LUMIRI SURGICAL

Dr. Tiffany Schatz
19 Shelly Lane, Fort Washington, PA 19034
Phone: (215) 695-2777 Fax: (215) 695-2052

# LUMIRI SURGICAL LLC

Dr. Tiffany Schatz

## General Consent to Treat

I voluntarily consent to medical care of a routine / emergency nature form the authorized professional staff of Lumiri Surgical LLC for myself or the above-mentioned patient for whom I am the parent / guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care. I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

## Financial Agreement

I authorize payment to Lumiri Surgical LLC of any medical benefits, which would otherwise by payable to me and which were established by my insurance company. The amount paid to Lumiri Surgical LLC shall not exceed the practice's regular charges for the services. I also authorize the release of my medical records to my insurance company / companies or other third party payers or my employer as required for the collection of payments. I understand that I am responsible for the payment of charges that are not paid by my insurance company.

## Medicare Agreement

The information provided by me in applying for payment of Social Security benefits is true and correct. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf. I request that the payment of benefits be made for me. The benefits due to me for services provided by my physician shall be paid directly to Lumiri Surgical LLC. In the event the physician does not receive such payment I authorize such physician to submit a claim to Medicare on my behalf.

If my current policy prohibits direct payment to Lumiri Surgical LLC, I hereby direct the check be made out to me and mailed to Lumiri Surgical LLC 19 Shelly Lane, Fort Washington, PA 19034.

## Payment Agreement

Our office requests that you read your insurance policy and by fully aware of any limitations of the benefits provided. You should be aware that this insurance agreement is between you and the insurance company. We will gladly help, you but it is your responsibility to know the limitations or your policy. Any change incurred beyond the reimbursement of your policy will be your financial responsibility.
I have read the above and understand my financial obligation.

| First Name | Middle Name / MI | Last Name | Date of Birth |
|---|---|---|---|
| | | | |

**Patient Signature**

**Date:**_____

**Patient Representative / Guarantor Signature**

**Relationship:**_____

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## Release of Information

I the undersigned patient and/or responsible party hereby authorize this office, its agents / employees to release and disclose all or part of the patient's medical records to any entity, which is, or may be liable for all or part of the provider charges.

I authorize the release and disclosure or any and all medical records to any other entity including by not limited to referring physicians, hospitals or other health care providers which may be of assistance in the opinion of this office, in providing for the treatment of patient.

I authorize the release of records necessary as assist in reimbursement of benefits to which I may be entitled. I authorized this office and / or its employees to release via fax machine medical records which are needed in order to provide patient with the most appropriate medical care.

**I authorize the release of my x-rays, labs and medical results to be left on my answering machine if I am unavailable.**

☐ Yes ☐ No

I the undersigned patient and / or responsible party hereby authorize this office to release medical, billing and appointment information to the following family members in lieu of myself:

1:_____Relationship:_____

2:_____Relationship:_____

3:_____Relationship:_____

I have read and understand the Lumiri Surgical LLC Release of information policy.

| **First Name** | **Middle Name / MI** | **Last Name** | **Date of Birth** |
|---|---|---|---|
| | | | |

**Patient Signature**

**Date:**_____

**Patient Representative Signature**

**Relationship:**_____

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## Authorization to Receive Medical Information

**Patient Name:**_____ **DOB:**_____ **Phone:**_____

**RECEIVE RECORDS FROM:** _____

**Phone:** _____ **Fax:** _____

**Information to be released: (if not clearly defined, the most recent 2 years will be released)**

☐ History & Physical _____ Date:

☐ Immunizations

☐ Post Op Report _____ Date:

**Most Recent:**

☐ Labs ☐ Diagnostic Studies ☐ Office Visit

☐ Other Information (Please specify) _____

**Purpose for which disclosure is being made: (please check one of the following)**

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

☐ _____ **Other:**

### EXCLUDE the following information from the records released (please initial):

Initials_____ Drug / Alcohol abuse / Treatment and diagnosis

Initials_____ Sexually transmitted disease

Initials_____ Mental Illness or psychiatric diagnosis and treatment

Initials_____ HIV / AIDS

MY RIGHTS: I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be re-disclosed and no longer protected by the HIPAA regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used / disclosed with this authorization. There may be a charge for these copies. This authorization will automatically expire six months from the date signed or until the 3rd party payer claim is secured. I understand that I may revoke this authorization any time except to the extent that action has been taken in relationship thereon. To revoke this authorization, I must submit my request in writing to Lumiri Surgical LLC.

**Patient Signature**

**Date:**_____

**Patient Representative Signature**

**Relationship:**_____

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## Electronic communication

At Lumiri Surgical, we attempt to create the most efficient processes for communication with patients in order to make your healthcare experience less stressful, while also taking our environmental responsibilities seriously. For these reasons, we attempt to communicate with our patients as paperless as possible. Therefore, we will use the patient portal for all private healthcare information, we will upload preoperative instructions and communications using the portal, and send reminders by email and text as often as possible. Added benefits to the patient port and electronic communication include the records being available at your convenience, in the case they are lost or need review. These materials can be downloaded and printed at home if desired.

I have read and understand the Lumiri Surgical LLC electronic communication policy. I understand I may change my selection below at any time by communicating in writing with Lumiri Surgical LLC staff.

☐ I the undersigned patient and / or responsible party hereby authorize this office, its agents / employees to use **electronic communication** for patient forms, bills, educational materials, and reminders.

☐ I the undersigned patient and / or responsible party request **paper** forms, bills, and educational materials in addition to electronic versions made available on the patient portal.

| First Name | Middle Name / MI | Last Name | Date of Birth |
|---|---|---|---|
| | | | |

**Patient Signature**

**Date:**_____

**Patient Representative Signature**

**Relationship:**_____

*We always are looking for ways to improve efficiency, ease of use, and convenience for patients and staff in order to benefit patient care. Please feel free to give feedback regarding your experience in order that we can continue to improve our processes. Thank you!

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**Patient Financial Policy**

Thank you for choosing the physicians of Lumiri Surgical for your expert surgical evaluation and treatment. We are committed to providing you with the best possible quality care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. If you have any questions about our fees, our policies or your financial responsibilities, please do not hesitate to contact us. Please take time to carefully review the following information and return this form to the front desk with your signature and today's date.

We require that all patients complete our Patient Financial Policy prior to seeing the physician. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

INSURANCE
• It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will make a copy for our records.
• If current information is not obtained at the time of service, it will become the patient's responsibility to pay the entire balance until current information is provided to our office.
• Your insurance policy is a contract between you and your insurance company. As a courtesy, and pursuant to contractual obligations, we file all your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. You are ultimately responsible for the timely payment of your account.

CO-PAYS
Co-payments are due at the time you check in at the front desk PRIOR to your being seen by our physicians.

DEDUCTIBLES, CO-INSURANCE and ESTIMATES:
• Balances related to unmet deductibles and estimation of co-insurance, as per the contract you have with your insurance, is to be paid at the time of service.
• For surgical and in-office procedures, an estimation of patient responsibility will be provided to you and is to be paid in full PRIOR to services being rendered.
• Additional balances due, if applicable, will be billed to you after the insurance carrier has processed the claim.
UN-PAID/OUTSTANDING BALANCES
• We ask that full payment to be made at the time of service unless prior arrangements have been made through the billing office.
• If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due.
• You may call to set up payment arrangements if necessary. Any overdue balances may be considered for further legal action. Forms of payment accepted: cash, checks, credit and debit cards.

RETURNED CHECKS
The charge for a returned check is $25.00 plus any additional bank charges accrued payable by cash, check, money order or credit card charge. This will be applied to your account in addition to the insufficient funds amount.

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MISSED APPOINTMENTS
Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment we request, at minimum, a 24-hour notice. Failure to provide notice after the 2nd missed appointment will result in a $35.00 missed appointment charge. This charge is the responsibility of the patient and is not covered by any insurance carrier.

ADDITIONAL FEE
Additional fee of $25 will be charged for FMLA and repeated request of other forms (e.g. medical abstract, return to work/school note, etc.).

CREDIT BALANCES
From time to time, you may accrue a credit balance on your account. Lumiri Surgical will maintain your credit until our Accounts Receivable staff processes your credit, to provide you a refund. If you make a request regarding your balance, please allow ample time for review of your entire account and processing through our billing company.

Like all businesses it is our intention to thoroughly explain our financial policies and set forth our expectations. Your assistance and cooperation are appreciated. We are pleased to have the opportunity to care for your surgical needs at this crucial time and encourage you to contact us with any further questions or concerns.

***I have read Lumiri Surgical Patient Financial Policy and acknowledge my responsibilities by affixing my signature below*.**

**First Name** _____ **Middle Name / MI** _____ **Last Name** _____ **Date of Birth** _____

**Patient Signature**

**Date:**_____

**Patient Representative / Guarantor Signature**

**Relationship:**_____