Michael Aguilar, M.D.
GENERAL SURGEON

FINANCIAL POLICY

Thank you for choosing Michael Aguilar, M.D. as your General Surgeon. Our goals are to provide you with excellent surgical care, minimize your out of pocket expenses, and make paying your balance as easy as possible. Our office is dedicated to informing you, to the best of our ability, of your estimated portion of the charges for your care and assisting you with any billing questions you may have.

To show your understanding and agreement with the info below, please read and initial each statement.

_____ INSURANCE: For the convenience of the patient, we will file medical claims with insurance plans with which we have an agreement as long as valid insurance information is provided to us. It is the responsibility of the patient to make accurate and detailed insurance information available to us to enable processing of his or her insurance claim. The patient is to be considered self-pay until this information is provided to us.

_____ The patient is responsible for notifying our office of any insurance changes prior to scheduled appointments. Insurance policies are an agreement between the patient and his or her insurance company. All account balances are the responsibility of the patient. Payment is due from the patient upon receipt of the first statement from our finance department.

_____ The patient is expected to know his or her insurance benefits to include deductible and co-payments. Co-payments are to be paid at the time of service. If the patient does not have medical insurance, or if Michael Aguilar, M.D. is not participating with his or her insurance carrier, all charges incurred during treatment are due and payable at the time of service.

_____ ALL CHECKS RETURNED FOR NON-SUFFICIENT FUNDS WILL BE ASSESSED A $25.00 CHARGE.

_____ CANCELLATIONS/FEES: If the patient is unable to keep a scheduled appointment or procedure, it is his or her responsibility to notify our office at least 24-hours prior to the scheduled appointment, or 48-hours prior to the scheduled procedure. Appointments cancelled after this time frame may be subject to a cancellation fee of $50.00 for appointments and $100.00 for procedures. Additional fees may also be applied to requests for medical records and completing paperwork for patients (i.e. Disability, FMLA forms). These fees are not covered by insurance, and the patient accepts full financial responsibility for all additional fees.

_____ RELEASE OF INFORMATION: I hereby authorize Michael Aguilar, M.D. to release information to my insurance company with regard to all treatment as is necessary to obtain payment for their services and to review activity related to the provider's participation with my insurance plan. I assign all benefits, to which the patient or insured is entitled for my treatment and medical services provided to me, to be paid directly to Michael Aguilar, M.D. I accept financial responsibility for any and all charges incurred by me that are denied or not covered by my medical insurance. I acknowledge I am bound to pay for services rendered, including all costs of collection and reasonable legal fees should collection become necessary. I have read and understand this Financial Policy, and by signing, I am in agreement and accept all terms and conditions described above.

_____ _____

Patient/Guardian Signature Date

79 Scripps Drive ▲ Suite 202 ▲ Sacramento, CA 95825 ▲ 916-923-3100

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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. ACKNOWLEDGEMENT OF PRACTICE'S *NOTICE OF PRIVACY PRACTICES*:
By subscribing my name below. I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____ _____ _____

Name of Patient | Date of Birth | Signature of Patient/Parent/Guardian Date

II. DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:
I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care in that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _____ Phone #: _____

Print Name: _____ Phone #: _____

Print Name: _____ Phone #: _____

III. REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

HOME TELEPHONE NUMBER:

_____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

WORK TELEPHONE NUMBER:

_____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

OTHER: _____

WRITTEN COMMUNICATION ADDRESS:

_____

____ OK to mail to address listed above

____ E-mail me at _____

FAX COMMUNICATION:

_____

____ OK to fax at the number listed above

____ E-mail me at _____

_____

_____ _____ _____

Name of Patient (Print) | Signature | Date