reena r. patel md, inc

CONSENT TO TREAT

- **CONSENT TO TREAT:** I hereby consent to the administration and performance of any and all diagnostic procedures and treatments, which in the judgment of my physician may be considered necessary or advisable.

- **RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:** I authorize the release of any medical information necessary (including but not limited to the release of information regarding sexually transmitted diseases, mental health, and substance abuse) to process a claim and hereby assign benefits payable to Reena R Patel MD INC, in the event of another health insurance becoming primary over your health. To further provide continuity of care, I authorize the release of medical information to specialty physicians who maybe involved and/or advise in your care. Furthermore, any services not covered by my insurance, will become my responsibility for full payment of services rendered by Reena R Patel MD INC.

- I authorize my insurance benefits to be paid directly to **Reena R Patel MD INC**, and I accept financial responsibility for any co-insurance due and any non-covered benefits.

- I also authorize **Dr. Reena R. Patel** to release any information required in claims processing.

HIPAA ACKNOWLEDGMENT OF PATIENT PRIVACY

- REENA R PATEL MD INC is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). During the course of your treatment, we may be required to share information with other medical providers for the benefit of your care. This is all within the regulations set by the Federal and State laws regarding PHI. Your information is only released with your written consent to do so and can be revoked at any time by you as provided by law. If you have any questions regarding this consent, please fell free to ask our staff members. We can provide you with a copy of our "notice of Privacy Practices" at your request, which states how we may use and/or disclose your health information.

- By signing this form to acknowledge that you have had your questions regarding our privacy practices answered. You may refuse to sign this acknowledgement, if you wish.

- By signing, I acknowledge that I have had the opportunity to request a copy of this office's Notice of Privacy Practices

- This form does not constitute legal advice and covers only federal, not state, law.

- Copies of HIPAA and Office Policies are available on website: www.ReenaMD.com

EMAIL/TEXT/TELEHEALTH CONTRACT

- To stay as Green as possible, Dr. Patel will be primarily be sending information that may contain protected, privileged, and highly confidential medical, Personal and Health Information (PHI), which may include labs/imaging/handouts, and or legal information via email. **Please understand that this information may not be entirely secure.** The information transmitted is the property of Dr. Reena R. Patel and is intended only for the use of the individual or entity to which it is addressed as it may contain confidential and/or privileged material. Any review, transmission, discussion, dissemination or other use of, or taking any action in reliance upon, the information sent by persons or entities other than the intended recipient(s) is prohibited. If you receive the information in error, please contact the sender at office@ReenaMD.com or call 626-765-7852 immediately and **confidentially** destroy and/or delete the information that was sent in error.

- At any time, you may notify Dr. Patel if you do not want or if there is certain information that you would prefer not to be sent via email.

- Recommend primarily using your patient portal via EMR Patient Fusion for more secure communication.

AFFIRMATION PAGE

- *Your signature in the box below indicates that the information you have entered in the documents listed below are true to the best of your knowledge.*

  * PATIENT DEMOGRAPHICS
  * MEDICAL HISTORY

- Payment Policy -

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, my staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered, including monthly/annual payments per your DPC membership plan. You are financially responsible for all treatments or procedures. We accept most major credit cards, check, and ACH (preferred) payments. If 30 days pass without payment, a warning notice is issued. With 60 days without payment, the membership is terminated without option to renew. **Please note: A 2% service fee will also be charged for any Credit Card or Debit Card transactions.** If payment is not made by either you or your insurance within 120 days, all upaid balances will be turned over to a collection agency. You will be responsibel for all collection costs, including court, attorney, collection fees, and interest fees.

24 hour CANCELLATION or RESCHEDULE Notice

- Our practice values our patients and specifically reserves an appointment time for you to address your questions and concerns. Because of this, we ask that you notify our office 24 hours in advance to reschedule or cancel your appointment.

- Medicare -

- ***For Medicare patients only****, your signature in the box below also authorizes the payment of Medicare benefits to be made on your behalf and gives the office of Dr. Reena R. Patel authorization to release any information to CMS required to process your claims. You also acknowledge that you maybe responsible for payment of any co-insurance or any servcies not covered by Medicare.*

PLEASE COMPLETE THE INFORMATION BELOW

The Office Documents listed above were completed by:

☐ Patient ☐ Parent / Guardian ☐Caregiver ☐ Staff ☐ Other: _____

This Affirmation Page will be signed by:

☐ Patient ☐ Parent / Guardian ☐Caregiver ☐ Staff ☐ Other: _____

X_____ _____

Signature Date

- Please check ☐ if you have reviewed and agree to the terms of the HIPAA Policies
- Please check ☐ if you have reviewed and agree to the terms of the Office Policies.
- Please check ☐ if you have reviewed and agree to the terms of the Email Contract.

Your signature below signifies your understanding and willingness to comply with the all above policies, and also gives the office of Dr. Reena R. Patel authorization to release any information required to process Medicare claims.

Patient Signature/Guardian: _____ Date: _____

Person filling out this form: _____ Relationship to patient: _____