Patient Disclosure

Hoffman and Associates OB/GYN

Patient Name: _____ Date: _____

Reason for Today's Visit

____ Routine Preventive Exam (I have no medical complaint or significant problem or abnormality that I am aware of).

____ I have a problem/complaint that I wish to have evaluated and/or treated by the doctor. My chief complaint is: _____.

____ My insurance plan covers Preventive Medical Services.

____ My insurance plan does not cover Preventive Medical Services.

____ I do not know if my insurance plan covers Preventive Medical Services.

I agree to pay for any and all medical services I receive from the Doctors/Providers of this Practice that my insurance company refuses to pay (for whatever reason). This office will file a claim on my behalf. However, if my insurance company refuses to pay, for whatever reason (e.g. non-covered service, does not pay for preventive medical visits, my failure to secure a referral from my primary care physician) I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is for the purpose of this agreement, a refusal to pay.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented on my medical record. To ask this office to change a diagnosis solely for the purpose of securing reimbursement from the insurance carrier is inappropriate and may result in a fraudulent act.

In the event I do not pay for these or any other services provided me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether nor not a lawsuit is commenced as part of the collection process.

By: _____ Witness: _____

Patient (or responsible party, if a minor)

This Disclosure /Agreement form is provided with the understanding that the publisher is not engaged in rendering legal or accounting advice.

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