MARINA I. PEREDO, M.D., P.C. OFFICE USE: acct #: initial:

NAME: _____ BIRTH DATE: _____

SIGNATURE/INITIAL IS REQUIRED IN ALL FIELDS

PATIENT ACKNOWLEDGEMENTS OF MARINA I. PEREDO, M.D, P.C. OFFICE POLICIES

Insurance Information; Co-payments and Deductibles _____ initial
Payment is required for all services at the time they are rendered. All applicable co-payments, deductibles and previous balances will be collected, prior to services being rendered, at reception. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. There will be a $25.00 fee for all returned checks. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances that are past due. Your initial signifies your understanding and willingness to comply with this policy.

Referral Information _____ initial
If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a valid referral for my visits, Marina I. Peredo, M.D., P.C. will reschedule my appointment.

Insurance Cards _____ initial
All patients must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand that I am responsible for notifying the office of any changes to my insurance or contact information.

Cancellation Policy _____ initial
Should you be unable to keep your appointment, please contact our office to cancel your appointment. Failure to contact the office with at least 24 hours notice will result in a $25.00 fee. This fee is not reimbursable by your insurance company.
***We require at least 72 hours cancellation notice for a cosmetic appointment.

Identification _____ initial
All patients are required to provide our office with a valid form of I.D. **every visit**. If the patient is a child under the age of 18 and does not have I.D., the parent or legal guardian accompanying the patient must provide their I.D.

All patients under the age of 18 must have a **parent or legal guardian** present at every visit to be treated. _____ **initial**

TO ALL PATIENTS-A FULL BODY EXAM IS RECOMMENDED ANNUALLY

It is strongly recommended that you have the Doctor/Physician Assistant/Nurse Practitioner examine your entire skin surface. Even if you have just been to your family physician, it is recommended that your Dermatologist examine your skin, thus extending, but not replacing a complete physical examination by your family physician. If you desire this examination, please tell the receptionist to schedule a full body for your next appointment.

Please note: no other procedures are performed during this type of appointment. **Patient or Parent/Guardian Initial _____**

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

REFERRAL REQUIREMENT: IF YOUR INSURANCE PLAN REQUIRES YOU TO OBTAIN A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN FOR YOU TO USE OUR SPECIALIST PHYSICIAN, YOU MUST BRING US A VALID, UNEXPIRED REFERRAL. WITHOUT SUCH REFERRAL, YOUR INSURANCE COMPANY WILL NOT PERMIT OUR SPECIALISTS TO EXAMINE YOU. IN SUCH CASE, IF YOU WANT AN EXAMINATION, YOU WILL BE CHARGED FOR SUCH SERVICES.

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICARE BENEFITS TO MYSELF OR ON MY BEHALF TO MARINA I. PEREDO, M.D., P.C. FOR PROFESSIONAL SERVICES RENDERED. I AUTHORIZE ASSIGNMENT OF COMMERCIAL INSURANCE CLAIM BENEFITS, OTHERWISE PAYABLE TO ME, TO MARINA I. PEREDO, M.D., P.C. OR THE PHYSICIAN INDICATED ON THE CLAIM.

RELEASE INFORMATION: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED (PATIENT OR PARENT, IF MINOR) _____ **DATE**_____

MARINA I. PEREDO, M.D., P.C.

NAME: _____ BIRTH DATE: _____

Acknowledgment of Receipt of Marina I. Peredo, M.D., P.C. Notice of Patient Privacy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Marina I. Peredo, M.D., P.C. from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name of Individual (please print)	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I acknowledge having received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

_____ _____

Patient Signature **Date**

I permit Marina I. Peredo, M.D., P.C. to disclose my protected health information; for the purposes of appointments/test results/procedure reminders and follow-up; by leaving such information in the form of a message on the following:

Home answering machine: Tel #_____ Cell voice mail: Tel # _____

Office voice mail: Tel #_____ ext_____ Other: _____ Tel #_____