Paul G. Hovsepian, M.D.
11 E. Adams Ave.
Alhambra, CA 91801

Payment Policy

CONSENT TO CARE:

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known.

_____ Initial

PATIENT RESPONSIBILITY:

· You are responsible for all charges resulting from treatment provided by Paul Hovsepian, M.D. We bill most insurance carriers; however, primary responsibility for the account is yours. Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made.

· **Your co-payment is always due at the time of service.** You are responsible for knowing what the amount of your co-pay is, and for assuring that it is collected at each visit. The fee will be assessed for any co-pay that your insurance assesses you that was not paid at the time of service.

· If we find it necessary to send your account to collections, you will be required to make a payment at the time of each of your next visits with us or you may be released as a payment.

· Minor: Patients under 18 years of age will be the responsibility of the custodial parent(s) _____ Initial

INSURANCE BILLING:

· Please bring your current medical card with you to each appointment as we require a copy of your insurance card to be on file with our office. This is to ensure accuracy.

· It is your responsibility to provide current, accurate insurance billing information. If your insurance information changes, please provide the new insurance information immediately so that we may insure all of your charges are billed to the correct insurance company. if your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges in full. _____ Initial

NOTIFICATION OF RELEASE FOR PAYMENT:

I understand that Paul Hovsepian, M.D. will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions. _____ Initial

RETURNED CHECKS:

It is our office policy to charge a $25.00 fee for checks that are returned regardless of the reason. _____ Initial

AUTHORIZATION TO RELEASE INFORMATION:

· In obtaining payment for services, I authorize Paul Hovsepian, M.D. to furnish information from my medical record to any company that may be responsible for payment of all or part of my charges

· If I have been referred by, or am being referred to another healthcare provider, I authorize Paul Hovsepian, M.D. release my medical information to this provider for continuing care.

· I also assign Paul Hovsepian, M.D. all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. _____ Initial

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE STATEMENTS ABOVE. I HAVE RECEIVED A COPY OF THIS INFORMATION.

_____ _____ _____

Patient Name (Please Print) Date

IF PATIENT IS UNDER THE AGE OF 18 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Patient is _____ year(s) of age is unable to sign because: _____

_____ _____ _____

Signature Relationship to Patient Date

Sign Below if Disclosure of Information is NOT Authorized:

Therefore, I agree to pay for costs of all treatment and services personally.

_____ _____ _____

Patient Name (Please Print) Date

HIPAA and NOTICE of PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of Paul Hovsepian, M.D. Notice of Privacy Practices. This Notice describes how Paul Hovsepian, M.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____ _____

Signature of Patient or Personal Representative Date Relationship to Patient