PETER CASTILLO MD, FACOG

MY SPECIALTY, YOUR SOLUTION

PATIENT INFORMATION

Date____/____/____ Home Phone_____ Work Phone_____ Cell Phone_____

Name_____ Social Security Number_____
Last Name First Name Middle Initial

Address_____ City_____ Zip_____

Age_____ D.O.B. ____/____/____ Single Married Widowed Separated Divorced

Email_____

Employer_____ Pharmacy_____

Whom may we thank for referring you? _____

In case of an emergency who should be notified?_____ Phone _____

PRIMARY INSURANCE

Subscriber (if not the Patient)_____ Relationship to Subscriber _____
Last Name First Name Middle Initial

Address (if different from Patient)_____ City_____ Zip_____

Phone_____ D.O.B. ____/____/____ Social Security Number _____

Employer_____ Occupation_____

Insurance Company _____

Subscriber ID/Member #_____ Group # _____

Is patient covered by additional insurance? ☐ **No** ☐ **Yes If yes, see reverse**.

ASSIGNMENT AND RELEASE

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT:

I hereby authorize the above-named physician to release any information acquired in the course of my examination or treatment to the named insurance company for the purpose of billing. I also authorize release of information to my employer if this is a work-related problem. I authorize payment directly to the above-named physician of any medical benefits otherwise payable to me for his services described, but not to exceed the reasonable and customary charge for these services. It is understood that any monies received from the insurance company over and above any indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges not covered by this authorization. I further agree to pay all finance charges, collections costs (40%), attorney fees, and any other cost that may be incurred to enforce collection of any amount.

I authorize the above-named physician to perform those diagnostic and/or therapeutic office procedures deemed necessary to evaluate and/or treat my current medical illness(es). I make this authorization with the knowledge that the above-named physician will verbally describe the nature of said procedures in lay terminology, including possible complications and side effects and obtain verbal and/or written consent prior to procedures. I retain the right to refuse any procedure, either diagnostic or therapeutic, after being informed of its nature, complications and side effects.

I UNDERSTAND THAT FAILURE TO PAY MY CO-PAY AT THE TIME OF SERVICE WILL RESULT IN AN ADDITIONAL ADMINISTRATIVE FEE.

_____ _____ _____

Signature Relationship to Patient Date

ADDITIONAL INSURANCE

Subscriber (if not the Patient)_____ Relationship to Subscriber _____
Last Name First Name Middle Initial

Address (if different from Patient)_____ City_____ Zip_____

Phone_____ D.O.B. ____/____/____ Social Security Number _____

Employer_____ Occupation_____

Insurance Company _____

Subscriber ID/Member #_____ Group # _____

CURRENT PROVIDERS

	Name	City	Telephone Number
Referring Provider:			
Primary Care Physician:			
OB/GYN:			
Urologist:			
Physical Therapist:			
G.I.:			
Other:			

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PRIVACY POLICY

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The privacy rule was also created to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those who we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we may have indirect treatment relationships with you (such as laboratories, radiology and pathology) that only interact with physicians and not patients and we may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information (PHI), but this must be in writing. Under the law effective April 14, 2003, we have the right to refuse to treat you should you choose to refuse disclosure of your (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA compliance officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy policy.

Print Name:_____ Signature:_____ Date:_____

(If patient is under 18 years of age, a parent or guardian must sign).
(This policy expires ten years from the original date signed).

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CONSENT FORM

Patient Name:_____ DOB: _____

I authorize the following person to represent me at the office of Peter A. Castillo, MD, if I am unable to personally authorize medical services for myself. This authorization is valid until withdrawn in writing.

_____

Name (other than person completing this form) Relationship to patient Phone

Authorization for Test Results (By checking the box you are authorizing us to leave a message):

Abnormal	Normal	
☐	☐	Home Telephone _____
☐	☐	Work Telephone _____
☐	☐	Cell Phone_____
☐	☐	Other contact (name, relationship, phone number) _____

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FINANCIAL POLICY AGREEMENT

Please initial all: Date: _____

_____ **Account Balances:** Full or partial payments due at check-in for all patient accounts.

_____ **Bounced/Returned Check Fee:** All returned checks will incur a **$25.00** administrative fee billed to the patient's account.

_____ **Cancellation and No-Show Policy:** If it is necessary to cancel your scheduled appointment, we request that you call one (1) working day in advance. A failure to cancel or present at the time of a scheduled appointment will be recorded in your chart as a "no-show" and an administrative fee of **$50.00** will be billed to your account. Patients with 3 "no-shows" may be dismissed from the practice.

_____ **Collections Policy:** All outstanding patient account balances will be sent to a third-party collections agency for payments not received within 90 days of services performed and billed. Patient further agrees to pay all finance charges, collections costs (40%), attorney fees, and any other cost that may be incurred to enforce collection of any amount.

_____ **Co-payments/Co-Insurance:** Due at time of services rendered; exact amount of cash is appreciated, as office carries minimal cash for change. Checks and credit cards (Visa, MasterCard, and American Express) are accepted.

_____ **Finance Charges:** All outstanding patient account balances will be assessed a finance charge of 2% (minimum $2.00) for payments not received within 60 days of services performed and billed. An additional finance charge of 2% will be assessed every 30 days that full payment is not received.

_____ **Insurance:** Your insurance policy is a contract between you and the insurance carrier; the Physician is not involved in this contract. You are contractually responsible for your co-payment, co-insurance, or any balance unpaid at the time of service.

_____ **No Insurance:** Patients who are self-pay are responsible for the entire balance at time of service.

_____ **Payment Plans:** Any patient with an account balance greater than $100 may set up a payment plan with our office. At minimum, 10% of the total balance must be collected each month.

_____ **Payment Methods:** The office of Peter A. Castillo, MD, offers several payment methods to help accommodate a patient's financial status. Patients can choose:

- Provide a credit card for the staff to keep on file. Any account balance will be charged to the card on file monthly;
- Receive monthly statements in the mail and pay the full balance promptly;
- Set up a payment plan with our office. Once established, the patient agrees to adhere to the chosen payment method until the balance is paid in full;
- Establish an account with one of our patient financing vendors (ask one of our staff members for additional information on patient financing options).

F I N A N C I A L P O L I C Y C O N S E N T

Please select preferred account payment method (CHOOSE ONE):

***In an effort to make our billing process easier, faster, and more efficient, the office of Peter A. Castillo, MD, has implemented a policy to collect credit card information at the time of your visit. Your card information will be held securely until your insurances have paid their portion and notified our office of the amount of your share. At that time, any balance owed by you will be charged to the credit card on file. This will be an advantage to you since you will no longer need to mail in a check, and it will be an advantage to our office since it will greatly reduce billing costs.*

This payment method does not apply to patients who are self-pay patients. Co-pays are still due at the time of service. Should you have any further questions, please contact our office staff.

☐ I authorize the office of Peter A. Castillo, MD, to charge my credit card for account balances remaining after my insurance policy has paid. No statement will be provided. Women's Pelvic Health Institute will send a detailed receipt within 5 business days of the transaction. If the charge is not accepted by the credit card company a monthly statement as described below will be sent and this selection will be voided until valid credit card information is received.

Visa, MasterCard, American Express (**Please circle one**)
Card Number:_____Exp. Date:_____CVV Code: _____
Card Holder Name: _____
Card Holder Signature: _____

☐ I prefer to receive a monthly statement in the mail, and I agree to pay the balance in full promptly.

☐ I have a Health Savings Account (HAS) that should automatically pay my account balance. I understand that by selecting this choice I will be billed monthly and will promptly pay my balance not paid by my HSA account.

I have read and agree to the Financial Policy for the office of Peter A. Castillo, MD.

Printed Patient Name: _____

Patient Signature:_____Date: _____

Thank you for your cooperation.

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