MADELEINE C. WEISER MD, PC

Teuta Henci MD   Alisa Hoffman MD

Patient Responsibility Agreement Over 18 HIPAA Release and Consent

Patient Name:____________________________________ DOB:________________________________

Patient's Contact #/Alternate Phone #:____

I understand and acknowledge that as of my 18th birthday, my parents and/or guardians will no longer be permitted access to my medical records, information, providers, or appointment status without my specific written permission. Madeleine C. Weiser MD, PC will not speak with my parents, permit my parents to schedule appointments or provide medical information to my parents unless in accordance with this document.

PRINT THE NAME(S) BELOW OF THOSE WHO MAY ACT ON YOUR BEHALF

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(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

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(PRINT NAME OF PARENT OR GUARDIAN, INDICATE RELATIONSHIP)

I wish to grant my parents and/or guardians access to my healthcare providers and/or medical information as follows:

(You must initial only ONE option)

________I give the above named individual(s) permission to act on my behalf with no limitations. I understand that they may contact any physician or member of the staff at Madeleine C. Weiser MD, PC to schedule appointments, discuss my healthcare and access my medical records. **THEY HAVE NO RESTRICTIONS.**

________I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Madeleine C. Weiser MD, PC to discuss my care and schedule any needed service or appointments. **I DO NOT GRANT ACCESS TO MY MEDICAL RECORDS.**

________I give the above named individual(s) permission to contact and speak with any physician or member of the staff at Madeleine C. Weiser MD, PC for the sole purpose of scheduling an appointment. No access to my medical records or information regarding my care can be discussed or provided. **APPOINTMENT ONLY ACCESS.**

_______I DO NOT GRANT ANY ACCESS TO MY PARENTS OR GUARDIAN. NO MEDICAL INFORMATION, RECORDS OR APPOINTMENT INFORMATION CAN BE RELEASED.

I understand that I can withdraw consent at any time by providing Madeleine C. Weiser MD, PC with a written consent indicating the changes in access.

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PATIENT SIGNATURE   DATE

MADELEINE C. WEISER MD, PC

Teuta Henci MD   Alisa Hoffman MD

FINANCIAL POLICY

Madeleine C. Weiser MD, PC is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. We ask you help by understanding and cooperating with our financial policy as is written below.

INSURANCES:
We participate with several different insurance companies. Please check with your insurance company to see if we participate with your plan. If we DO participate with your insurance company, all services performed in our office will be submitted to them, unless we have received prior notification of non-covered services. **All copays and deductibles are the patient/guardian's responsibility and will be due at the time of service.**

If we do NOT participate with your insurance company, this means that we will not bill your insurance carrier AND we will not accept payment from them as payment in full for the services performed. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement.

It is your responsibility to make sure that you provide us with your current insurance information. We will require you to present your insurance card at every visit. If we do not have current information you may be liable for the balance even if you were covered by insurance at the time of service.

IT IS IMPORTANT FOR YOU TO FULLY UNDERSTAND YOUR INSURANCE COVERAGE AND THIS CONTRACT THAT YOU OR YOUR EMPLOYER HAS WITH THE COMPANY. We must emphasize that as medical providers, our relationship is with your, not your insurance company. It is often necessary for you to inquire and explore your benefits with your insurance carrier. Due to the fact that we do accept a variety of insurances it is not possible for us to know all of your plan provisions. We will be happy to assist you with any questions that you have regarding non-covered services.

BILLING & PAYMENTS:
Our office accepts Visa, MasterCard, Discover, American Express, cash, and check. All payments are expected at the time of service. Any outstanding balances that are incurred as per your insurance company are due within 21 days of your billing statement. IF A SECOND BILL HAS TO BE SENT FOR ANY OVERDUE BALANCES, A $10.00 FEE WILL BE ASSESSED TO YOUR ACCOUNT. Should your account be sent to a collections agency, you will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the delinquent balance. Medical services will not be provided until all outstanding balances are paid in full unless other arrangements have been made with our billing department.

It is our office policy to charge the following fees that are not billed to your insurance.
$20 – Returned Checks (Plus the full amount of the original check) $5 – Completed and Signed Medical Form
$35 – Sunday/Holiday Office Visits (In addition to your copay) $20 – Driver's License Physical
$20 – Appointments missed without 24 hour cancellation notice $35 – Ear Piercing

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY MADELEINE C. WEISER MD, PC AND I AGREE TO THE TERMS OF THE FINANCIAL POLICY.

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Signature of Patient/Guardian   Date