Fischer Family Medicine, P.A.

1191 Fischer Blvd. Toms River, NJ 08753
(732) 506-7888 / Fax (732) 506-7766

FINANCIAL SUMMARY OF POLICY

***** INSURANCE CARD MUST BE SHOWN AT EVERY VISIT *****

A) INSURANCE / COPAYMENTS:
- It is your responsibility to know your insurance and your copay. If not, a $10 administration fee will be applied to your account for resubmission of claims or to bill a copay.

B) BILLING:
- Statements go out monthly. If you are unable to pay your bill, please contact the billing department in order to set up a financial agreement.
- Balances that go unpaid after one statement has been sent, get a $5 billing fee applied to your account for every month the bill continues to go unpaid.
- Fees for unpaid/bounced checks: $50. Redeposit checks: $20. All future visits must be paid in cash.

C) MISSED OR CANCELED APPOINTMENTS:
- If you cancel within 24 hours of your appointment, you will incur a $15 cancellation fee.
- If you miss your appointment, you will incur a $30 no-show fee.

D) MEDICAL RECORDS:
- $1 per page for the first 100 pages, $.25 for each additional page, up to $200; or a $10 fee for an electronic copy.

E) FORM FEES:
- All forms are $25. Lost scripts are $5.

F) NEW PATIENTS:
- You are considered a new patient if you have not been here within the last three years. This will affect the charges of your initial visit.

HIPAA SUMMARY OF POLICY

FFM understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of any personally identifiable information (PII) that we obtain from you or others that relates to your past, present, or future physical or mental health, the health care you have received, or payment for your health care (your "Protected Health Information").

I wish to be contacted in the following manner:

Primary Contact Number: _____ (Check one of the boxes below)

☐ Leave message with detailed information ☐ Leave message with call back number only

The following people are permitted to receive my Protected Health Information: (Enter N/A if no one is to be contacted)

NAME: _____ RELATION TO SELF: _____

NAME: _____ RELATION TO SELF: _____

BY SIGNING THIS FORM, YOU ARE AGREEING TO BOTH OF OUR DETAILED FINANCIAL AND DETAILED HIPAA POLICIES. NO EXCEPTIONS. IF YOU WISH TO OBTAIN A COPY FOR YOUR RECORDS, PLEASE ASK THE FRONT DESK. WE ARE OPERATING UNDER THE ASSUMPTION YOU HAVE READ ALL THE DETAILED TERMS AND HAVE AGREED TO THE ALL TERMS SET FORTH.

_____ _____ ____/____/_____

Print Patient Name | Patient/Guardian Signature | Date