DR MOAYAD IS AN OUT OF NETWORK PROVIDER FOR PPO INSURANCES

OFFICE POLICY: We appreciate your patronage. The purpose of our policy is to inform patients of their responsibility before their appointment. If you do not understand any part of the policy below, please ask our office staff.

Release of Medical Information:
I hereby authorize Hamid Moayad, D.O., P.A. to furnish information to my insurance carriers, physicians and other facilities concerning my illness and treatments. I certify that I have given correct and complete information with regards to my insurance coverage.

Assignment of Benefits:
I hereby assign Hamid Moayad, D.O., P.A. all payments for medical services rendered. I understand that I am responsible for any amount not paid by my insurance company, including diagnostics services, evaluation, laboratory tests, non-covered services, copays, deductibles, and co insurance balances.

Insurance Policy:
It is the policy of this office to collect copays and deductables at the time of your appointment. It may also be necessary to collect payment in full for some lab services. (Lyme Igenex Testing) that is not covered by insurance.

If for any reasons you cannot pay at the time of service, you may notify the office so we may set up a payment option plan for you. If you do not call the office if you cannot make your appointment, a fee will be applied to that date of service and will be due at your next appointment.

In the event that you give our office out-dated information and payment is subsequently denied or withheld, you are responsible for payment of outstanding balances after an attempt to file the correct information.

Referrals:
If you insurance company requires you to have a referral, it is your responsibility to make sure our office has an active referral at the time of your visit. This includes in network referrals.

General Consent to Treat:
I authorize and direct Hamid Moayad, D. O., P.A. to treat my medical condition in the way they may determine advisable for my well being. I acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the outcome of my treatment.

Date and sign that you understand our office policy, release of medical information, assignment of benefits, referrals, insurance policy, and general consent to treat.

Patient Signature: _____

Guardian Signature: _____

Witness: _____