Delo Medical Associates
Board Certified Family Physicians
514 SE Port St. Lucie Blvd.
Port St. Lucie, FL 34984
Office: 772-871-5900
Billing: 772-871-5611

Consent for Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me and for obtaining payment for my health care. I understand the diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this form.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health operations of the practice. Delo Medical Associates is not required to agree to the restrictions that I may request. However, if this practice agrees to a requested restriction, this restriction is binding on Delo Medical Associates.

I have the right to revoke this consent in writing at any time, except to the extent that this practice has taken action in reliance on this consent.

My “protected health information” means health information, including demographic information, collected from me and created by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past present or future physical or mental health condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have the right to review Delo Medical Associates’ Notice of Privacy Practices prior to my signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of charges or in the performance of health care operations at this practice. This Notice of Privacy Practices also describes my rights and the duties of Delo Medical Associates with respect to my protected health information. Delo Medical Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a copy of the revision by calling this office.

Financial Policy

Thanks for choosing Delo Medical Associate as your health care provider. We are committed to providing you with quality care. We require that you read and sign this policy prior to your visit as payment for services is considered part of your treatment.

Your personal information is important and confidential. Our ethics and policies require that this information be held in strictest confidence. We maintain protocols to ensure the security and confidentiality of this information. We have physical security in our building, passwords to protect databases, compliance audits, as well as virus detection software.

Within our practice, access to your information is limited to those employees who require this data for the performance of their duties.

When we are a participating provider for your insurance, we may accept an assignment of insurance benefits, or agree to submit insurance claims on your behalf. Whether your insurance company pays or not, the balance is your responsibility.

This includes any non-covered services, deductibles, co-pays and any other charges not paid by your insurance company.

1. We DO NOT bill for co-pays. All co-pays and charges not covered by insurance are your responsibility and are due and collected PRIOR to seeing our providers. If you arrive without your co-pay due, you may be asked to reschedule your appointment or a $20.00 administrative fee will be added to the original co-pay amount if not received within 5 working days.
2. If you are self-pay, meaning you have no health insurance, you will be required to pay $75.00-$150.00 depending on the type of appointment you have scheduled **PRIOR** to seeing our providers.
3. When you have a balance on your account it will need to be paid **PRIOR** to seeing the providers, except in emergencies or when prior arrangements have been made. In cases where a partial payment is received, it will be applied to the oldest charges first.
4. Labs, procedures and tests which are not urgent will not be performed without payment.
5. Disability, FMLA, and other form completion requests will be processed after a form fee of $25.00 is received.
6. Insurance claims require that you provide us with current, complete and accurate insurance information.
7. Your insurance policy is a contract between you and your insurance company only, and it is not a guarantee of payment to Delo Medical Associates.
8. We file your secondary insurance after Medicare as a courtesy only.
9. If your insurance company has not paid your claim within 60 days, the balance may automatically be your responsibility.
10. Please be aware that some and perhaps all of the services provided may not be considered reasonable or necessary services under Medicare or other Insurance guidelines.
11. We will make every effort to verify your insurance coverage before you see your doctor so you will be aware of the possible charges in advance. However, sometimes the actual coverage may differ from the original information received by our office. **It is ultimately your responsibility to know your coverage.**
12. In cases where we are unable to verify insurance coverage, you will be required to pay in full.
13. When lab work is performed at an outside lab, you will be billed directly from that lab.
14. Payments are due upon receipt of your statement.
15. A returned check fee is $35.00 and our office will only allow 10 days to make payment in full before taking further action.
16. Frequent cancelations and/or no-show appointments will result in a deposit to schedule or termination from our practice.

Appointments

Unless cancelled 24 hours in advance, our policy is to charge a $40.00 fee for a missed appointment.

Delinquent Accounts

A collection fee will be added to delinquent accounts which are referred to a collection agency. The additional collection cost will be at least 30% of the delinquent balance, excluding attorney fees and court fees.

Signature:_____ Date:_____

Printed Name:_____

Patient name if different than signer:_____

Updated
07/01/2023