Internal Medicine & Healthy Lifestyle

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AUTHORIZATION , ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE.

I hereby authorize the release of medical information including complete medical records, test results and billing information to my insurance company, and other medical professionals and institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate or make payment of a claim, and to review records for quality improvement initiatives, audit compliance , utilization management and complaint resolution. I authorize payment directly to Internal Medicine & Healthy Lifestyle for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments , co-insurance, deductibles and non-covered services. A photocopy of this authorization shall be considered as effective and valid as the original.

FINANCIAL AGREEMENT

I understand that I'm directly responsible for all the charges incurred for medical services for myself and my dependents regardless of insurance coverage. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements.Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. I furthermore agree to pay legal interest, collection expenses and attorney fees incurred to collect any amount I owe. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable.
AGREEMENT: This above information is for the purpose of obtaining credit and is warranted to be true.
Any document to complete will have an additional cost (Example: FMLA, Parking ID, long or short disability document ... etc.)

CANCELATION / NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However; When you do not call to cancel an appointment , you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient falls to cancel and we are unable to schedule you for a visit, due to the seemingly "full" appointment book. If an appointment is not canceled at least 24 hr in advance you will be charged a $ 30 dollar fee; this will not be covered by your insurance company, and it has to be paid before your next appointment

SCHEDULED APPOINTMENTS

We understand that delays can happen however we must try to keep the other patients and doctor on time. If a patient is 15 minutes past their scheduled appointment time we will have to reschedule the appointment.

ACCOUNT BALANCES

We will require that patients with self pay balances pay their account balance to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances must make payment prior to future appointments being made.

REQUEST FOR TREATMENT

I authorize the group personnel to perform the care ordered by my physicians. I understand that I have the right to be informed by my physician of the nature of any proposed procedure and any available alternatives, methods or treatment together with an explanation of the risk associated with each procedure. This form is not a substitute for such explanations, which are the responsibility of my physician to provide according to recognized standard of medical practice, and I acknowledge that the group and its personnel are responsible for providing this information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form you acknowledge receipt of the Notice of Privacy Practices for Internal Medicine Services LLC (dba Internal Medicine & Healthy Lifestyle) . Our Notice of Privacy Practices information about how we may use and disclose your protected information. We encourage you to read it carefully. Our Notice of Privacy Practices is subject to change.

Signature : X_____ Date : _____
Patient/ Parent / Guardian

X_____ _____
Name of Patient or Representative (Print Please) Relationship to Patient

Office use : We attempted to obtain written acknowledgement, but couldn't be obtained for the following reason:
- ❑ Patient or Representative refused to sign
- ❑ Emergency situation prevented signature
- ❑ Other :_____
- ❑ Initials of Employer :_____

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