AFC Health

HIPAA/Financial Policy

Please fill the form below

FINANCIAL POLICY

Payment is due at the time of service. Balance becomes the patient's responsibility and will be added to the account. Patient must resolve balance prior to rendering of any further services.

I authorize payment for services rendered to me or my dependents to be paid directly to ACTION FAMILY CARE, PLLC, DR. HOSS MANSOORI, DC, FNP-C from my insurance company, my attorney, or any other party who may become obligated to
pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled. I understand that all charges incurred are the personal responsibility of the patient/guarantor. Commercial insurance is filed as a courtesy to the patient, and managed care insurance is filed with a contracted carrier. The patient/guarantor is responsible for all residual balances including but not limited to co-pays, deductibles, co-insurance and services or charges not paid by insurance for any reason, after consideration of contractual adjustments.

In the event any insurance company, attorney, or other person obligated by contractual agreement to make payment to me for your service charges, refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against such company, attorney, or person and authorize you to prosecute said action either in my name or your name or for you to resolve said claim as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my Account.

I hereby direct my attorney not to interfere with or claim any lien upon, any medical payment benefits to which I may be entitled from either my health insurance or medical payment sources. And if any said medical payment checks include my attorney's name, I direct my attorney to sign his name to these checks for the benefit of the medical provider herein.

In the event that this account goes into default and our office turns it over to our outside collections agency/attorney for collections, it is accepted and agreed that thirty percent (30%) of the principal amount of the balance due will be added as collection/attorney fees.

It is also agreed and accepted that in the event that a lawsuit is filed, you, the patient will be liable for any and all court costs expended whether judgment has been entered or not.

Name

Last Name

First Name

Date

Month Day Year

Authorization to Release Information

I authorize ACTION FAMILY CARE, PLLC, DR. HOSS MANSOORI, DC, FNP-C and it's physicians to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment including disability related information to any third party payer (including Medicare), or their contracted agents, to validate or determine benefits payable for services rendered to myself or any dependents.

- ○ Yes, I understand.

Name

First Name Last Name

Date

Month Day Year

I request that payment of authorized Medicare or insurance benefits be made to my physician on my behalf for any services furnished to me. I authorize any holder of medical information about me to be released to my insurance company to process payment for medical services received. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment, and I accept financial responsibility for non-covered services.

- ○ Yes, I understand

Name

First Name Last Name

Date

Month Day Year

LATE CANCELLATION/ NO SHOW POLICY

Due to the increased demand for appointment times, ACTION FAMILY CARE, PLLC implements a Cancellation/No Show Policy. Our concern for seeing patients in a timely manner has prompted us to take these steps. We ask for a 24 hour notice for all cancellations.

After TWO (2) no-shows, or late cancellations, and a patient's appointment has been confirmed and the patient fails to keep said appointment, there will be a fee assessed to total amount of $30.00.

Insurance will not cover charges for no-show or late-cancellation fees.

Payment of the no-show, or late cancellation fee, must be made in cash, or a valid credit card before further appointments are allowed.

○ Yes I understand

Name

First Name Last Name

Date

Month Day Year

Phone Communications Consent Form

By signing this agreement, you specifically request, expressly consent to receive, and authorize ACTION FAMILY CARE, PLLC, its affiliates, business associates, and service providers to deliver, or cause to be delivered, calls and SMS/text and voice messages to your cell phone, and residential line as applicable, using an automatic telephone dialing system and/ or using an artificial or pre-recorded voice. This could result in charges to you according to your data plan. These calls and messages will be for health care and other purposes including but not limited to, for the purpose of appointment reminders, office closure announcements, and clinic operations.

○ Yes I

Name

First Name Last Name

Date

Month Day Year

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act) law allows for use of the infromation for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected health information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health infromation may be disclosed or used for treatment, payment, or healthcare operations
The practice reserves the right to change the privacy policy as allowed by law
The practice has the right to restrict the use of the infromation but the practice does not have to agree to those restrictions
The patient has the right to revoke the consent in writing at any time and all full disclosures will then cease
The practice may condition the receipt of treatment upon execution of this consent

May we discuss your medical condition with any member of your family?

- ○ Yes
- ○ No

If yes, please provide name(s) and contact number (s)

Name

First Name Last Name

Date

Month Day Year