

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, M.D.

Telemedicine Patient Consent Form

I, _____, a patient of Central Florida Primary Care, agree to participate in a telemedicine evaluation. Inasmuch I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by an available Provider of Central Florida Primary Care (M.D., ANRP, PA) and other person involved in my medical care. [Note: The likelihood of this transmission being intercepted by person other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine a session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a Medical Provider in person.

I understand that medical records of telemedicine services will be kept at both the Provider site facility and the consulting site facility, if needed.

I understand that some or all of my medical information may be used for teaching or educational purposes.

FOR DEMONSTRATIONS ONLY: I agree to permit other persons who are not involved in my medical care to observe my evaluation. I understand that I may withdraw this permission at any time during my evaluation. **DECLINE** _____ **(initials of patient)**

Signature of patient: _____ **Date:** _____

Please print the above name: _____

Signature of Witness: _____

- *For withdrawal from a telemedicine evaluation, please complete the information on the bottom of this page*
- **(MARK THIS BOX AND SIGN BELOW FOR WITHDRAWAL ONLY).** I have chosen not to participate further in this telemedicine evaluation.

Signature of patient: _____ **Date:** _____

Please print the above name: _____

Signature of Witness: _____

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD, Internal Medicine
Jonathan P. Peach, DNP, ARNP

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Cesar Corretjer, MD
Iveth Mastrapa, ARNP

Date: _____

Dear New Patient:

On behalf of Dr. Pedro Ortega, we would like to welcome you to our practice. We would like to take the time to thank you for choosing us to provide all of your Internal Medicine needs. For your convenience, our offices hours are **Monday-Thursday 8:00am-5:30pm and Friday 8:00am-3:00pm.**

If you experience a medical problem after hours, please call us first at **(407) 478-0028.** We are on call 24/7. Non-Life-threatening emergent telephone access is handled immediately.

As part of the preventative health care that we practice, all new members are given a physical examination. After this initial visit, we will be seeing you on a regular basis, the frequency of which you will be seen will depend on your individual needs.

Included with this letter are our office policies regarding hospitalizations, referrals, authorizations, prescription refills, etc. Please familiarize yourself with these policies and bring a signed copy with you at your first visit or we will have a copy for you to sign at that time.

We look forward to providing you with quality medical services in the most courteous and efficient manner possible.

If you have any questions, please do not hesitate to call us.

Sincerely,

Central Florida Primary Care

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD, Internal Medicine
Jonathan P. Peach, DNP, ARNP

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Cesar Corretjer, MD
Iveth Mastrapa, ARNP

Office Policies/Procedures

EMERGENCIES/HOSPITALIZATIONS: Our Answering Service is available **BEFORE** and **AFTER** office hours. Do not wait for your symptoms to get to the point that you have to go to the emergency room.

Please call this office **BEFORE** going to the hospital, even after hours, or on the weekend. We must try to prevent unnecessary emergency room visits. If it's a life threatening emergency, call 911.

In the event that you do go to the hospital, please let them know that you are a patient of Dr. Ortega.

REFERRALS/AUTHORIZATIONS: Per the Health Plan, all referrals and authorizations **MUST** come from this office. This provides Dr. Ortega the opportunity to identify your issues/concerns and to determine and proper treatment plan. It also allows us to provide your Health Plan with the required documents and office notes if there is a need for a referral/authorization or pre-certification. Dr. Ortega has developed a professional relationship with many specialists and will recommend which one you should see. You need to make an appointment with us after you see the specialist for follow up care. Once we receive the recommendations from the specialist, Dr. Ortega will determine if your specific condition is stable and he will decide if you need further testing or follow up referrals. Your prescriptions and follow up testing will be ordered by the office. Lab services are required to go to lab authorized by your health plan and we will recommend which free standing radiology center to use. Authorizations and Pre-Certifications require review from the Health Plan and may be denied by the Health Plan. We will require 5 business days for any routine referrals and at least 5-7 business days for authorizations or pre-certifications.

PRESCRIPTION REFILLS: Generic medications will be used whenever available. **Please give our office a 72 hour notice** for all prescription refills to be called in. Refills will **NOT** be given if you have not been seen recently in the office or after hours and weekends.

CANCELLATION AND TARDINESS: Please let us know at your earliest convenience if you cannot make your appointment. This will assist in accommodating other patients. Failure to comply with this policy could result in a **\$25.00 missed office visit charge**. You **MUST** cancel 24 hours in advance either in person or over the phone. Cancellations made through voicemail or the answering service will not be accepted as notice. If you anticipate being more than 15 minutes late for your appointment, please call our office to see if your appointment needs to be rescheduled.

By signing below, you are indicating that you have read and agree to the above policies.

Patient Name (Please Print): _____

Signature of Patient or Legal Guardian: _____ Date: _____

REGISTRATION FORM

PATIENT INFORMATION					
Patient's Last Name:		Middle:		First Name:	
Marital Status: (Circle One) Single Married Divorced Widowed Separated	Preferred Language:	Email Address:		Date of Birth:	Age:
Sex: (Circle One) Male Female					
Address:					
Social Security Number:		Home Phone Number:		Cell Phone Number:	
Preferred Pharmacy Name:		Pharmacy Phone Number:		Pharmacy Location:	
Race: (Circle One) American Indian/ Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander Hispanic White/Caucasian Decline Other _____			Ethnicity: (Circle One) Hispanic/Latino Non-Hispanic/Latino Decline		
RESPONSIBLE PARTY / INSURANCE INFORMATION					
Name of Primary Insurance:					
Patient's Last Name:		Middle:		First:	
Address: (If Different):					
Date of Birth:		Relation:		Social Security Number:	
Occupation:					
Home Phone Number:		Cell Phone Number:		Work Phone Number:	
Other:					
Subscriber Last Name:		Subscriber First Name:		Date of Birth:	
Group Number:		Policy Number:		Relation:	
Name of Secondary Insurance (if applicable):					
Subscriber's Last Name:			Subscriber's First Name:		Group Number:
Policy Number:					
IN CASE OF EMERGENCY					
Emergency Contact's Full Name:		Relationship to patient:		Address:	
Best Contact Phone Number:					
<p>The above information is true to the best of my knowledge. I understand that I am responsible for all charges incurred for services rendered and that payment is due at the time of service unless other arrangements are made in advance. I understand that I am responsible for any services that are not covered by my insurance carrier. I authorize Central Florida Primary Care and staff to release to my insurance carrier and its agent(s) any information concerning health care services and treatment. I authorize my insurance company or any other responsible party to make payment directly to Central Florida Primary Care for any services rendered.</p> <p>All self-pay and non-participating insurance patients must pay in full prior to medical services being rendered. We are unable to file a claim with non-participating insurance companies.</p> <p>I understand that I will receive regular monthly statements of my account reflecting a balance due and that FINAL PAYMENT OF MY ACCOUNT REMAINS MY SOLE RESPONSIBILITY regardless of or lack of payment by my insurance carrier.</p> <p>This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned.</p> <p>I hereby consent & authorize Central Florida Primary Care, its healthcare providers, technical, nursing, and/or other healthcare personnel, as may be necessary to diagnose and render care to the above named patient as deemed necessary.</p>					
<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature of Patient or Legal Guardian				<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Date	

CENTRAL FLORIDA PRIMARY CARE

Pedro L. Ortega, MD, Internal Medicine
Jonathan P. Peach, DNP, ARNP

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Cesar Corretjer, MD
Iveth Mastrapa, ARNP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY - We are obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. This notice takes effect as of April 21, 2015 and will be in effect until we replace it. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us at Central Florida Primary Care, 3727 N. Goldenrod Rd., Suite 106 Winter Park, FL 32792, Phone: (407) 478-0028 Fax: (321) 203-4720.

USES AND DISCLOSURES OF MEDICAL INFORMATION - We use and disclose medical information about you for treatment, payment, and health care operations. This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs and PPOs, managed care organizations, IPAs, CMS, or other governmental or third-party payers, or any organizations contracting with any of the above entities to perform such functions. Copies of your medical information may be delivered to any other physician who is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your medical information to notify a family member or another person responsible for your care based on our professional judgment and the circumstances. We may use your medical information to contact you to provide appointment reminders, and to attempt to call you to notify you that lab test results are available. We may use your name and your location in our facilities directories.

We may use or disclose your medical information for purposes involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, organ donation, judicial and administrative proceedings, law enforcement, abuse, neglect or domestic violence issues and workers' compensation issues.

INDIVIDUAL RIGHTS - This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You may have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. We will charge a cost-based fee for copying of records and for postage.

QUESTIONS AND COMPLAINTS - You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

X

Signature of Patient or Legal Guardian

Date

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CONSENT TO USE OR DISCLOSE HEALTHCARE INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (“PHI”) about you. You have the right to review our Notice before signing this form. Your signature below acknowledges that you have received a copy of our Notice of Privacy Practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting one of our offices. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health operations as described in our Notice. These disclosures may be by phone, mail, fax or electronic transmission. **Unless you indicate otherwise in writing, if you allow a third party other than one of the practice’s physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent Form you are consenting to the disclosure of your PHI to that third party.** You have the right to revoke this consent, in writing except where we have already made disclosures in reliance on your prior consent. If you refuse to sign this consent or revoke this consent, Central Florida Primary Care may refuse treatment or provide further treatment as of the time of the revocation, except to the extent that treatment is required by law.

I am consenting to the disclosure of my protected health information (“PHI”) to the following individuals:

Name:	Relation:
Name:	Relation:
Name:	Relation:
Name:	Relation:
Name:	Relation:

I have read and understand the information in this acknowledgement. I am the patient or I am authorized to act on behalf of the patient to sign this document. By signing below, I will acknowledge and agree to the above conditions.

X

Signature of Patient or Legal Guardian

Date

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PERSONAL MEDICAL HISTORY

Patient Name: _____ DOB: _____

Please check off if you have had any problems in the past or a presently experiencing any of the following:

	Past	Current		Past	Current		Past	Current
Allergic Rhinitis	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Lymphoma	<input type="radio"/>	<input type="radio"/>
Abdominal Discomfort	<input type="radio"/>	<input type="radio"/>	Diabetes Type 1	<input type="radio"/>	<input type="radio"/>	Macular Degeneration	<input type="radio"/>	<input type="radio"/>
Abnormal Bleeding	<input type="radio"/>	<input type="radio"/>	Diabetes Type 2	<input type="radio"/>	<input type="radio"/>	Migraines	<input type="radio"/>	<input type="radio"/>
Alzheimer	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	Myocardial Infarction	<input type="radio"/>	<input type="radio"/>
Anesthesia Issues	<input type="radio"/>	<input type="radio"/>	Difficulty Urinating	<input type="radio"/>	<input type="radio"/>	Nausea/Vomiting	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>	Eczema	<input type="radio"/>	<input type="radio"/>	Osteoporosis	<input type="radio"/>	<input type="radio"/>
Abnormal Vaginal Discharge	<input type="radio"/>	<input type="radio"/>	Epilepsy (Seizures)	<input type="radio"/>	<input type="radio"/>	Overactive Bladder	<input type="radio"/>	<input type="radio"/>
Angina	<input type="radio"/>	<input type="radio"/>	Fibroids	<input type="radio"/>	<input type="radio"/>	Painful Intercourse	<input type="radio"/>	<input type="radio"/>
Aortic Stenosis	<input type="radio"/>	<input type="radio"/>	Frequent Urination	<input type="radio"/>	<input type="radio"/>	Painful Periods	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	Fibromyalgia	<input type="radio"/>	<input type="radio"/>	Palpitations	<input type="radio"/>	<input type="radio"/>
Aneurysm	<input type="radio"/>	<input type="radio"/>	Erectile Dysfunction	<input type="radio"/>	<input type="radio"/>	Pancreatitis	<input type="radio"/>	<input type="radio"/>
Arterial Thrombosis	<input type="radio"/>	<input type="radio"/>	Gall Bladder Disease	<input type="radio"/>	<input type="radio"/>	Rectal Bleeding	<input type="radio"/>	<input type="radio"/>
Arthritis (Rheuma)	<input type="radio"/>	<input type="radio"/>	Gallstones	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Arthritis (Osteo)	<input type="radio"/>	<input type="radio"/>	Gastritis	<input type="radio"/>	<input type="radio"/>	Shortness of Breath	<input type="radio"/>	<input type="radio"/>
Back Pain	<input type="radio"/>	<input type="radio"/>	Gout	<input type="radio"/>	<input type="radio"/>	Stent (Heart)	<input type="radio"/>	<input type="radio"/>
Atrial Fibrillation	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	Stent (Leg)	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	GERD	<input type="radio"/>	<input type="radio"/>	Strong urges to Urinate	<input type="radio"/>	<input type="radio"/>
B12 Deficiency	<input type="radio"/>	<input type="radio"/>	Headache	<input type="radio"/>	<input type="radio"/>	Swollen Ankles	<input type="radio"/>	<input type="radio"/>
Blood Disorders	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Blood in Stool	<input type="radio"/>	<input type="radio"/>	Hematuria (Blood in Urine)	<input type="radio"/>	<input type="radio"/>	Unexplained Weight Gain	<input type="radio"/>	<input type="radio"/>
Bronchitis	<input type="radio"/>	<input type="radio"/>	Hemorrhoids	<input type="radio"/>	<input type="radio"/>	Unexplained Weight Loss	<input type="radio"/>	<input type="radio"/>
Cancer (Melaoma)	<input type="radio"/>	<input type="radio"/>	Heart Disease	<input type="radio"/>	<input type="radio"/>	Venereal Diseases	<input type="radio"/>	<input type="radio"/>
Cancer (Colon)	<input type="radio"/>	<input type="radio"/>	(Circle One) Hepatitis A B C	<input type="radio"/>	<input type="radio"/>	○ Other		
Cancer (Lung)	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>		Past	Current
Cancer (Breast)	<input type="radio"/>	<input type="radio"/>	High Cholesterol	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
Cancer (Ovarian)	<input type="radio"/>	<input type="radio"/>	Hypothyroidism	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
Cataract	<input type="radio"/>	<input type="radio"/>	Incomplete Emptying	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
Changes in Bowel Habits	<input type="radio"/>	<input type="radio"/>	Indigestion	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
Cancer (Prostate)	<input type="radio"/>	<input type="radio"/>	Infertility	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
Chest Pain or Chest Tightness	<input type="radio"/>	<input type="radio"/>	Involuntary/Unintended Urine Loss	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
Cancer (Skin)	<input type="radio"/>	<input type="radio"/>	Irritable Bowel Syndrome	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
Chronic Kidney Disease	<input type="radio"/>	<input type="radio"/>	Kidney Disease	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
Cogestive Heart Failure (CHF)	<input type="radio"/>	<input type="radio"/>	Kidney Stones	<input type="radio"/>	<input type="radio"/>			
Colon Polyp	<input type="radio"/>	<input type="radio"/>	Lightheadedness	<input type="radio"/>	<input type="radio"/>			
Constipation	<input type="radio"/>	<input type="radio"/>	Lower Back Problems	<input type="radio"/>	<input type="radio"/>			
Coronary Artery Disease	<input type="radio"/>	<input type="radio"/>	Lupus	<input type="radio"/>	<input type="radio"/>			

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Cesar Corretjer, MD
Iveth Mastrapa, ARNP

PERSONAL MEDICAL HISTORY (CONTINUED)

Patient Name: _____ DOB: _____

Allergies to Medications, X-Ray Dyes or Other Substances: No Yes

(Please Specify)

Surgeries: (Please list and provide dates for each surgery)

Year	Reason

Hospitalizations: (Please list and provide dates for each hospitalization)

Year	Reason

Immunization History: (Which have you had?)

Pneumovax Immunization	<input type="radio"/> No <input type="radio"/> Yes	Date:
Influenza (Flu) Immunization	<input type="radio"/> No <input type="radio"/> Yes	Date:
Shingles Immunization	<input type="radio"/> No <input type="radio"/> Yes	Date:

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PERSONAL MEDICAL HISTORY (CONTINUED)

Patient Name: _____ DOB: _____

Current Medications: (Prescription, Over the Counter, Vitamins, Herbs, etc...)

Medication	Dosage	Medication	Dosage

Exams: (Please provide the last time you had any of these exams done)

Colonoscopy	Date:
Mammogram	Date:
Eye Exam	Date:
Pap Exam	Date:

Family History: (Has any member of your family including Parents, Grandparents, and Siblings ever had any of the following illness)

Illness	Which Family Member	Age when diagnosed
Cancer (Describe Type)		
High Blood Pressure		
Heart Disease		
Diabetes		
Stroke		
Mental Disease		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Disease		
Other: _____		

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NOTIFICATION OF ADVANCE DIRECTIVES

(In compliance with the Patient Self-Determination Act)

An Advance Directive is a written statement about how you want medical decisions made should you not be able to make them yourself.

**** ALL PATIENTS ARE STRONGLY ENCOURAGED TO HAVE AN ADVANCE DIRECTIVE ****

At this time, I have prepared a:

Living Will	<input type="radio"/> No <input type="radio"/> Yes
Advance Directive	<input type="radio"/> No <input type="radio"/> Yes
Durable Power of Attorney	<input type="radio"/> No <input type="radio"/> Yes
Designation of Healthcare Surrogate	<input type="radio"/> No <input type="radio"/> Yes

I understand that the information I have provided may be changed at any time, and I must provide another copy after any changes have been made.

I understand that it is my responsibility to provide my physician with a copy of my Advance Directives.

I have provided my physician at Central Florida Primary Care a copy of my:

Living Will	<input type="radio"/> No <input type="radio"/> Yes
Advance Directive	<input type="radio"/> No <input type="radio"/> Yes
Durable Power of Attorney	<input type="radio"/> No <input type="radio"/> Yes
Designation of Healthcare Surrogate	<input type="radio"/> No <input type="radio"/> Yes

X

Signature of Patient or Legal Guardian

Date

X

Printed Name of Patient or Legal Guardian

Date

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FINANCIAL POLICY

INSURANCE: We accept most insurances, Medicare and Medicaid assignments. We are not contracted with worker compensation carriers. Please call your insurance company to assure if your office visit will be covered. Patients are responsible for co-pays, co-insurance, and/or deductibles at time of visit.

LAB SERVICES: We do have the ability to collect blood work in our in-house lab for a convenience fee of \$20 for patients with insurance and a TBD price for self-pay patients. We also send our patients out to the laboratories that their insurance companies are contracted with. Insurance companies change their contracts with laboratories all the time, so each patient needs to know which laboratories their insurance allows them to go to. This will help us send them to the correct laboratory. We work very diligently to make sure you are sent to the correct lab. If for any reason a lab bill is denied for payment, it is not the doctor's or the practice's responsibility to pay this bill. All lab bills are the patient's responsibility. If you choose to go to another lab, which is not paid by your insurance you will be responsible for the balance.

PATIENT'S RESPONSIBILITY: Our policy states that as a courtesy to our patient, we submit their claims to their insurance companies as a way of helping them ensure the payments are sent for the services that we rendered. We are not responsible for claims that are not filed in a timely matter for reasons such as (wrong insurance information was given; wrong ID numbers or claims that are sent to the wrong insurance address). Ultimately, it is the patient's responsibility for payment of services that are rendered. The patient is responsible to pay the balances left from deductibles, co-insurance or any balance due to a change in co-pay amounts within 30 days after the insurance pays your claim.

PAYMENTS: **ANY**, and **ALL** co-payments, which are determined by the patient's insurance companies, **are required to be paid at the time services are rendered**. If the patient is a self-pay patient, we require payment in full for all services. At times exceptions are made in order, to assist a patient due to financial hardship. We are dedicated to help patients obtain the healthcare they need.

FORMS OF PAYMENT: We accept cash or credit (Visa, MasterCard, Discover or American Express). **ALL balance of \$40 or less must be paid in CASH, IS NOT ALLOWED to pay those balances with Credit or Debit Cards, without exceptions.**

FORMS TO BE FILLED: If a patient needs a form to be filled out, such as an FMLA form, a fee of \$25 and up will be charged according to the document. Forms will not be filled out immediately, they

can take up to 3-5 business days for the providers' ample time to review the patient's record and fill them out accordingly. Our staff will call the patient when the form is ready to be picked up or faxed to collect payment.

NO SHOW POLICY: Patients' sign this agreement at the time a patient becomes part of the practice, so they understand how important it is for us to help all patients obtain an appointment. There is a \$25 no show fee that will be assessed to the patient's account automatically if the patient does not show up or call.

COLLECTION PROCESS: We work diligently to resolve all claims with the patient's insurance companies. We send patient statements/bill every month to each patient with a balance. This is done each month along with a collection letter attached to the second and third request. At the end of 60 days, we call each patient to remind them that a balance for services rendered has not been paid as of today and it is past due. We try to obtain payment for these accounts. If payment is not received in the allotted time, we then transfer this patient's account to our in-house collections and the account is placed in a frozen status. When all efforts have been exhausted, we then dismiss the patient from the practice after giving them one last chance to pay their balance. Although we will be able to provide emergency services to you on a cash only basis for the next 30 days, you must arrange to have medical services elsewhere. A 35% handling fee will be added to all patient balances when they are transferred to an outside collection agency and will become the patient's responsibility to pay. At which time the patient will be dismissed from our practice.

REFUND POLICY: All refunds to the insurance companies and patients are done at the end of each month if there are no pending claims. We do no refund any payments made by a self-pay patient that is in the process of obtaining insurance. The patient has the options to reschedule their appointment and wait for their insurance to be active.

Signature of Patient or Legal Guardian:	Date:
Signature of Witness:	Date: