Jacobo Futran, MD.

PATIENT INFORMATION

Last Name:_____First Name:_____MI__ __DOB_____Sex_____

Address:_____Apt._____City_____State___Zip_____

Home Telephone (____)_____Work Telephone (____)_____Cellular (____)_____

Race: White___ African/American___Hispanic____Asian____Native American___ Other____Refuse to report_____

Ethnicity: Non-hispanic_____ Hispanic____ No answer_____

Preferred language_____Pharmacy_____

Emergency contact_____Relationship_____Telephone_____

Referring Physician:_____Referring physician address:_____

Name of primary care physician_____

EMPLOYER NAME _____ TELEPHONE_____

PRIMARY INSURANCE

Insurance carrier_____Group No._____

INSURANCE ID _____POLICY HOLDER:_____

SS#_____DOB _____

Relationship to patient: Self____ Spouse____ Child_____ Other_____

I certify that the above information is correct to the best of my knowledge. I, the undersigned, also certify that I have insurance with _____and assign beneficts directly to Jacobo Futran, MD. I also authorize release of any and all my medical information and / or records. I also authorize Jacobo Futran, MDto use or disclose my protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Jacobo Futran, MD 'NOTICE OF PRIVACY PRACTICES' for a more detailed description of such disclosures for which at any time I have the right to review. By signing this form I also certify that I have received a copy of such upon request. I have the right to request Jacobo Futran, MD restrict how it uses or discloses my PHI to carry out TPO. Please contact the privacy officer for any questions or concerns.

PATIENTS NAME: (please print) _____

SIGNATURE OF PATIENT _____ DATE: _____

JACOBO FUTRAN, MD
OFFICE POLICIES

PAYMENT POLICY

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF VISIT.
IF YOU NEED SPECIAL CONSIDERATIONS PLEASE SPEAKE WITH OFFICE MANAGER PRIOR TO SEEING THE DOCTOR.
PLEASE ASK THE FRONT DESK FOR WHICH TYPE OF INSURANCE PLANS IN WHICH WE PARTCIPATE.
IF WE DO NOT PARTICIPATE, YOU MUST PAY AT THE TIME OF SERVICE.
WE ACCEPT CASH AND CHECKS ONLY. THERE WILL BE A FEE FOR BOUNCED CHECKS THAT ARE RETURNED.
ALL MEDICARE PATIENTS, IF YOU HAVENOT MET YOUR DEDUCTIBLE, YOU ARE RESPONSIBLE FOR THE DEDUCTIBLE AND / OR CO-INSURANCE.

REFERRALS.

-IF YOUR INSURANCE COMPANY REQUIRES THAT YOU OBTAIN A REFERRAL IN ADVANCE FOR YOUR VISIT, IT IS **YOUR** RESPONSIBILITY TO MAKE SURE YOU BRING IT WITH YOU OR HAVE IT SENT TO US PRIOR TO YOUR VISIT. **WE REGRET THAT WE CANNOT CALL FOR YOU**.

-IF YOUR PRIMARY CARE DOCTOR'S OFFICRE ISSUES REFERRALS ELECTRONICALLY, IT IS **YOUR** RESPONSIBILITY TO OBTAIN **THE CONFIRMATION/AUTHPORIZATION NUMBER** AND # OF VISITS ALLOWED.

IF YOU COME WITHOUT A REFERRAL, YOU MUST PAY THE DISCOUNTED FEE FOR THE OFFICE VISIT OR RESCHEDULE YOUR APPOINTMENT.

WE REGRET THAT WE CANNOT CALL YOUR DOCTORS OFFICRE FOR YOU.

CO-PAYMENTS.

CO-PAYS ARE DUE AT THE TIME OF SERVICE. THERE ARE NO EXCEPTIONS. WE CAN NO LONGER BILL PATIENTS FOR NOMINAL FEES. IF WE ARE FORCED TO BILL YOU FOR A CO-PAY, WE WILL CHARGE AND ADDITIONAL "BILLING" FEE.

PLEASE REMEMBER TO CANCEL APPOINTENTS AT LEAST 24 HOURS IN ADVANCE.

MISSED APPOINTMENTS.

-PLEASE REMEMBER TO CANCEL APOINTMENTS AT LEAST 24 HOURS IN ADVANCE. IF YOU MISS AN APPOINTMENT, WE RESERVE THE RIGTH TO CHARGE YOU A PENALTY FEE.

FOR ALL PATIENTS.

I UNDESTAND THAT I AM RESPONSIBLE FOR ALL CHARGES FOR SERVOCES RENDERED TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURSNCE BENEFITS ACCORDING TO MY INDIVIDUAL CONTRFACT. I AGREE TO PAY THE BALANCE IN FULL FOR ANY REASON MY INSURACNE DENIES PAYMENT.

PLEASE SIGN BELOW TO CONFIRM THAT YOU HAVE REVIEWED THESE PRACTICE POLICIES AND UNDERSTAND THEM. PLEASE FEEL FREE TO ASK ANY QUESTIONS.

_____ _____
PATIENTS NAME (please print) Date

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