PATIENT LABEL

Emed Multispecialty Group

DISCLOSURES AND AUTHORIZATIONS

PLEASE READ AND INITIAL NEXT TO EACH STATEMENT

Patient Consent for Treatment

Initials ___________ I authorize medical evaluation and treatment, and release of information for insurance/medical purposes concerning my illness and treatment. I hereby, authorize payment from my insurance company to *Emed Multispecialty Group* for services rendered. I will be responsible for any amount not covered by my insurance.

Initials ___________ I understand that a facial photograph may be taken at the first visit for identification purposes only and that it will be part of my medical record and will be subject to all protection that other personal health information receives.

Patient Assignment of Benefits Agreement

Initials ___________ I authorize direct remittance of payment of all insurance to *Emed* for all covered services, and I authorize *Emed* to act as my designated representative concerning all aspects of insurance claim filing, including, but not limited to, appeals for services rendered by *Emed*. I understand and agree that my Assignment of Benefits will have continuing effect for as long as I am receiving services from *Emed*. I authorize my insurance company to mail ALL PAYMENTS directly to *Emed Multispecialty Group*.

Initials ___________ I understand that I ultimately have the financial responsibility for the payment of all fees associated with the services provided by *Emed*. I will be responsible for all charges not covered by my insurance and if I receive any payment from my insurance carrier directly for services rendered by *Emed*, I will immediately forward such payment to *Emed*.

Initials ___________ I understand the estimated out-of-pocket expenses are due prior to receiving any services. The *Emed* billing department can be reached directly at (904) 514-3240 during normal business hours Monday – Friday for any billing related questions.

Initials ___________ I understand that I am fully responsible to provide all active insurance plans at each appointment to the front desk. I am responsible to ensure *Emed* and Dr. Rene Pulido is participating with my insurance. I understand if my policy requires referrals and Dr. Rene Pulido is NOT the assigned PCP, I am responsible to ensure *Emed* has an active and valid referral on file for each date of service I seek treatment. I understand if there is not an active referral on file that I may be billed and responsible for any denied claim.

Financial Policy, Past Due Accounts, and Patient Identification

Initials ___________ I understand that as a courtesy to me, *Emed* will file all claims to any participating insurance plan(s) I provide. I understand if any claims are not paid within 90 days from the date of service, the claim will be considered past due. I understand that any claim that is more than 90 days past due, I hereby agree to pay all such charges. I also understand that in the event my account is placed with a collection agency due to nonpayment on my behalf, I will be responsible for all costs of collections, including, but not limited to, any collection fees.

Initials ___________ I understand any deductible, copay, and coinsurance is collected at the time of service. If I have accumulated a past due balance, the balance will be collected in full or by a payment plan with the billing department. I understand that *Emed* only accepts payment in the form of cash, credit/debit, cashier's check, or money order. If I make a credit/debit card dispute with my financial institution, I am aware I will be responsible for a $75.00 administration fee.

Initials
___________ I understand I must have a valid state or government ID to have services rendered at *Emed*. Expired ID will not be accepted. I understand claims will be submitted to my insurance plan with the name listed on the valid ID. For any name changes I will provide an updated valid ID. Parent/guardian of minors must have a copy of their Birth Certificate at their initial visit.

Receipt of Notice of Privacy Practices, Patient Rights and Responsibilities

Initials
___________ I have received and reviewed the attached HIPPA Notice of Privacy Practices, and the Patient Rights and Responsibilities. I understand my rights as stated in these documents. These documents are also visibly displayed at the front desk and available on the Emed website at *www.emedmultispecialtygroup.com*.

Patient Consent for Use and Disclosure of Protected Health Information

This request of your consent will not restrict the normal use or disclosure of your protected health information necessary by *Emed Multispecialty Group* for the purpose of providing treatment, obtaining payment, or supporting the day-to-day health care operations of the clinic.

By signing this disclosure, I consent that the clinic may call my home or cell and leave a message on voicemail or in-person in reference to appointment reminders and insurance and billing items. In addition, the clinic may mail to my home patient statements and any other necessary patient documents and information.

I designate the following individual(s) who the clinic or billing staff can communicate with on my behalf. **If I do not designate anyone, I understand that the clinic or billing staff will be unable to speak with anyone regarding my medical condition or insurance billing.**

Name: ______________________________________ Relationship: ______________________

Name: ______________________________________ Relationship: ______________________

Name: ______________________________________ Relationship: ______________________

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Patient Name (PRINT) Signature Date of Birth Date

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If Minor, Responsible Party Name (PRINT) Signature Date

Authorization for Minor Patients (PATIENTS UNDER 18 YEARS OF AGE)

I authorize the treatment of my minor child, ___________________________________ by *Emed*. I understand that as the parent/guardian presenting this minor for treatment, I am personally financially responsible for payment of the account, regardless of any divorce, custody order or legal arrangements. I authorize *Emed* to act as my agent in helping me obtain payment from this minor's insurance companies. I authorize use of this form on all insurance submissions. I authorize release of information (including the minor's health information and billing information) regarding all services rendered. I understand it is my responsibility to obtain a referral from this minor's primary care physician (if required by the insurance company) and that if payment is not made due to lack of a referral, I am personally financially responsible for payment of the account. I authorize a copy of this authorization to be used in place for the original.

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Name of Responsible Party of Minor (PRINT) Signature Date