Family Doc's Clinic

E. James Daros, D.O. Antony Daros, D.O. Kelly Treadway, DNP, RN, AGNP-C

Consent for Payment Policy

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policy, payment is expected at the time services are rendered. Knowledge of insurance deductibles and co-payments are the patient's responsibility. **You will be responsible for your part of the charges at each visit unless arrangements are made in advance. We accept cash, check, American Express, Discover, MasterCard, and Visa for your convenience.** Your signature below indicates that you understand and accept this policy.

X _____ _____

Signature of Patient or Personal Representative **Date**

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Family Doc's Clinic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Family Doc's Clinic**. I understand that diagnosis or treatment of me by **the physicians of Family Doc's Clinic** may be conditioned upon my consent as evidenced by my signature on this document.

I understand 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 healthcare operations of the practice. **Family Doc's Clinic** is not required to agree to the restrictions that I may request. However, if **the physicians of Family Doc's Clinic** agree to a restriction that I request, the restriction is binding on **Family Doc's Clinic** and **the physicians of this clinic.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **my physician** or **Family Doc's Clinic** has taken action in reliance on this consent.

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

I understand I have a right to review **Family Doc's Clinic's** Notice of Privacy Practices prior to signing this document. The **Family Doc's Clinic's** Notice of Privacy Practices has been made available to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of **Family Doc's Clinic**. The Notice of Privacy Practices for **Family Doc's Clinic** is also **located in each patient examination room.** This Notice of Privacy Practices also describes my rights and **Family Doc's Clinic's** duties with respect to my protected health information.

Family Doc's Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

X _____ _____

Signature of Patient or Personal Representative **Date**

_____

Description of Personal Representative's Authority

X _____ _____

Patient Name (PRINT) **Date of Birth**

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Physician Notice to Medicare Beneficiary

Medicare Part B pays only for services that are determined to be reasonable and necessary under section 1862(a)(1) of the Medicare law. If a particular service is not reasonable and necessary under Medicare standards, although it would otherwise be covered, Medicare Part B denies payment for that service. I believe that, in your case, Medicare Part B is likely to deny payment for non-covered services (such as tetanus injections and pneumonia injections if given less than five years apart), as well as Medicare Part B's annual deductible and co-payment's unless you have a secondary supplemental insurance that covers these costs.

Beneficiary Agreement to Pay

- Medicare does not pay for non-covered services.
- Medicare does not pay the annual Part B deductible or co-payments.

I have been notified by my physician that, in my case, Medicare Part B is likely to deny payment for the services identified above. I have read and understand the above statement. I accept liability for those services not paid by Medicare.

X _____ _____

Signature of Beneficiary or Personal Representative **Date**

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Description of Personal Representative's Authority