Virella
NEURO SURGERY
Complex Spine & Brain Specialists

WELCOME

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

PATIENT INFORMATION

Patient's Name _____ Marital Status _____

Date of Birth _____ SS# _____ Sex: ☐M ☐F

Primary Doctor _____ Referring Doctor _____

Patient Address _____

City _____ State _____ Zip _____

Home # _____ Cell # _____

Occupation _____

Employer _____ Employer Phone # _____

Email _____

INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber's Name _____ Subscriber's Birth Date _____

Subscriber's ID # _____ Co-Pay $ _____

Secondary Insurance Company _____

Subscriber's Name _____ Subscriber's Birth Date _____

Subscriber's ID # _____ Co-Pay $ _____

IN CASE OF EMERGENCY

In the event of an emergency, who should we contact?

Name _____ Relationship _____

Home # _____ Work # _____ Cell # _____

The above information is true to the best of my knowledge. I authorize and request my insurance company to pay directly to Dr. Virella insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for my services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature _____ Date _____

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information below to the best of your ability.

Date _____

Patient's Name _____ **Birthdate** _____

Chief Complaint _____

HISTORY OF PRESENT ILLNESS:

Where is the pain/problem? _____

How severe is the pain/problem on a scale of 1-5? *(5 being the most severe, circle one)* 1 2 3 4 5

Does the pain/problem occur at a specific time? _____

What other associated problems have you been having? _____

_____

How long have you had this pain/problem?, or, When did it start? _____

Where were you at the onset of this pain/problem? _____

What makes this pain/problem worse/better?, or, Any previous episodes? _____

PAST MEDICAL HISTORY:

Have you had the following: *(circle "yes" or "no", leave blank if uncertain)*

Measles	no	yes	Anemia	no	yes	Back Trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chicken Pox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray _____			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes			
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	_____		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_____		
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Tranfusions	no	yes	Stroke	no	yes	_____		

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES: When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICATIONS: *(Include nonprescription)*

_____

_____

_____

ALLERGIES:

_____

_____

_____

PATIENT SOCIAL HISTORY:

Marital Status : ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Children: ☐Yes ☐No How Many? _____

Use of Alcohol: ☐Never ☐Rarely ☐Moderate ☐Daily

Use of Caffeine: ☐Never ☐Rarely ☐Moderate ☐Daily

Use of Tobacco: ☐Never ☐Previously, but quit ☐Current packs/day

Use of Drugs: ☐Never Type/Frequency _____

FAMILY MEDICAL HISTORY:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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MEDICAL INFORMATION QUESTIONNAIRE

General Medical Review of Systems

ALLERGIES
- ☐ Asthma
- ☐ Hay Fever
- ☐ Skin Eruption

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ High/Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

CONSTITUTIONAL
- ☐ Chills/Sweats/Fever
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Nervousness
- ☐ Weight Loss

EARS, NOSE, MOUTH & THROAT
- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Earache
- ☐ Ear Discharge
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Nose Bleeds
- ☐ Persistent Cough
- ☐ Ringing in the Ears
- ☐ Sinus Problems

ENDOCRINE
- ☐ Rapid Weight Loss/Gain
- ☐ Multiple Broken Bones
- ☐ Cessation of Menstrual Period
- ☐ Excessive Hunger/Thirst
- ☐ Loss of Libido

EYES
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Double Vision
- ☐ Vision Flashes or Halos

GENITOURINARY
- ☐ Blood in the Urine
- ☐ Lack of Bladder Control
- ☐ Painful Urination

GASTROINTESTINAL
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Poor Appetite
- ☐ Rectal Bleeding
- ☐ Stomach/Abdominal Pain

HEMATOLOGIC/LYMPHATIC
- ☐ Swollen Lymph Nodes
- ☐ Easy Skin Bruising
- ☐ Prolonged Bleeding

INTEGUMENTARY
- ☐ Skin Rashes or Skin Eruptions
- ☐ Chronic Skin Itching

MEN
- ☐ Breast Lump
- ☐ Lump in Testicle
- ☐ Penis Discharge
- ☐ Sore on Penis

MUSCULOSKELETAL
Do you experience **pain, weakness, numbness, or swelling** *in any of the following?*

- ☐ Hands
- ☐ Wrists
- ☐ Hips
- ☐ Knees or Joints
- ☐ Arms or Legs

NEUROLOGICAL
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Numbness

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Panic Attacks
- ☐ Restlessness

RESPIRATORY
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Night Sweats
- ☐ Wheezing

WOMEN
- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse

Last Menstrual Period: _____

Last Pap Smear: _____

Last Mammogram: _____

Are You Pregnant? _____

Number of Children _____

Ages _____

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NOTICE OF PRIVACY PRACTICES

Mina- Practice Manager- (805) 449-0088

Effective Date: _____

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical

information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing.** Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,
   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. **Sale of Health Information.** We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. **Required by Law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities.** We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization.** We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. **Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. **Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate
22. **Psychotherapy Notes.** We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health

oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

23. **Research.** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
24. **Fundraising.** We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and

complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.
After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov
The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

ANTHONY A. VIRELLA, M.D.
DIPLOMATE, AMERICAN BOARD OF NEUROLOGICAL SURGERY

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phone (661) 388-5281
fax (805) 449-0046

Notice of Privacy Practices
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy of Practices. Our Notice of Privacy Practices provides information about how we use and disclose health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our "Notice", you may obtain a copy of the revised " Notice" by contacting our office at (805)449-0088.

If you have any questions about our Privacy Practices, do not hesitate to contact our office.

I acknowledge receipt of the Notice of the Privacy Practices

Patient Name_____ Date of Birth _____

Patient Signature _____ Date _____

Protected Health Information (PHI) Disclosure Record

In general, the HIPPA privacy rules give an individual the right to request a restriction on uses and disclosures of the Protected Health Information (PHI). The individual is also provided the right to request confidential communications of PHI is made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner:

Home Phone _____
Cell Phone _____
Work Phone _____

Notice to Consumers:
Medical doctors are licensed and regulated by the:
Medical Board of California
(800) 633-2322 • mbc.ca.gov

Patient Signature: _____

Would you prefer us to leave a call back number only, or is it ok to leave a message with a call back number? _____

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Payment Policy

It is the policy of our practice to receive payment in full at the time services are rendered unless other arrangements have been made in advance. Please be aware that Dr. Virella is NOT contracted with many providers. **In many instances, you will directly receive a check from your provider for professional services rendered by Dr. Virella (surgical procedures) . It is your legal responsibility to forward ALL such checks to our office staff within 72 hours. Failure to do so may result in legal and collection action and significant civil fines and penalties.**

If you wish our office to bill an insurance company, a copy of the insurance card (front and back) and/or complete billing information is required and must be presented before services are rendered. The billing information required is the correct billing name, address, phone number, the I.D. / subscriber number, and group/policy number. We also need the name of the insured along with the date of birth and name of the employer.

Enrollment in an insurance plan is NOT a guarantee of payment.

Deductibles, co-payments and patient responsibility amounts are due at the time of service.

Our office does not assume responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan before services are rendered. This also applies to any facility or provider your doctor may refer you to. Any portion of the balance not paid by the insurance company due to patient co-pays, deductible amounts, non-covered services, services deemed by the insurance company as not medically necessary, doctor nonparticipation in a plan or any other reason for nonpayment or reduced payment ***is the responsibility of the patient or responsible party.*** It is the policy of this medical group to receive payment in full 30 days from the date of service.

HMO's and other insurance plans that require an authorization for treatment from a Primary Care Physician or other source must send written (or faxed) authorization for treatment to our office prior to services being performed. Self referrals and services provided by out of network providers are usually not covered.

Authorization does not guarantee payment by the insurance company.

A statement of charges will be sent to the patient or responsible party each month showing the portion billed to the insurance company and the patient due balance. Balance is due and payable 30 days from the date of service. Delinquent balances may be referred to an outside agency for collection.

We accept cash, checks, money orders, Visa, MasterCard,, or Discover as your method of payment.
The fee for a returned check is **$35.00.**
I have read the above policy and understand I am financially responsible for all medical services rendered.

Signature of Patient or Responsible Party:_____

Print Name: _____

Date: _____