PATIENT RESPONSIBILITY

Having the correct information at all times is very important to us.

Most insurance companies have a timely filing period of 60 days. If we are given inaccurate information and bill the wrong insurance, it could affect the filing time limit with the correct carrier. So please, anytime you have new information, let us know immediately. Please read the following and sign below. Thank you.

I am aware that all the insurance information I have provided First Choice Medical is accurate and up-to-date. I am also aware that I am responsible to follow all the rules and regulations, as well as benefits and restrictions that are implemented by my insurance carrier. If my insurance does not cover my visits for any reason, I am responsible for the payment within 30 days of the denial.

I understand that there will be a billing service charge of $10 for each statement mailed to me. I also understand that if I do not pay the balance in full within 60 days of the statement, First Choice Medical may enter this balance on credit reporting registries, which will likely affect my overall credit rating.

I understand that all cancellations require 24 hours notice. Failure to notify our office as stated will result in a $25 service charge for a regular appointment and a $50 fee if the appointment is for a physical exam.

Print Name: ____ Date: _____________

Patient Signature: ____

First Choice Medical
203 Union Avenue, Holbrook, NY 11741
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: _______________________

OFFICE USE ONLY

I attempted to obtain the patient's (or guardian's) signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason: