
This authorization may be revoked by either me or my insurance carrier at any time in writing.

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Initials

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Bluepoint Medical Associates for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. **I understand and agree that I am financially responsible for charges not paid by my insurance company.**

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Initials

PAYMENT POLICY

Payment for services is due at the time services are rendered. All returned checks are subject to a ***$50 returned check fee.*** If it becomes necessary to refer my account to an outside collection agency, I agree to pay 33.3% interest on the debt.

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Initials

CANCELLATION POLICY

If you are unable to keep a scheduled appointment, we ask that you give us a proper notice in advance.

- Missed appointments or cancellations less than ***48 hours*** before the scheduled **consult appointments** are charged a *$50.00* fee**.**
- Cancelling a **scheduled surgery for** any reason other than medical without a ***two (2) weeks'*** notice will be charged a *$200.00* fee.
- Missed appointments or cancellations less than ***48 hours*** before the scheduled **sleep study** are charged a *$200 fee.*

(Insurance companies will not reimburse these charges).

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HIPAA PRIVACY NOTICE

The department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (The Health Insurance Portability and Accountability Act of 1996) (HIPPA), mandates that we issue this revised Privacy Notice to our patients. This notice to our patients meets all current requirements as it relates to Standards for Privacy of Individually Identifiable Health Information (IIHI); affecting our patients. You are urged to read this.

Our privacy notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: "any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual."

Our office will use or disclose your PHI for purposes of treatment, payment, and other healthcare purposes as required to provide you the best quality healthcare services that we offer. It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a "minimum necessary information" restriction to that access.

You, as our patient, may revoke any Consent at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process. To revoke the Consent you will have to provide this office with a written request with your signature and date and your specific instructions. Any revocation will not apply to information already used or disclosed.

You the patient have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes. If the physician agrees with the request, we are bound by law to abide to any changes.

Please sign below and date the form indicating that you have received this privacy notice. Thank you.

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Signature of Patient or Personal Representative Date