GENERAL CONSENT FOR TREATMENT

ASSIGNMENT OF BENEFITS **CANCELLATION POLICY AND NO-SHOW CHARGE**

PHOTOGRAPHY RELEASE **FORMS CHARGE**

I acknowledge that by signing this form:

I am giving my general consent for treatment by **Dr. Arora and associates**.

I understand that the practice of medicine and surgery is not an exact science. I understand that no guarantees or promises have been made to me in regards to the results of any procedures or treatments. This may include routine diagnostic, radiology and laboratory procedures and medication distribution.

I authorize my payment directly to **Avery Arora MD PC** for all treatment and treatment-related charges. I understand that I am financially responsible for all charges not covered by my insurance company, third party payor(s), workmen's compensation, and auto claims. I authorize the physician to release information requested by my insurance company and/or payor(s) in order to verify and process any claim.

I am aware that Dr. Arora may obtain photographs of my injury and/or issue for scientific, medical, and/or legal purposes. I authorize use of these photographs in this manner.

I understand that for a successful physician/patient relationship, it is important for me as a patient to return for scheduled appointments and comply with the plan of care. Dr. Arora reserves the right to discontinue treatment in the event of my non-compliance.

I will provide at least 24 hours notice to reschedule or cancel an appointment, otherwise I understand that a charge of **$50** will be assessed to my account.

I understand that completion of paperwork associated with disability, or FMLA, or other involved forms, will incur a **$30** fee, payed in advance. I understand that paperwork processing can take up to 14 business days.

_____
Name of Patient

_____ _____
Signature of Patient, Parent, or Guardian Date

_____ _____
Witness Signature (Employee) Date

PAYMENT POLICY

Thank you for choosing our practice.
This practice is committed to providing you quality healthcare.

1. **INSURANCE:** The Practice participates in most insurance plans. If you are insured by a plan we participate with, but do not have a valid insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **CO-PAYMENTS AND DEDUCTIBLES**: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on the Practice's part to collect co-payments and deductibles from patients could be considered fraud. Please help the Practice in upholding the law by paying your co-payment at each visit. Your health insurance policy is a contract between you and your insurance company. The Practice will send a claim to your health insurance company on your behalf. By working together, the Practice can minimize misunderstandings, payment delays and billing costs. However, you are responsible for any charge not covered by your benefit plan.

3. **NON-COVERED SERVICES**: Please be aware that some and perhaps all of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **PROOF OF INSURANCE**: All patient must complete our patient information from before seeing the doctor. The Practice must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide the Practice with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **CLAIMS SUBMISSION**: The Practice will submit your claims and assist you in any way the Practice reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; the Practice is a party to that contract.

6. **COVERAGE CHANGES**: If your insurance changes, please notify the Practice before your next visit so the Practice can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **NON-PAYMENT**: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account. Please be aware that if a balance remains unpaid, the Practice may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only treat you on an emergency basis.

I have read and understand the payment policy and agree to abide by its guidelines:

_____

Name of Patient

_____ _____

Signature of Patient OR Responsible Party **Date**

Patient Consent and Acknowledgement of Privacy Practices

For the Use and/or Disclosure of Protected Health Information to Carry Out Treatment, Payment, Healthcare Operations

, hereby states that by signing this Consent, I agree and acknowledge the following:

1. The Practice's Privacy Notice has been offered to me prior to my signing this consent. The Privacy notice includes a description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its normal operations. I understand that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encourage me to read the Privacy Notice carefully prior to my signing this Consent. The Practice reserves the right to change its privacy practices that are described in its Practice Notice, in accordance with applicable law.

2. I understand that, and consent to, the following appointment reminders that will be used by the Facility:
   a. A postcard mailed to me at the address provided by me; and/or
   b. Telephoning my home or cell phone and leaving a message on my answering machine or with the individual answering the phone; and/or,
   c. An email appointment reminder at the email address provided by me; and/or,
   d. A text message on my cell phone at the cell phone number provided by me

3. The Practice may use and/or disclose my PHI (which includes information about my health or condition as the treatment provided to me) in order for the Facility to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

4. I understand that I have the right to request that the that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on them.

5. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this consent, in writing, at any time and for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already acted in reliance on this Consent. I understand that if I revoke this Consent at any time, the Practice has the right to refuse treatment to me.

6. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the practice will not treat me.

Disclosure to Friends and/or Family Members:
Do you want to designate a family member or other individual with whom the provider may discuss your medical condition?
If yes, whom?

I give permission for my Protected Health Information to be disclosed for purposes of communicating

Name	Relationship	Phone Number

I have read and understand the forgoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____ _____
Name of Individual (Printed) Signature of Individual Date

_____ _____
Name & Signature of Legal Representative & Relationship (e.g. Attorney, Guardian, Parent if Minor) Date

CENSUS QUESTIONNAIRE

We would like to thank you for taking the time to complete this short questionnaire. Electronic Health Records serve as an important facilitator for collecting patient demographic data.

The 2009 economic stimulus bill and 2010 health system reform bills, both strongly encourage collection of this data.

Due to government initiatives to promote the use of electronic health records and in compliance with government regulations, the *reporting* of patient's racial background is *not* a requirement.

Please complete the following information regarding the patient.

If you are uncomfortable answering the questions, you may select "refuse to report."

Race:

- ◯ African American
- ◯ White
- ◯ Hispanic
- ◯ Asian
- ◯ Hawaiian/Other Pacific islander
- ◯ American Indian or Alaskan Native
- ◯ Other
- ◯ Refuse to report

Language:

- ◯ English
- ◯ Spanish
- ◯ Other

Ethnicity:

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Refuse to Report