North Naples Internal Medicine
Michael S. Shahla, M.D.
Board Certified in Internal Medicine

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of North Naples Internal Medicine, LLC **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice.

SIGNIATURE:_____ DATE:_____
*This contract is **active until written notice** of your revocation **is received***

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship**:** _____Witnesses by**:**_____

TO DESIGNATE A SPOKESPERSON

Our policy is to speak about the patients' condition to the patient only, and only in person. If you wish to designate one spokesperson that is authorized to speak for you in the event of your indisposition or need for translation, you must indicate your preference in writing.

Spokesperson_____

Relationship_____

Telephone #_____

TELEPHONE/ANSWERING MACHINES

May we call you to remind you of upcoming appointments, surgery date and time, and yearly recalls? If you have an answering machine at home, may we leave a message?

YES_____ (initial) NO_____ (initial)

For internal use only:

Office personnel who witnessed signature:

_____ Date _____

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FINANCIAL POLICY

1. Insurance is a contract between you and your insurance company. We are not a party to this contract, in most cases. We will inform you if we are a party to your insurance, and will handle claims in accordance with our agreement, if one exists. We file insurance claims as a **courtesy**. We will not become involved in a dispute between you and your insurance company regarding **deductibles, co-payments, secondary insurance, usual and customary charges, etc.,** other than to supply factual information as necessary.

2. You are responsible for timely payment of your account. All deductibles, co-payments, and co-insurance are due at time of visit. If a balance remains after 30 days we retain the right to recover this amount as soon as possible. Accounts over 120 days past due will be turned over to a collection agency regardless of insurance coverage.

3. If the bank, for insufficient funds, returns any patient check, we reserve the right to add a penalty charge to that patient's account. The current charge for any returned check is $25.00.

4. If your insurance company pays you directly, you are obligated to forward reimbursement check to this office. If not forwarded within 7 days you will be held accountable not for insurance allowance, but for the entire amount billed.

5. On **each** visit to our office, please **bring your insurance cards with you**. Since insurance information changes so frequently, it is very difficult for us to stay current with these changes. By bringing your card each time, it ensures that all paperwork is correct and reduces errors in billing to both you and the insurance carrier.

6. **At the end of your visit you will be expected to pay your co-payment/co-insurance and or deductible. Payment will be accepted as cash, check, or credit card/debit card.** If we do not receive your co-payment at the time of service, we will not be able to accommodate you with your next appointment until your account balance is paid in full.

SIGNATURE: _____ DATE: _____

ASSIGNMENT OF BENEFITS

I allow a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or North Naples Internal Medicine, LLC. Regulations pertaining to medical assignment of benefits apply. Also I declare that I have listed all the medical and/or health insurance plans for which I may receive benefits.

SIGNATURE: _____ DATE: _____