A.K. M.D.

www.angelakeen.com

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES FOR ANGELA KEEN M.D.

I acknowledge that a copy of the HIPAA Notice of Privacy Practices policy for Angela Keen MD has been made available to me to read. I understand that I may request a paper copy of the Notice of Privacy Practices for my own records at any time.

Patient's Name: _____

Patient's Signature: _____

Date: _____

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Financial Policy

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy, which we ask that you read and sign prior to any treatment.

Preferred Provider Insurance Plans
We contract with certain managed health care plans. With these contracts we agree to accept the allowable fees for our services. In general, there are co-payments, which are your responsibility. Co-payments are due at the time of office visits and prior to surgery. If we accept assignment of your insurance benefits and you have paid appropriate co-payments, you will have no outstanding balance after your insurance has paid. Should your insurance company deny payment or you become ineligible for benefits, responsibility will transfer to you.

Non-preferred Provider Plans
There are health care plans for which we are not a contracted provider. With these plans we will assist you by filing claims directly to your insurance company. You are responsible for paying your deductible, co-payment, and any amount above that which your insurance company reimburses. We require payment of estimated co-payment prior to surgery.

Cosmetic Surgery
Health care insurance does not cover cosmetic surgery. It is our policy to collect for office visits at the time of service. Surgical fees are payable two weeks in advance of scheduled cosmetic surgery.

Authorization for Release of Information
I hereby authorize Angela M. Keen, M.D. to release information requested by my insurance company or worker's compensation carrier. I also authorize release of information to any hospital of physician to whom I may be referred by this office.

Assignment of Benefits
I hereby authorize assignment and payment of medical benefits due me directly to Angela M. Keen, M.D. I understand that all fees for services rendered are my responsibility and that benefits are provided per the contract between my insurance carrier and myself.

Miscellaneous
I understand that a cancellation fee of $500.00 will be incurred if I cancel or reschedule elective surgery less than fourteen days prior to my surgery.

I understand that a finance charge of 1½% per month will be assessed on unpaid balances that are over 30 days old unless prior arrangements were made. I authorize the use of my cell phone (phone calls or SMS/text) and/or email by first or third party exclusively for the use of communication with me regarding my account status at any time.

I/we agree to pay all attorneys fees, court costs, filing fees, and all collection costs. Up to 40% of the amount owing may be assessed by any collection agency retained to pursue the matter.

I understand and agree to the above Financial Policy:

X_____ **Date**_____

Signature of Patient or Responsible Party