MOISES SIPERSTEIN, M.D. P. A.
10377 SOUTH US HIGHWAY 1.SUITE 102. PORT ST. LUCIE, FL. 34952
PHONE: (772)337-7811 FAX: (772)337-7833

NEW PATIENT INFORMATION. WELCOME TO OUR PRACTICE!

PATIENT INFORMATION
LAST NAME_____FIRST NAME_____MIDDLE INITIAL_____
PERMANENT MAILING ADDRESS_____ _____
APARTMENT NUMBER_____
CITY_____STATE_____ZIP CODE_____SEX_____
HOME PHONE_____WORK PHONE_____EXT_____ MOBILE PHONE_____
DATE OF BIRTH_____AGE_____SS #_____MARITAL STATUS_____
EMPLOYER_____POSITION_____
STREET ADDRESS_____
CITY_____STATE_____ZIP CODE_____
EMERGENCY CONTACT
NAME OF NEAREST RELATIVE _____
HOME PHONE_____WORK PHONE_____EXTENSION_____

REFFERED BY :_____

If you would like us to communicate with you over the Internet, please list your email address. Do not list an email address if you are uncomfortable having your personal information on the Internet.
Email.address:_____@_____

POLICYHOLDER INFORMATION (THE PERSON WHO PAYS THE INSURANCE PREMIUM)
(I.E. WHO'S PAYCHECK IS DEDUCTED - SELF, HUSBAND, WIFE, EX-HUSBAND, EX-WIFE, IF CHILD, MOTHER, FATHER, STEP PARENT)
LAST NAME_____FIRST NAME_____MIDDLE INITIAL_____
EMPLOYER_____
DATE OF BIRTH_____SS#_____
HOME PHONE_____WORK PHONE_____EXTENSION_____
INSURANCE COMPANY INFORMATION
PLEASE PRESENT YOUR INSURANCE CARDS TO PHOTOCOPY AND TELL US THE FOLLOWING:
NAME OF **PRIMARY** INSURANCE_____
NAME OF **SECONDARY** INSURANCE_____

IF MINOR, PARENT/GUARDIAN INFORMATION
LAST NAME_____FIRST NAME_____MIDDLE INITIAL_____
RELATIONSHIP TO PATIENT_____
STREET ADDRESS_____
APARTMENT/LOT NUMBER_____
CITY_____STATE_____ZIP CODE_____
EMPLOYER_____POSITION_____
STREET ADDRESS_____
CITY_____STATE_____ZIP CODE_____
HOME PHONE_____WORK PHONE_____EXTENSION_____
DATE OF BIRTH_____SS#_____

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FINANCIAL POLICY AND NOTICE OF SERVICES

1. I understand that this office will submit claims to Medicare and selective other insurance companies we have a contract with. I understand, that, when possible, this office will make a single attempt to process claims through to my secondary insurance.
2. Payment is due at the time of service. We accept Cash, Checks, Debit Cards, Visa, MasterCard and American Express
3. I understand that Medicare and insurance companies do not pay for all medical services. I agree to pay all legal claims which are not paid by my insurance company. Payment is due upon receipt of a statement from our office.
4. I agree to assume the responsibility for resolving payment problems with my insurance company.
5. I understand that there will be a $30 administration fee added to all returned checks.
6. There is a $40 "no show" fee if I miss any appointment and did not give 24 hour notice
7. I have received a copy of this office's Notice of Privacy Practices, and the Office Policies.
8. I authorize the release of any medical, sensitive or psychiatric information acquired in the course of my treatment to my insurance company, which is necessary to process claims.
9. I hereby assign to Moises Siperstein, M.D. any insurance or other third party benefits available for health care services provided to me. If these benefits are not assigned to **Moises Siperstein, M.D**. I agree to forward all payments that I receive for services rendered to me by him, his associates or agents. A photocopy of this Assignment shall be considered as effective and valid as the original
10. I (or my legal guardian or parent) authorizes **Moises Siperstein, M.D.** to provide medical care reasonable by today's standards.
11. **Medicare patients only: Notification to Medicare B patients**
    Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. It is believed that, in your case, Medicare will deny payment for routine physical examinations, and any testing associated with this exam, and immunizations such as Tetanus injections. Therefore, payment for those services will be expected at the time the service is provided.

I have read and understand the Practice's Financial Policy and Notice of Services and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the Practice from time to time. I agree to make all payments, including co-payments, at the time of service. I understand that if my eligibility for coverage by my insurance company cannot be confirmed at the time of my office visit I will be held responsible for payment of all services provided

_____
Signature of patient (or responsible party, if minor)

_____
Date.

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SHARING INFORMATION

Hereby I acknowledge having received a copy of the Practice's Notification of Privacy

To protect the confidentiality of our patients, we ask you fill out this form. Please indicate who you will allow us to discuss your medical care with and confirm appointments. If you do not let us know who we may talk to, we will not discuss your medical care with them.

NAMES OF PEOPLE WE MAY DISCUSS YOUR MEDICAL CARE AND TREATMENT WITH:	**REALATIONSHIP TO YOU**

NAMES OF PEOPLE WE MAY CONFIRM YOUR APPOINTMENTS WITH:	**RELATIONSHIP TO YOU**

Please be aware if you do not specify who we may speak with on this form we will not discuss anything relating to your medical care with anyone.

_____

Patient Name (or Representative). Signature and Date

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Name _____ Age _____ Birth Date _____
Occupation _____. Gender: __ Male. __ Female .
Marital Status _____
If Married, spouse's name _____
Children's names and ages _____
ALLERGIES TO MEDICATIONS, XRAY DYES, FOOD OR OTHER SUBSTANCES: ___ NONE
IF YOU KNOW TO BE ALLERGIC, PLEASE LIST NAMES OF MEDICINES AND TYPE OF REACTION

Current Medications (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.) ___ NONE
(Please list names of medicines, the dose and frequency of use. For example: Aspirin 81mg one per day)

Past Medical History and Review of Symptoms
Please check off if you have had any of these problems, or are presently experiencing any of the following:

	High Blood Pressure		Asthma		constipation		Arthritis
	Diabetes		Bronchitis		Unexplained weight loss		Low back problems
	Cancer		Pneumonia		Weight gain		Hemorrhoids
	Coronary disease		cough		Gall bladder disease		Skin disorders
	Heart attack		T.B.		Colitis		Blood disorders
	Chest pain		Hay Fever		Hepatitis or Jaundice		Anxiety
	Stroke		Abdominal pain		Thyroid disease		Depression
	Shortness of breath		Indigestion		Headache		Alcohol abuse
	Swollen ankles		Heartburn		Kidney stones		Drug abuse
	Palpitations		Nausea		Kidney disease		Gout
	Lightheadedness		Vomiting		Difficulty urinating		Anemia
	Frequent urination		Constipation		Leakage of urine		Rheumatic Fever
	Blood cloths in the legs		Diarrhea		Impotence/erectile dysfunction		Migraines
	Blood transfusion		Blood in the stool		Menstrual pain		Seizure
	Bleeding disorders		Stomach ulcers		Venereal diseases (STDs)		OTHER:

Please list and supply the dates of operations:

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_____

Hospitalizations other than surgery:

_____

_____

PREVENTION. PLEASE ANSWER YES OR NO, DO YOU?

YES	NO	:
		Wear a bike helmet? N/A?
		Wear seat belts?, if NO, why not?
		Exercise?, if YES, type, duration and days/week:
		SMOKE? If yes, how many packs per day and for how long now:
		DRINK ALCOHOLIC BEVERAGES? If yes, how many per week?:
		USE DRUGS (marijuana, cocaine, crack,etc), if YES, explain:
		Engage in activities that put you at risk for AIDS?, if YES, explain:
		Wish to be tested for AIDS
		Have a gun in your home? unloaded? _____. out of reach? _____
		Work with chemicals, paints, asbestos or hazardous materials, explain:
		Use a birth control method?, if YES:
		Have a living will?
		Have a donor card?
		Buckle up?
		Have a relationship in which you have been physically hurt by your partner? (slapped, kicked, punched or bruised?) if YES explain:

FAMILY HISTORY: Has any member of your family ever had any of the following?:

	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Granfather	Maternal Grandmother	Other
Cancer (type)							
Hypertension							
Diabetes							
Sudden death							
Heart attack							
Stroke							
Anxiety							
Depression							
Drug addiction							
Alcohol Addiction							
Glaucoma							
other							

GYNECOLOGIC AND OBSTETRIC HISTORY

Age at onset of periods _____. Frequency _____ Lenght of periods _____

Pregnancies _____ Births _____. Miscarriages _____

YES	NO	PROLONGED OR ABNORMAL BLEEDING	YES	NO	ABNORMAL MAMMOGRAM PREVIOUSLY?
		LEAKAGE OF URINE			BREAST CANCER
		PELVIC PAIN			CERVICAL/UTERINE CANCER
		ABNORMAL DISCHARGE			OTHER
		ABNORMAL PAP SMEAR WHEN?_____			

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NOTIFICATION OF PRIVACY:

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. A. OUR COMMITMENT TO YOUR PRIVACY Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information: 1) How we may use and disclose your IIHI, 2) Your privacy rights in your IIHI and 3) Our obligations concerning the use and disclosure of your IIHI The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time. B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Moises Siperstein, M.D., 10377 South US Highway 1. Suite 102., Port St Lucie , FL , 34952 , Requests for information must be made in writing. C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS The following categories describe the different ways in which we may use and disclose your IIHI. 1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment. 2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts. 3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations. 4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment. 5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives. 6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you. 7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take a child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information. 8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law. D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES The following categories describe unique scenarios in which we may use or disclose your identifiable health information: 1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for purposes such as: maintaining vital records, such as births and deaths, reporting child abuse or neglect, preventing or controlling disease, injury or disability, notifying a person regarding potential exposure to a communicable disease, notifying a person regarding a potential risk for spreading or contracting a disease or condition, reporting reactions to drugs or problems with products or devices, notifying individuals if a product or device they may be using has been recalled, notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information, notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance. 2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general. 3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court or administrative order protecting the information the party has requested. 4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official: Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement, Concerning a death we believe has resulted from criminal conduct, Regarding criminal conduct at our office, In response to a warrant, summons, court order, subpoena or similar legal process, To identify/locate a suspect, material witness, fugitive or missing person, In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator) 5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. 6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. 7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI. 8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. 9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces

(including veterans) and if required by the appropriate authorities. 10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. 11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals. 12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs. E. YOUR RIGHTS REGARDING YOUR IIHI You have the following rights regarding the IIHI that we maintain about you: 1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Moises Siperstein, M.D, 10377 South US Highway 1. Suite 102., Port St Lucie, FL. 34952 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request. 2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to to Moises Siperstein, M.D, 10377 South US Highway 1. Suite 102.. Port St Lucie, Fl. 34952. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply. 3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Moises Siperstein, M.D, 10377 South US Highway 1. Suite 102.. Port St Lucie, Fl. 34952 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews. 4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Moises Siperstein, M.D, 10377 South US Highway 1. Suite 102.. Port St Lucie, Fl. 34952. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information. 5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to to Moises Siperstein, M.D, 10377 South US Highway 1. Suite 102.. Port St Lucie, Fl. 34952. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs. 6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact to Moises Siperstein, M.D, 10377 South US Highway 1. Suite 102.. Port St Lucie, Fl. 34952 7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact to Moises Siperstein, M.D, 10377 South US Highway 1. Suite 102.. Port St Lucie, Fl. 34952. All complaints must be submitted in writing. You will not be penalized for filing a complaint. 8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the purposes described in the authorization. Please note, we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact to Moises Siperstein, M.D, 10377 South US Highway 1. Suite 102.. Port St Lucie, Fl. 34952. Request for information must be made in writing.

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OFFICE POLICIES

APPOINTMENTS

- Patients are seen during regular office hours and by appointment only, except in emergency circumstances. Occasionally, our office schedule must be altered due to the unplanned arrival of a seriously ill patient. We realize that your time is valuable, and we try our best to stay on schedule.
- Please make a phone number available so that we may reach you 1-2 hours prior to your appointment if we are running behind or ahead of schedule. Dr. Siperstein tries to give each patient as much time as required by their needs. This may sometimes result in your appointment running late. Your patience and understanding is appreciated.
- If you find that you cannot keep your appointment, please call to cancel 24 hours in advance so that time will be available for other patients.
- Patients who miss their appointment three (3) times without cancellation will be discharged from the practice.
- There is a $40 fee charged if a patient misses an appointment without a timely cancellation

MEDICATION REFILLS AND PRESCRIPTIONS

- Medications will not be prescribed for any conditions that Dr. Siperstein has not evaluated.
- Refills of routine medications are not considered emergencies and are not refilled during weekends and after office hours.
- Please allow for 24 hours for your refill.
- Pain medications and other controlled substances (sleeping pills, tranquilizers) are ONLY filled during an office visit.
- CHANGES: If you need Dr. Siperstein to prescribe a generic equivalent or your insurance does not cover your current prescription and you need a different medicine, this changes need to be done during an office visit
- THE OFFICE DOES NOT FAX NOR MAIL PRESCRIPTIONS TO ANY PRESCRIPTION BENEFIT MANAGEMENT COMPANY.
- If you have not been evaluated during the last 3 months please call the office for an appointment.

INSURANCE AND PAYMENT Insurance plans vary greatly and each plan has its own policies, eligibility requirements, and restrictions. Please present your insurance card at the time of your visit to help us determine your financial responsibility. We currently participate with Medicare and many other health insurance plans. All HMO insurances must indicate Dr. Siperstein as your primary care provider. If this is an auto accident we do accept auto coverage and will bill your carrier. If you have medical coverage, we will not bill accident related claims to a medical carrier. If we are a participating provider with your insurance plan, we will ask you to pay your co-payment, deductible, or co-insurance at the time of your visit and we will file the necessary claim to your insurance company. If we are not a participating provider with your insurance plan, you are expected to pay in full at the time of service. Some services such as yearly physicals, blood work and other testing may not be covered by your insurance, but may be required. We accept cash, personal checks, MasterCard, Visa, and most debit cards. Dr. Siperstein tries to accommodate patient requests to complete various medical forms on behalf of our patients. In some cases, a fee will be required. Co-payments and balances are to be paid at time of service and will be collected upon check in and registration. If your balance is not paid in a timely matter you may be subjected to a late fee. Patients who do not make reasonable progress toward settling their outstanding balance may, at the sole discretion of the provider, be discharged from the practice. Furthermore, the practice may turn over the account to a collection agency and report the unpaid balance to a credit bureau. Patients discharged from the practice will be given 30 day notice during which time their emergency medical care needs will be provided. Patients are still financially responsible for any services rendered.

REFERRALS Certain types of insurance plans need referrals before patients may receive a specialty consultation (an appointment with a specialist such as a cardiologist or endocrinologist, for example). If Dr. Siperstein approves a consultation, our office will obtain an authorization for you to see the specialist. Please don't make an appointment with a specialist before you contact our office. For routine referrals please allow 48 hours to prepare your authorization. In an emergency, this process can be expedited.

I have read and understood the above office policies.

Patient (or Patient Representative) : _____.
Signature _____. Date_____