Insurance and Payment Policy Information for John R. Gilmore, M.D.

We are committed to providing you with the best possible care. If you have medical insurance, we will be happy to file your insurance for you and help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment is due at the time services are rendered. We accept cash, checks, money orders,Visa, Mastercard and Discover.

We will glady discuss your proposed treatment and answer any questions relating to your insurance. We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. Not all services are a covered benefit. We are a Medicare provider. This means that we have a contract with Medicare to accept their fee schedule for reimbursement for services rendered. You are responsible for any deductible portion not me tand any co-insurance amounts. Supplies are not a covered benefit and will be due at the time of service.

We realize that financial hardship may affect timely payment of your account. Please contact us promptly for assistance in the management of your account if you need payment arrangements. We turn all accounts over 90 days past due to our Collection Service. In the event that your account is turned over to the Collection Service, you will be responsible for the commission percentage that is charged to us.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

Appointment Cancellation Policy:

Patients will be charged a $25.00 cancellation fee for not canceling an appointment within 24 hours of their scheduled appointment. Patients will be dropped from the practice if this becomes a perpetual problem.

I understand and agree that I am responsible for the balance on my account. I understand that there will be an interest charge on accounts more than 30 days past due and agree to pay this interest at a rate of 24% annual rate.

I authorize the release of any medical or other information necessary to process my claim.

By my signature below, I declare that this is the only insurance I have. I will notify you immediately if there are any changes in my insurance. Failing to alert this medical office may result in my responsibility to pay for any and all medical services. (Por medio de mi firma hago constar que no tengo otra aseguranza ademas de esta. En el caso de obtener otra aseguranza, prometo avisarles de inmediato. Ademas prometo avisarles de cualquier cambio en mi aseguranza. Estoy consciente de que si falto en avisarles pudiera ser responsible por todos los cargos en mi cuenta.)

_____ _____

Patient's Signature/Firma del paciente Date/Fecha

_____ _____

Parent's Signature/Firma del paciente Date/Fecha

JOHN R. GILMORE, M.D.

HIPAA/PATIENT CONSENT FORM

Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Name _____

Date of Birth _____ Social Security # _____

I understand that as part of my healthcare, Dr. Gilmore originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Dr. Gilmore's Notice *of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that the Dr. Gilmore reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the Dr. Gilmore is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that Dr. Gilmore has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed Dr. Gilmore's *Notice of Privacy Practices* dated April 14, 2003.

_____ _____

Signature of Patient or Legal Representative, Date Witness, Date

_____ _____

Print Name of Patient or Legal Representative Print Name of Witness

*I request that changes to the *Notice of Privacy Practices* be sent to me at this address: _____

_____

Office Use Only:

□ Accepted
□ Denied _____ _____ _____

Signature Title Date

JOHN R. GILMORE, M.D.

Patient Preference Regarding Communication of Health Information

Patient Name: _____ Patient Identifier #: _____

I. Who to Contact

I hereby grant permission to **Dr. John R. Gilmore** to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

II. How to Contact- We do not respond by E-Mail. This is not HIPAA compliant.

I wish to be contacted in the following manner:

Telephone:

Home/Work/Cell Telephone: ____ OK to leave a message with detailed information
(Please circle) ____ OK to leave message with call back number on

Written Communication:

____ OK to mail to my home address _____

____ OK to mail to my work/office address _____

____ OK to Fax to this number _____

The duration of the authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____
Signature of Patient or Legal Representative Date

_____
Witness Signature

_____ **I DO NOT WISH TO GIVE PERMISSION FOR FAMILY MEMBERS, RELATIVES OR CLOSE PERSONAL FRIENDS TO HAVE ACCESS TO ANY INFORMATION REGARDING MY MEDICAL CONDITION.**

_____ _____
Signature of Patient or Legal Representative Date

_____
Witness Signature