

**PATIENT REGISTRATION DISCLOSURE FORM**

**Financial Policy**

**Your Insurance**

All services are to be paid at the time services are rendered under the terms of your policy. This office extends 30 days to file your insurance as a courtesy for those contracts in which we participate. Balance for services rendered are due 45 days from the date of services. We are sorry we do not file secondary insurances.

We make every effort to follow the guidelines required by your insurance company. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

You may receive a separate bill from an off-site laboratory (Quest or LabCorp, etc.) for any lab tests your physician may order. Please discuss any lab billing discrepancies with that laboratory.

**If I am covered by an HMO, I understand that I will be responsible for 100% of charges incurred if I have not selected Dr. Kaplan as my Primary Care Physician.**

**Appointment Policy**

Patients arriving 10 minutes or more after their scheduled well visit appointment will be asked to reschedule. We acknowledge that your time is valuable and have adopted this policy in an effort to better service our other well and sick children in a timely manner.

**\*\* THERE WILL BE A \$50.00 CHARGE TO ANY PATIENT THAT NO SHOWS FOR AN APPOINTMENT. PATIENTS WILL BE DISCHARGED BY THE PRACTICE AFTER 3 NO SHOW APPOINTMENTS. \*\***

**Consent to Treat**

I give permission to the physician and whomever he may designate as his assistant(s) / (associate(s) to administer such treatment as is deemed necessary, and to perform any medical care or procedures as are considered therapeutically necessary based on findings during examination or treatment.

One copy of on site medical records will be available at no charge. Additional copies will be available for a processing fee of \$50.00. Off site medical records are available at a cost of \$50.00 and off site shot records are available at a cost of \$5.00.

**Authorization to Release Information**

I authorize release of any information concerning my (or my child's) health care, advice and treatment, provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

**I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.**

**Date:** \_\_\_\_\_

**Authorized Person's Signature:** \_\_\_\_\_