Jose I Lopez , M.D., P.A.

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care. I understand that diagnosis or treatment of me by Jose Ignacio Lopez MD PA may be conditioned upon my consent as evidenced by my signature on the document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of practice. The above organization is not required to agree to the restriction that I may request. However, if the above organization agrees to a restriction that I request, the restriction is binding on the above organization.

I have the right to revoke this consent, in writing at any time, except to the extent that the above organization has taken action in reliance on the consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the above organization Notice of Privacy Practice prior to signing this document .The Notice of Privacy Practice has been provided to my .The Notice of Practice describe the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of above organization. The Notice of Privacy Practice are also provided at the above organization and the website if applicable. This Notice of Privacy Practice also describe my right and the above-named organization's duties with respect to my health information.

The above-named organization reserved the right to change the privacy practice that are described in the Notice of Privacy Practices. I may obtain a revised notice of practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of patient or personal representative

_____
Name of patient or personal representative

_____
Description of Personal Representative's Authority

_____
Date

Jose Ignacio Lopez, MD
Diplomats American Board of Internal Medicine

Due to our continuing efforts in meeting the needs of all outpatients, we need to make you aware of some policies. Please sign and print your name at the bottom of the form showing that you have read and understand each policy. By signing this page, you also are giving us consent to apply each policy.

LABS/X-RAYS:

When the physician order Labs or X-Rays, it is important that you obtain this right away. This will allow time to review the results prior to your next appointment as well as ensure that your results are ready by the follow up appointment. If they are not completed timely, you will be subject to reschedule your future appointment until all results are received.

RESULTS OF LABS & X-RAYS:

We require all patients to follow up with the physician to receive results of any labs, X-rays, or diagnostic test. This is necessary so that the physician can answer any questions you may have regarding your care as well as discuss any future and/or treatment options with you.

NO SHOW POLICY:

If you have an appointment with our office and, are unable to attend, you must give our office 24-hour notice so that we may give the appointment to another needy person. If a 24-hour notice cannot be given, please give our office a courtesy call as soon as possible. If we do not receive a call to cancel or reschedule your appointment, you will be responsible for a $25.00 NO SHOW FEE. *This is not covered by your insurance and must be paid before the next visit.* After the third missed appointment, without notification, we will no longer be able to offer medical care for you.

RETURNED CHECK CHARGE:

If we receive a returned check from your bank due to non-sufficient funds, account closed, etc. you will be charged an administrative fee of $25.00. This fee and any balance due will need to be paid by you prior to your next appointment. *Please note that is not covered by your insurance*.

COLLECTIONS ON ACCOUNTS:

If your account is laced with a collection agency due to non-payment for any guarantor balances, you will be responsible for any costs associated with these collection efforts. Possible cost could include collection percentage for outside company fees and attorney/court fee that may apply.

COMMUNICATION CONSENT:

All incoming and outgoing calls are being monitored and recorded for quality assurance. Excellent service is our priority.

AUDIO/VIDEO RECORDING:

This Practice prohibit patients from making Audio/Video recordings in public areas to maintain privacy of other patients and staff members. The use of recording devices in clinical encounters needs to be acknowledged by the medical staff and physician. For security reasons, waiting room, reception area, medication storage and entrances to the building are monitored with the use of Audio/Video recording.

Signature _____ Print Name _____ Date Signed _____