Clinic Policies

Acknowledgement & Consent

Patient name:_____Date of birth: _____

I acknowledge that all of the information supplied on the patient registration form is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize and request that payments under my insurance plans be made directly to the physician(s) or medical clinic for any services furnished to me: (a) Granting an irrevocable assignment of your patient's right and or my right to reimbursement for covered services rendered ("Covered Services"); and (b) Granting you a power of attorney to submit, negotiate, and appeal that claim in the patient's name.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgment of my doctor may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

I understand that all inactive medical records are destroyed after six years; and that if I want them I need to claim them before six years. I also authorize the release of any information required to process insurance claims including any information relating to drug or alcohol abuse, and AIDS/HIV.

Financial Arrangements:
For your convenience, our clinic participates with most insurance plans. Our list of plans may change periodically. You are responsible for making sure that we are currently participating with your carrier. You are responsible to notify us which diagnostic testing laboratory your insurance is contracted with, otherwise you may be liable for non-contracted laboratory services.

We offer the following methods of payment: Cash, Personal Check, Visa, and MasterCard. If you do not have insurance, we require full payment at the time of service. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance prior to your appointment.

Forms are completed free of charge on or before the day of surgery or during your 30-day post-operative checkup. At any other time, I agree to pay for any letter; note; forms required for a return to work, disability, insurance, DMV, or for legal purposes; that I request to be completed and signed at $50/page and $25 each additional page. I agree to pay a $6.00 rebilling fee for each month that I carry a balance beyond 60 days. I agree to pay $60 for a missed appointment or $600 for a missed surgery if cancelled with less than 16 hours' notice.

Acknowledgment of Receipt of Privacy Notice:
I have been presented with a copy of the clinics "Notice of Privacy Policies", detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I place no additional restriction(s) concerning my personal medical information:_____.
This authorization regarding how my information may be used and disclosed, in order to maintain my privacy, may be revoked in writing by me at any time.

Signed: _____ Date: _____
(If patient is a minor - signature of parent/guardian)