IMPORTANT OFFICE POLICIES

RELEASE OF MEDICAL INFORMATION
I authorize Tooraj Zahedi, MD, FACE & Associates to release my medical records to any physician, hospital, or agency involved in the my care.

ASSIGNMENT OF MEDICAL BENEFITS
I authorize my insurance carrier to assign all medical benefits to Tooraj Zahedi, MD, FACE & Associates. I also authorize release of medical information necessary to process all medical insurance claims.

PAYMENT POLICY
Co-payments are to be collected at the time services are rendered. We accept cash, checks and credit cards. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing manager.

CANCELLATION POLICY
Our office requests that if an appointment needs to be cancelled that we receive notice no later than 4 hours prior to the appointment. We reserve the right to charge $50.00 for a "no show" appointment, to be collected on or before your next appointment.

REFERRAL POLICY
I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____

Social Security: _____

Email Address: _____

Pharmacy Name & Number: _____

Date: _____

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office and will provide you with a current copy, and an opportunity to object, as detailed above. The notice will contain, on the first page, in the top right hand corner the effective date.

COMPLAINTS

If you believe your privacy rights have been violated you may file a complaint with the Office Administrator or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Dated: 2019, Forest Hills, NY 11375

Date: _____, 2019

X_____ X_____

Signature of Patient or Representative Print Patient's Name

X_____

Name of Personal Representative (if applicable)

X_____

Relationship to Patient