1706 BERGLUND LANE, MELBOURNE FL, 32940

PHONE NUMBER: 321-421-7525

FAX NUMBER: 321-622-6860

Viera Heart & Vascular Clinic

NEW PATIENT PAPERWORK

TODAY'S DATE:	PRIMARY DR:

PATIENT INFORMATION

PATIENT'S NAME:	DOB:	AGE:	IS THIS YOUR LEGAL NAME: YES NO
IF NOT, WHAT IS YOUR LEGAL NAME:	MARITAL STATUS: SINGLE MARIED DIVORCED WIDOW	MR MRS MISS MS	SEX: MALE FEMALE
ADDRESS:	CITY/ STATE:	ZIP CODE:	PHONE NUMBER:
SOCIAL SECURITY NUMBER:	EMAIL ADDRESS:	OCCUPATION:	
REFFERED TO CLINIC BY: ☐ DR ☐ FAMILY / FRIEND ☐ ONLINE	RACE: ASIAN WHITE BLACK INDIAN HISPANIC OTHER	ETHNICITHY: HISPANIC NOT HISPANIC	

LANGUAGE:

ENGLISH INDIAN SPANISH RUSSIAN THAI KOREAN OTHER: _____

PHARMACY: _____ PHONE NUMBER: _____

PREFFERED LAB: _____ LOCATION: _____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR THE BILL:	DOB:	PHONE NUMBER:
PRIMARY INSURANCE:	SUBSCRIBER NAME:	SUBSCRIBER NUMBER:
GROUP NUMBER:	CO-PAYMENT: $: _____	YOUR RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD
SECONDARY INSURANCE:	SUBSCRIBER NAME:	SUBSCRIBER NUMBER:
GROUP NUMBER:	SUBSCRIBER DOB:	PHONE NUMBER:
YOUR RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD		ADDRESS (IF DIFFERENT)

Viera Heart & Vascular Clinic

NAME:	DOB:

MEDICATIONS LIST

MEDICATION NAME:	DOSAGE: (MG / ML)	INSTRUCTIONS (FREQUENCY)

PAST MEDICAL HISTORY (CHECK BELOW IF YOU HAVE ANY OF THE FOLLOWING)

☐ CORONARY ARTERY DISEASE	☐ MYOCARDIAL INFARCTION	☐ HIGH CHOLESTEROL
☐ DIABETES	☐ HEART VALVULAR DISORDER	☐ BLOOD DISORDER
☐ ARRHYTHMIA	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ KIDNEY DISEASE	☐ TOBACCO USE	☐ ATRIAL FLUTTER
☐ LOW BLOOD PRESSURE	☐ AFIB	☐ CORONARY ARTERY DISEASE
☐ OTHER: _____	☐ COPD/ ASTHMA	☐ PERIPHERAL VASUCLAR DISEASE
	☐ VENOUS INSUFFICIENCY	

DRUG ALLERGIES

NAME:	**REACTION:**

ARE YOU ALLERGIC TO LATEX: ☐ YES ☐ NO

NAME:	DOB:

SURGERIES

TYPE	DATE

LAST HOSPITAL VISIT: _____ **HOSPITAL:** _____

FAMILY HISTORY:

RELATIVE	ALIVE	DECEACED	CAUSE OF DEATH	MEDICAL HISTORY
MOTHER				☐ HEART ATTACK ☐ CANCER ☐ STROKE ☐ MENTAL ILLNESS ☐ DIABETES ☐ CORONARY ARTERY DISEASE ☐ HYPERTENSION ☐ OTHER: _____
FATHER				☐ HEART ATTACK ☐ CANCER ☐ STROKE ☐ MENTAL ILLNESS ☐ DIABETES ☐ CORONARY ARTERY DISEASE ☐ HYPERTENSION OTHER: _____
SISTER				☐ HEART ATTACK ☐ CANCER ☐ STROKE ☐ MENTAL ILLNESS ☐ DIABETES ☐ CORONARY ARTERY DISEASE ☐ HYPERTENSION OTHER: _____
BROTHER				☐ HEART ATTACK ☐ CANCER ☐ STROKE ☐ MENTAL ILLNESS ☐ DIABETES ☐ CORONARY ARTERY DISEASE ☐ HYPERTENSION OTHER: _____
SON				☐ HEART ATTACK ☐ CANCER ☐ STROKE ☐ MENTAL ILLNESS ☐ DIABETES ☐ CORONARY ARTERY DISEASE ☐ HYPERTENSION OTHER: _____
DAUGHTER				☐ HEART ATTACK ☐ CANCER ☐ STROKE ☐ MENTAL ILLNESS ☐ DIABETES ☐ CORONARY ARTERY DISEASE ☐ HYPERTENSION OTHER: _____

SOCIAL HISTORY:

TOBACCO USE

DO YOU SMOKE TOBACCO PRODUCTS? ☐ YES ☐ NO

IF YES, WHEN DID YOU START? _____ TOTAL YEARS SMOKED: _____ YEAR STOPPED: _____

HOW MANY CIGARETTES PER DAY: _____ CIGARS_____ CHEWING_____ VAPE_____

EXERCISE

DO YOU CURRENTLY EXERCISE? ☐ YES ☐ NO

FREQUENCY: _____ ACTIVITY: _____

ALCOHOL/ DRUG USE

DO YOU CURRENTLY CONSUME ALCOHOLIC BEVERAGES? ☐ YES ☐ NO

IF YES, INDICATE THE QUANTITIES COMSUMED PER DAY?

BEER: _____ **WINE:** _____ **DISTILLED SPIRITS:** _____

Viera Heart & Vascular Clinic

NAME:	DOB:

HAVE YOU USED DRUGS OTHER THAN THOSE FOR MEDICAL REASONS IN THE PAST 12 MONTHS?
☐ YES ☐ NO
IF YES, PLEASE LIST THE NAMES: _____
DO YOU USE MEDICAL MARIHUANA? _____
HAVE YOU EVER BEEN TREATED FOR DRUG OR ALCOHOL ADDICTION? _____

CAFFEINE USE
DO YOU CONSUME CAFFEINE PRODUCTS? ☐ YES ☐ NO
QUANTITY PER DAY _____

REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT APPLY

GENERAL:
☐ CHILLS ☐ FEVERS ☐ NIGHT SWEATS ☐ WEIGHT GAIN ☐ WEIGHT LOSS

EAR, NOSE, THROAT:
☐ DECREASED HEARING ☐ SORE THROAT ☐ SWOLLEN GLANDS

ENDOCRINE:
☐ FATIGUE ☐ COLD INTOLERANCE ☐ EXCESSIVE THIRST ☐ HEAT INTOLERANCE

RESPIRATORY:
☐ COUGH ☐ SHORTNESS OF BREATH ☐ SPUTUM PRODUCTION ☐ WHEEZING

CARDIOVASCULAR:
☐ COLD SWEATS ☐ CHEST PRESSURE ☐ CHEST PAIN ☐ FAINTING ☐ PALPITATIONS
☐ LEG SWELLING ☐ IRREGULAR BEAT

GASTROINTESTINAL:
☐ ABDOMINAL PAIN ☐ BLOODY STOOL ☐ NAUSEA ☐ VOMITING ☐ HEART BURN

MUSCULOSKELETAL:
☐ LEG CRAMPS ☐ PAINFUL JOINTS ☐ WEAKNESS

PERIPHERAL VASCULAR:
☐ VARICOSE VEINS ☐ COLD EXTREMITIES ☐ PAIN/ CRAMPING ☐ ULCERS ON FEET

SKIN:
☐ DISCOLORATION ☐ DRY SKIN ☐ ITCHING ☐ RASH ☐ SCARS

NEUROLOGICAL:
☐ TREMMORS ☐ DIZZINESS ☐ HEADACHE ☐ FOCAL WEAKNESS ☐ MEMORY LOSS ☐ NUMBNESS

HEIGHT: _____

WEIGHT: _____

Viera Heart & Vascular Clinic

NAME:	DOB:

FALL RISK ASSESMENT

RISK FACTOR	LEVEL	RISK SCORE
RECENT FALLS	NONE IN LAST 12 MONTHS…….. ONE IN LAST 12 MONTHS……..... ONE OR MORE IN LAST 3-12 MONTHS……	0 2 4
MEDICATIONS SEDATIVES, ANTIDPRESSANTS, ANTI-PARKINSONS, DIURETICS, ANTI-HYPERTENSIVES.	NOT TAKING ANY OF THESE…… TAKING ONE…… TAKING TWO…… TAKING THREE…… TAKING THREE OR MORE……	1 2 3 4
AGE	UNDER 75……..…….. 75 -85……..…….. OVER 85……..	0 1 2
MOBILITY	DOES NOT REQUIRE ASSITANCE…… REQUIRES CANE……..……..…… REQUIRE WALKER……..……..…… UNABLE TO AMBULATE……..	0 1 2 3
MENTAL SATAUS	ORIENTED TO TIME AND PLACE……..…… DEVELOPMENTALLY DELAYED……... DISORIENTED……	0 1 2
TOTAL		TOTAL: _____/15

CARDIAC ASSESMENT:

DO YOU HAVE HISTORY OF MYOCARDIAL INFARCTION? ☐ YES ☐ NO

IF YES, WHAT YEAR? _____

DO YOU CURRENTLY HAVE A PACEMAKER? ☐ YES ☐ NO

IF YES, WHO INTERROGATES THE PACEMAKER? _____

SERIAL NUMBER: _____ BRAND: _____ YEAR PLACED: _____

HAVE YOU HAD HEART CATHETERIZATION BEFORE? ☐ YES ☐ NO

DO YOU HAVE AN ARTIFICIAL HEART VALVE? ☐ YES ☐ NO

ARE YOU ON BLOOD THINNERS? ☐ YES ☐ NO

NAME:	DOB:

IN CASE OF AN EMERGENCY		
NAME OF RELATIVE OR FRIEND	RELATIONSHIP	PHONE NUMBER

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize insurance company to release any information required to process my claims.

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCECARRIER PAYMENTS, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR THESERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE VIERA HEART AND VASCULAR CLINIC (dba BREVARDHEART CARE) TO FURNISH THE INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESSAND TREATMENTS AND I HEREBY ASSIGN TO VIERA HEART AND VASCULAR CLINIC (dba BREVARD HEART CARE) ALL PAYMENTS FOR MEDICALSERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HER/HIS ASSISTANT TO ADMINISTER TREATMENT,PHYSICAL EXAM, E-RAY STUDIOS, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MYCASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OF PART OF MY (PATIENT'S) RECORD TO ANY PERSON OR CORPORATION WHICH ISOR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL ORPART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERSCOMPENSATIONTHE PATIENTS EMPLOYER.

PATIENT INFORMATION CONSENT:

I UNDERSTAND THAT VIERA HEART AND VASCULAR CLINIC (dba BREVARD HEART CARE) MAY NEED TO USE AND DISCLOSE INFORMATION ABOUTMY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENTFOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OFTREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES VIERA HEART AND VASCULAR CLINIC (dba BREVARD HEART CARE) TOREPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLEDISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS). I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW VIERA HEART AND VASCULAR CLINIC (dba BREVARD HEART CARE) PRIVACY NOTICE TOREQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION AND REVOKE MY CONSENT AT A LATER DATE. I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, OR OPERATIONS, VIERA HEART AND VASCULAR CLINIC (dba BREVARD HEART CARE) MAY REFUSE TO UNDERTAKE MY CARE. I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS,ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE I TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIESAND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY ORADVISABLE BASED ON THE JUDGEMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES, I FULLY UNDERSTAND THAT THIS ISGIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTENT THIS CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED INWRITING. I UNDERSTAND THAT VIERA HEART AND VASCULAR CLINIC (dba BREVARD HEART CARE) MAY INCLUDE CONSENT AT SATELLITE OFFICESUNDER COMMON OWNERSHIP. MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO VIERA HEART AND VASCULAR CLINIC. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNARILY TO ITS CONTENT. ALSO, THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

Prescription History Consent

I give my consent to have Viera Heart and Vascular Clinic (Dba Brevard Heart Care) to obtain my prescription history from external sources.

Patient or Authorized Person's Signature: _____ DATE: _____

DATE OF BIRTH: _____

PATIENT NAME: _____

HIPAA CONTACT INFORMATION

IN ORDER TO ASSIST YOU IN RECEIVING YOUR HEALTH INFORMATION FROM VIERA HEART AND VASCUAR CLINIC, PLEASE COMPLETE THIS FORM.

____ VIERA HEART AND VASCULAR IS PERMITTED TO SHARE ALL MEDICAL INFORMATION WITH THE INDIVIDUALS LISTED BELOW, INCLUDING TEST RESULTS, SENSITIVE INFORMATION AS STIPULATED BY THE STATE OF FLORIDA AND INFORMATION DISCLOSED DURING OFFICE VISITS.

OR

____ VIERA HEART AND VASCULAR IS PERMITTED TO SHARE ALL MEDICAL INFORMATION WITH THE INDIVIDUALS LISTED BELOW, INCLUDING TEST RESULTS, SENSITIVE INFORMATION AS STIPULATED BY THE STATE OF FLORIDA AND INFORMATION DISCLOSED DURING OFFICE VISITS EXCEPT:
_____.

PERSONS AUTHORIZED TO RECEIVE ANY MEDICAL INFORMATION:

NAME RELATIONSHIP PHONE NUMBER

_____

_____

_____

YOU MAY NOTIFY ME WITH RESULTS, APPOINTMENT REMINDERS, AND ALL OTHER INFORMATION REGARDING MY HEALTH INFORMATION AS FOLLOWS:

- ☐ MESSAGE ON ANSWERING MACHINE PHONE NUMBER: _____
- ☐ MESSAGE ON CELL PHONE PHONE NUMBER: _____
- ☐ MESSAGE ON WORK PHONE PHONE NUMBER: _____

EMAIL: _____

I UNDERSTAND THIS REMAIN IN EFFECT UNTIL IT IS REVOKED BY ME IN WRITING.

_____ _____
PATIENT NAME SIGNATURE

_____ _____
DOB DATE

DO YOU HAVE A DNR? ☐ YES ☐ NO
DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO
DO YOU HAVE POWER OF ATTORNEY? ☐ YES ☐ NO IF YES, WHO? _____

Viera Heart & Vascular Clinic

Vascular Disorder Questionnaire

Name: _____ DOB: _____
Date: _____

Venous Disorders

1. Do you have leg heaviness, fatigue, throbbing, or aches? □ Yes □ No
2. Do you have swelling of legs and ankles? □ Yes □ No
3. Do you have leg cramping or restless leg? □ Yes □ No
4. Do you have painful varicose vein? □ Yes □ No
5. Do you have easy bruising or skin discoloration? □ Yes □ No

Arterial Disorders

1. Do you have pain or cramps at calves, thigh, or buttocks when you walk? □ Yes □ No
2. Does the pain go away with rest? □ Yes □ No
3. Do you have coolness or numbness in the legs/feet? □ Yes □ No
4. Do you have weakness in your leg? □ Yes □ No

Risk factors

Check the conditions that applies to you.

□ Diabetes □ Hypertension □ Smoking

□ High Cholesterol □ History of stroke □ History of angioplasty/bypass

Viera Heart & Vascular Clinic

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MEDICAL RECORD REQUEST

PATIENT NAME: _____ DOB: _____

I HEARBY AUTHORIZE: _____ TO RELEASE THE FOLLOWING INFORMATION ON MY BEHALF:

___ ENTIRE MEDICAL RECORDS FROM: _____ TO: _____

___DEMOGRAPHIC INFORMATION:

___ INSURANCE INFORMATION

___ PARTIAL MEDICAL RECORDS

___ DICTATED NOTES

___ RADIOLOGY REPORTS

___ LAB WORK

___ MEDICATIONS PRESCRIBED

___ CARDIAC TESTING AND REPORTS

___ OTHER: _____

_____ _____ _____ _____

PARTIAL/ LEGAL REPRESENTATIVE SIGNATURE | DATE | WITNESS SIGNATURE | DATE

PLEASE SEND VIA:

_____ FAX

_____ MAIL

MAILING ADDRESS

_____

_____

_____

I understand these records may contain information from other health care providers, as well as information which is administrative in nature. This information will be given only to those specified on this form and only through the expiration date stated below. I also understand I have the right to revoke this authorization at any time through written notice and that written notice must include 1) the patient's name, social security number and date of birth, 2) make reference to this specific authorization and the name so those authorized by this form to receive information, 3) a statement that the patient wants to revoke this authorization, the effective date of revocation, and the signature of the patient or a legal guardian.

I understand that once the above information is disclosed, it may be re-disclosed by federal privacy laws or regulations may not protect the recipient and the information.

HONG JEONG, M.D.

1706 Berglund Lane Melbourne, FL 32940

Tel: 321-421-7525 Fax: 321-622-6860

Office no show policy

For us to maintain our efficiency in our office and with procedures as well as considering the physician, technicians and staff, it is necessary for us to implement a cancellation policy for Dr. Jeong's office schedule.

If you need to cancel your office visit, we ask that you do so **at LEAST** 24-48 hours before the scheduled appointment.

No show Follow-Up Visits will be charged a $50.00 fee.

No show for Ultrasounds will be charged a $150.00 fee.

No show for in office procedures will be charged $300.00 fee.

No show for stress test will be charged $250.00 fee.

PLEASE BE ADVISED THAT ANY NO SHOW IS YOUR PERSONAL REPSONSIBILITY. CHARGES WILL NOT BE FILED WITH YOUR INSURANCE COMPANY.

We thank you in advance for your cooperation and understanding of the procedure scheduling process.

_____ _____

Patient Signature Sun Jeong-Office Manger

_____ _____

Patient Printed Name Date

Viera Heart & Vascular Clinic

Office Mandatory Policy Acknowledgement form

Dear Patients,

At our medical practice, we have a ***mandatory policy*** regarding consultations with our Nurse Practitioner (NP). Our NP holds a doctorate in nursing and has over 30 years of specialized experience in cardiology. She was carefully selected by Dr. Jeong to ensure the highest quality of care for our patients.

It is the policy of this office that all patients alternate visits between our nurse practitioner and Dr. Jeong. ***This policy is non-negotiable and essential to the functioning of our practice.***

If this policy presents a conflict with your preferences or schedule, we regret any inconvenience but kindly suggest seeking medical care elsewhere. Ensuring your best interest in medical care is our priority, and we appreciate your understanding and cooperation in adhering to our office policy.

Thank you for entrusting us with your healthcare needs.

Patient Print name _____

Patient Signature _____

Thank you,
Dr. Hong Jeong,

Hong J. Jeong, M.D.

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, with less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the in-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

SIGNATURE/ RESPONSIBLE PARTY DATE

_____ _____

NAME OF PATIENT / RESPONSIBLE PARTY RELATIONSHIP TO PATIENT