BRIDGET SILVA, M.D.
FAMILY MEDICINE
10220 W SAMPLE ROAD
CORAL SPRINGS, FL 33065
(954) 340-1123

PATIENT INFORMATION:

DATE _____

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

PRIMARY PHONE _____SECONDARY PHONE _____

BIRTHDATE _____ AGE _____PHARMACY#_____

HOW WERE YOU REFERRED TO OUR OFFICE _____

OCCUPATION _____ WORK NUMBER_____

EMPLOYER _____

MARITAL STATUS S___ M___ D___ W___ SPOUSE NAME_____

EMERGENCY
CONTACT_____RELATIONSHIP_____

TEL# _____

PRIMARY INSURANCE _____ID#_____

PHONE # _____ GROUP # _____

PRIMARY NAME ON INSURANCE POLICY_____

PRIMARY BIRTHDATE _____ CLAIMS ADDRESS_____

_____

SECONDARY INS _____ SEC ID_____

PARTICIPATING LAB_____

(IF YOU DO NOT KNOW PLEASE CALL THE CUSTOMER SERVICE NUMBER ON YOUR CARD)

PATIENT SIGNATURE _____

BRIDGET SILVA, M.D., PA

Authorization and General Consent

Family Medicine

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

I hereby authorize the physician or physicians in charge of the named patient to administer any treatment, as she or they deem necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to results of treatments or examination. The physician is not responsible for what my insurance does or does not cover.

STATEMENT OF FINANCIAL RESPONSIBILITY

The undersigned agrees, whether he signs as Agent or as Patient, that in consideration of the Services to be rendered to the patient, he hereby individually obligates himself to pay his account in accordance with the regular rates and terms of the practice of Bridget Silva, MD, PA. If the amount owed is not fully satisfied by the due date, then **a fee of 35% of the outstanding balance** as calculated on the due date will be added to the outstanding balance and sent to our collection agency.

INSURANCE DEPARTMENT ASSIGNMENT

In the event the undersigned is entitled to professional service benefits of any type, arising out of any policy of insurance insuring patient, said benefits are hereby assigned to the appropriate physician for application on patient's bill. It is agreed that the appropriate physician may receipt for any such payment which shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and the patient are responsible for all charges not covered by this assignment.

MEDICARE ASSIGNMENT OF BENEFITS

I request authorization of payment of Medicare/Medicaid benefits on my behalf for any services furnished me by the above physicians to be made to said physician. I authorize any holder of medical or other information about me to release to Medicare/Medicaid and its agents, any information needed to determine these benefits for related services.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned hereby authorizes the above physicians to release or make available for medical review or their related information to insurance companies or medical assistance programs (including their agents, representatives or assignees) through which payment of benefits in connection with hospital and/or professional services are or may be available.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ FULLY AND UNDERSTANDS THE ABOVE STATEMENTS/AUTHORIZATIONS AND EXPLANATIONS THEREIN REFERRED TO HAVE BEEN MADE; HE FURTHER CERTIFIES HE IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERM.

_____ _____

Patient Signature *Date*

_____ _____

Patient's agent or Representative *Relationship to Patient*

_____ _____

Guarantor *Relationship to Patient*

PATIENT RESPONSIBILITIES

Thank you for choosing us as your primary care providers. We realize that you have a choice and we are committed to providing you with the utmost quality of care. We ask that you become familiar with our office policies and procedures, and understand they are in effect so that we can provide all of our patients with the best care possible.

When calling our office, we have a menu of options to help expedite your call. Please listen to the message and choose the prompt you are looking for.

APPOINTMENT CHECK-IN

Please inform the front desk personnel of any **address, phone or insurance changes**, as they can result in a claim denial by your insurance company or being sent to collections. Co-pays, deductibles, lab fees and outstanding balances will be collected prior to your visit with the practitioner. This eliminates delays when checking out. We accept cash, check, or credit cards.

PRESCRIPTION REFILLS

The doctor gives you enough medication to cover you to your next appointment. You will need an appointment if you have run out of refills. If you are requesting prescription for other reasons leave a message on the prescription line. Be sure to speak slowly and clearly, leave the spelling of your name, prescription name, dosage and pharmacy phone number. Please allow one week to be filled. Follow up with your pharmacy. **Note: Under no circumstances will controlled substances be refilled without an appointment.**

Some medications may require a prior authorization from your insurance company. Obtaining approval involves extensive phone calls and paperwork and may require a doctors' visit. This does not guarantee authorization, as that is up to your insurance company.

LAB

We provide you with a lab order to take with you to your contracted drawing station and input it directly into the Quest system. You will receive a call from us with the results approximately two weeks from the time your lab is drawn. We will inform you if the labs are normal. **If there are any abnormal results, or you wish to go over normal labs in more detail, the practitioner requires you to make an appointment to go over the results**. The staff is not authorized to go over detailed results with you over the telephone. You can also set up your own portal with Quest Diagnostics to view your personal results.

REFERRALS

If your insurance requires you to obtain referrals for specialist visits, you may be required to see a practitioner here prior to obtaining the referral for the reason you are visiting the specialist. Please allow 7 days for the referral to be completed. We will notify you when it is ready so that you may pick it up.

FORM/ LETTER FEE

If you require forms to be filled out for any reason, or a letter written on your behalf, there is a $30.00 fee to do so. It is necessary for you to make an appointment for the doctor to complete them correctly the first time, according to your wishes.

APPOINTMENT TIMES/CANCELLATIONS

The doctors make every effort to see all patients in need of medical treatment. For this reason, if you are late for your scheduled appointment time, you may be asked to reschedule.

If you need to cancel an appointment, we ask for your consideration. Please notify us 6 hours before your scheduled appointment if you are unable to make it, so that we may give a patient in need, that spot. **Failure to notify us will result in you being charged a $50.00 No Show Fee**, which will be collected prior to any future appointments.

COLLECTIONS

In the event you do not pay your bill after **3 invoices** are sent to you, you will be sent to collections by our billing company. **You will be responsible for all charges incurred, including the 35% collection and/or attorney's fees.**

AFTER HOURS CALLS

After-Hours calls are for Medical **Emergencies only.** For Refills, Referrals or Questions you must call the office during normal business hours. Your call will not be returned if you leave a message on the emergency line for a non-urgent issue. **You will be charged an after-hours call fee of $50.00 if you choose to have a practitioner paged, as well as your normal copay/deductible**.

PAYMENT FOR NON-COVERED SERVICES

Due to the high volume of insurance companies, and their agreements with varying provider networks, we cannot be responsible to track the specifics of each patient's benefits. If your insurance company does not cover a particular lab or procedure, you will be responsible for payment of that service. It is Your Responsibility to know your benefits.

_____

Printed Name

_____ _____

Patient Signature Date