

Jeffrey E. Goldberg, M.D., P.C.
4245 Johns Creek Parkway, Suite D Suwanee, GA 30024
OFFICE (770) 495-3820 FAX (770) 495-3825

DATE _____

PATIENT REGISTRATION FORM
PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

PATIENT'S LEGAL NAME _____ DOB _____ SEX _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT'S NAME (if pediatric patient) _____

PRIMARY CARE PHYSICIAN _____

REFERRED BY: PRIMARY CARE PHYSICIAN FRIEND (name) _____

PRIMARY INSURANCE/ RESPONSIBLE PARTY (information regarding **adult** responsible for payment)

CARRIER _____ ID# _____ GROUP # _____

INSURED (ADULT) NAME _____ DOB _____

INSURED SS# _____ RELATION TO PATIENT _____

ADDRESS (IF DIFFERENT) _____

EMPLOYER _____ WORK PHONE _____

SECONDARY INSURANCE

CARRIER _____ ID# _____ GROUP # _____

INSURED NAME _____ DOB _____

INSURED SS# _____ RELATION TO PATIENT _____

ADDRESS (IF DIFFERENT) _____

EMPLOYER _____ WORK PHONE _____

EMERGENCY INFORMATION

CONTACT NAME _____ RELATION TO PATIENT _____

PHONE NUMBERS _____

ADDRESS (IF KNOWN) _____

CONSENT TO RELEASE MEDICAL INFORMATION

I hereby consent to the release of medical information to any insurance carrier, other treating physician office, or other party that I may direct by the staff of Jeffrey E. Goldberg, M.D., P.C. I further direct that all payments from insurance carriers be assigned and sent to Jeffrey E. Goldberg, M.D., P.C. for services rendered.

CONSENT TO MEDICAL TREATMENT

I hereby consent to the medical treatment for the above mentioned patient by the medical staff of Jeffrey E. Goldberg, M.D., P.C. I further state that I am duly authorized under law to consent to the medical treatment obtained.

AUTHORIZED SIGNATURE _____ DATE _____

PRINT NAME _____

Jeffrey E. Goldberg, M.D., P.C.
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Answering all questions on this form as completely as possible will help to avoid any delay at your scheduled visit.

Name: _____ Date of Birth: ____/____/____ Appt Date: ____/____/____

What problem(s) would you like to address at your appointment with Dr. Goldberg?

Medication Allergies:

No known drug allergies

<input type="checkbox"/> Allergic to:	Drug Name	Reaction	Date
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____

Food and Environmental Allergies:

No Previous Allergy Testing

Negative environmental allergy testing by Dr. _____ Date: _____

Allergic to: Food _____ Reaction _____ Date _____

Allergic to: Dust, Mold, Pollen _____ Reaction _____ Date _____

Allergic to: Other _____ Reaction _____ Date _____

Medications Taken Daily or As Needed (prescription, over the counter, herbal, vitamins) Use additional sheet if needed

Name of Drug	Dosage	Taken How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the patient taken any of the following medications in the last 14 days?

1. Aspirin NO / YES Date and amount of last dose: _____

2. Ibuprofen/Advil/Motrin NO / YES Date and amount of last dose: _____

Pediatric Patients (Please Circle)

1. Is your child exposed to tobacco smoke? YES NO

2. Is your child in day care/afterschool/mother's morning out? YES NO

3. Is your child's immunization up to date? YES NO

4. Birth History: _____

(Please Circle) **Adult Patients**

1. Do you smoke or chew tobacco? YES NO Number of packs per day _____

2. Alcohol Intake? YES NO How Often _____

3. Recreational drug use? YES NO How Often _____

Name: _____ Date of Birth: ____/____/____ Appt Date: ____/____/____

Weight: _____ Height: _____

Does the patient or any relative have any of the following medical problems or chronic illnesses?

Patient has complained of: (Please circle or highlight the symptom)		Family Member Has:	
No	Loss of peripheral vision/Double vision/Vision loss/Glaucoma	Eyes	Glaucoma / Other Who:
No	Hearing loss/Ear pain/Vertigo/Ringing in the ear/ Nasal congestion or obstruction/Sinusitis/Allergies Other:	ENT	Hearing Loss/Ear Infections/ Allergies Who:
No	Sore throat/Snoring/ Sleep Apnea / Halitosis/Dentures/ Cancer Other:	Mouth/ Throat	Sleep Apnea, Cancer Who:
No	Swelling of hands-feet/Heart murmur/ Arrhythmia fainting/Heart attack/Angina/VSD/ASD/ Hypertension	Heart	Heart murmur/Heart attack/ VSD/ASD Arrhythmia Who:
No	Coughing phlegm or blood/ Dry cough/ Asthma/ Wheezing / Shortness of breath/ Emphysema/ Tuberculosis	Respiratory	Emphysema / Asthma / Tuberculosis/Cancer Who:
No	Indigestion/Heartburn/GERD /Blood in stool / Diarrhea/ Constipation /Abdominal pain	Gastrointestinal	Cancer Who:
No	Frequent or involuntary urination / Painful urination/Blood in urine / Hepatitis	Genitourinary Tract & Liver	Liver Cancer / Bladder/ Kidney Cancer Who:
No	Unexplained weight loss/ Loss of appetite/ Night sweats / Fever /Chills	Constitutional	
No	Headaches/Loss of coordination/ Seizure/ Paralysis/ Stroke/ Numbness or tingling	Neurological	Stroke / Seizure / Headaches Who:
No	Depression/Anxiety	Psychiatric	Mental Illness Who:
No	Heat-cold intolerance/Hair loss / Excessive thirst/Skin texture change/Diabetes / Thyroid Other:	Endocrine	Diabetes / Thyroid problems /Cancer Other: Who:
No	Bleed excessively / Easy bruising / Anemia / Swollen lymph nodes/ Lymphoma/ Leukemia	Hematologic or Lymphatic	Bleeding Disorder / Cancer Who:
No	Arthritis / allergy injections / HIV / AIDS	Allergy/Immune	Arthritis Who:

Please list any other serious illnesses or symptoms not mentioned above: _____

Please list any surgeries requiring general anesthesia (being put to sleep):

_____ Age: _____
 _____ Age: _____
 _____ Age: _____
 _____ Age: _____

Reviewed and accepted into Patient History by _____ Date: _____

**JEFFREY E GOLDBERG, MD , PC
CHILDREN'S ENT ASSOCIATES
FAMILY ENT SERVICES**

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

**Nikki Lee
4245 Johns Creek Parkway, Suite D
Suwanee, GA 30024
770-495-3820**

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice –

including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or

other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For

instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Nikki Lee** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IHI, you must make your request in writing to **Nikki Lee**. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Tracy P. Beatty** in order to inspect and/or obtain a copy of your IHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Tracy P. Beatty**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IHI kept by or for the practice; (c) not part of the IHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IHI for non-treatment or operations purposes. Use of your IHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Tracy P. Beatty**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Tracy P. Beatty 770-495-3820**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Tracy P. Beatty 770-495-3820**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Nikki Lee 770-495-3820**.

Jeffrey E. Goldberg, M.D., P.C.
4245 John's Creek Parkway
Suite D
Suwanee, GA 30024

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received Notice of Privacy

Practices from Jeffrey E. Goldberg, M.D., P.C.

Patient's Name

Date

Signature of Patient/Parent/Guardian

Jeffrey E. Goldberg, M.D., P.C.
4245 Johns Creek Parkway, Suite D
Suwanee, GA 30024
OFFICE (770) 495-3820 FAX (770) 495-3825

OFFICE PROCEDURE CONSENT

Please be aware that when a patient requires a visit to a specialist, there are diagnostic procedures required to diagnosis and evaluate for treatment that cannot be done by a pediatrician or family physician. These procedures may be done during the normal course of the exam by the specialist. Your insurance company and our billing may call these procedures by slightly different names, but they are determined by the procedure codes. The possible procedures you or your child may expect based upon the presenting complaints and/or findings during the exam are listed below, but are not limited to:

92504 - Binocular Microscopy (Microscope guidance) / 69210 - Cerumen Removal (ear wax) / 69200 - Foreign Body Removal (ear) / 30300 - Foreign Body Removal (not ear) / 31575 - Laryngoscopy / 31231 - Nasal Endoscopy / 30901 - Nasal Hemorrhage Control (nose bleed) / 92511 - Nasopharyngoscopy with endoscope / 92542 - Positional Nystagmus Test / 92541 - Spontaneous Nystagmus Test / 92567 - Tympanometry / 95992 - Canalith repositioning / 92557 - Comprehensive Hearing Test / 92582 - Play Audiometry / 92579 - VRA

Depending on your insurance policy, these procedures and others may fall under a separate benefit other than your office copay, such as a deductible or coinsurance. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim; therefore, any quote for services will be considered an estimate only and any payment will be considered a partial payment only until such time that the insurance company processes your claims. Your insurance is a contract between you and your insurance carrier; payment for services is ultimately your responsibility. It is extremely important for you to know your coverage.

FIBEROPTIC ENDOSCOPY

Dr. Goldberg may look in your/your child's nose and throat with a fiber optic endoscope to determine if you/your child have significant nasal, sinus, or throat problems. (Codes 92511, 31231, 31575, 31579).

Dr. Goldberg is looking for abnormal problems of the nose, sinuses or throat. The nature of these areas is not clearly visible without the use of these endoscopes. Endoscopes assist Dr. Goldberg to accurately evaluate, diagnose and treat the symptoms you/your child is experiencing. Refusal to undergo endoscopy could undermine the ability to diagnose a serious or life-threatening problem, or to initiate appropriate treatment.

The nose is first sprayed with Afrin - a topical decongestant that will shrink down the nasal membranes, and with Pontocaine - a numbing medicine. The nasal spray has a bitter taste. The throat will also feel numb for about 30 -45 minutes. Also Cetacaine may be sprayed into the mouth for additional throat numbing. Possible side effects from the procedure include mild nasal bleeding, sneezing, and coughing. The procedure is usually quick; you/your child will feel the endoscope, but pain is rare. Please notify Dr. Goldberg if you/your child feel pain or discomfort.

Please notify the nursing staff and Dr. Goldberg if you/your child have an allergy to the medications used for this procedure before the nose or mouth is sprayed.

Your nurse and Dr. Goldberg will answer any questions you/your child may have about the procedures and you may sign the consent form at that time to accept or refuse the procedure(s)

I { } accept OR I { } refuse **this/these procedures.**

Signing this consent to have an endoscopy procedure will allow Dr. Goldberg to perform these procedures for today's office visit and for future office visits as well. Consent may revoke at any time.

Patient/Guardian Signature

Date

Witness Signature

Date

Jeffrey E. Goldberg, M.D., P.C.
4245 Johns Creek Parkway, Suite D
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Your insurance benefits are a contract between you, your insurance carrier and (if applicable) your employer. We ARE NOT a party to that contract. As such, we file claims only as a courtesy to our patients, so that you do not have to pay up front for all services and file the claims for reimbursement. Payment is required from your insurance carrier within 90 days...if a claim remains unpaid after that period of time it becomes your responsibility. It is imperative that you familiarize yourself with your health benefits. All plans and contracts are different, and many have restrictions or special requirements for attaining benefits on certain services. If you have questions regarding your plan, please consult your benefits package or contact your insurance carrier. Ultimately ALL charges are your responsibility for any services rendered by your doctor.

RESPONSIBLE PARTY ACKNOWLEDGEMENT (Please Initial on each line)

_____ It is the policy of Jeffrey E. Goldberg, MD, PC (JEGMDPC) that patients or their legal guardians are responsible for obtaining any referrals required by insurance plans. Our office **WILL NOT** call to obtain referrals from the referring physician. If we do not have an active referral for a visit and one is required by your insurance plan, you may be asked to reschedule your appointment. If you are seen and your insurance company denies the claim, you are responsible for payment.

_____ Proof of valid insurance for all patients must be available to JEGMDPC at each visit. If acceptable proof of insurance can not be provided, you will be responsible for all charges at the time of the visit or at anytime thereafter. You are responsible for all charges if seen by JEGMDPC and we are not contracted with your insurance plan; insurance coverage is not available at the time of the visit; current or correct insurance information is not provided. If incorrect insurance information is provided and a claim has to be re-filed there will be a \$35.00 fee.

_____ Appointments not cancelled or rescheduled at least 24 hours in advance are subject to a "No Show" fee of \$25.00. I understand that this charge is not covered by insurance, and agree to pay it in full upon demand.

_____ The nature of our specialty requires that we work by appointments. There is a \$20.00 convenience fee in addition to your copay for walk in appointments. You may be directed to an urgent care facility or emergency room if we are unable to see you.

_____ Patients arriving later than 15 minutes after the scheduled appointment time will have the option to reschedule or wait for the next available appointment that day. Please be courteous and notify us as soon as possible if you will not be keeping your appointment, so that we may offer the appointment time to other patients.

_____ Co-pays are due at the time of service. If you do not have your co-pay at the time of service, we will bill you for your copay in addition to a \$15.00 administrative fee. If someone other than the parent or guardian is bringing a minor (child) to the visit, a notice stating approval of the visit must be signed by the parent/guardian and presented at check in.

_____ It is your responsibility to know which facilities your insurance company contracts with for lab and radiology services. Each insurance company contracts with different companies.

_____ It is your responsibility to contact your insurance company and find out whether or not JEGMDPC is participating within your particular insurance plan. Some insurance carriers have a PPO, HMO, POS, or indemnity status, and it is very possible that JEGMDPC may participate in only one of these areas, not in all. Certain services and procedures including office endoscopy, audiological testing and minor surgical procedures may not be covered by an office copay depending on your specific insurance policy. The following circumstances may result in your being billed directly: 1. Insurance coverage is not in effect at the time of service. 2. Non - covered lab work is ordered. 3. A non - covered service is performed or denied for the reason "not medically necessary". 4. Treatment received is subject deductible or co-insurance benefits.

_____ In the event my account becomes delinquent and is referred to a third party for collection effort, I agree to pay all collection expenses, court costs and attorney's fees in addition to the primary amount owed to the practice.

_____ Concerning "divorce" or "custody" arrangements, JEGMDPC regards the adult party who brings the patient to our office for appointments to be the responsible guarantor for that patient's account in all cases and without exception.

_____ I understand the Privacy Practices in place at JEGMDPC and will be provided a copy of notice upon request.

I have read and understand the above mentioned policies, procedures and notices.

Patient Name: _____

Signature of Responsible Party: _____ **Date:** _____