OPTIMAL HEALTH CLINIC AND INTEGRATED MEDICAL CENTRE OF BONITA SPRINGS
28315 S Tamiami Trail, Suite 101, Bonita Springs, FL 34134 – 239-9471177

NOTICE OF INFORMATION PRACTICES

PROTECTING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION IS IMPORTANT TO US. THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IS CAREFULLY.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION WITHOUT AUTHORIZATION IS STRICTLY LIMITED TO DEFINED SITUATIONS THAT INCLUDE EMERGENCY CARE, QUALITY ASSURANCE ACTIVITIES, PUBLIC HEALTH, RESEARCH, AND LAW ENFORCEMENT ACTIVITIES. ANY OTHER DISCLOSURES FOR THE PURPOSES OF TREATMENT, PAYMENT, OR PRACTICE OPERATIONS WILL BE MADE ONLY AFTER OBTAINING YOUR CONSENT. YOU MAY REQUEST RESTRICTIONS ON DISCLOSURES.

DISCLOSURES OF PROTECTED HEALTH INFORMATION IS LIMITED TO THE MINIMUN NECESSARY FOR THE PURPOSE OF THE DISCLOSURE. THIS PROVISION DOES NOT APPLY TO THE TRANSFER OF MEDICAL RECORDS FOR TREATMENT.

YOU MAY INSPECT AND RECEIVE COPIES OF YOUR RECORDS WITHIN 30 DAYS OF A REQUEST TO DO SO. THERE MAY BE REASONABLE COST-BASED FEE FOR PHOTOCOPYING, POSTAGE, AND PREPARATION.

YOU MAY REQUEST CHANGES TO YOUR RECORDS. OUR PRACTICE HAS THE RIGHT TO ACCEPT OR DENY YOUR REQUEST.

IN THE FUTURE, WE MAY CONTACT YOU FOR APPOINTMENT REMINDERS, ANNOUCEMENTS, AND TO INFORM YOU ABOUT OUR PRACTICE AND ITS STAFF.

OUR PRACTICE IS REQUIRED TO ABIDE BY THIS NOTICE. WE HAVE THE RIGHT TO CHANGE THIS NOTICE IN THE FUTURE. ANY REVISIONS WILL BE PROMINENTLY DISPLAYED IN A CLEARLY VISIBLE LOCATION IN OUR OFFICE.

YOU MAY FILE A COMPLAINT ABOUT PRIVACY VIOLATIONS BY CONTACTING OUR OFFICE MANAGER.

KIM BAKER AT 239-947-1177.

THE EFFECTIVE DATE OF THIS NOTICE OF INFORMATION PRACTICES IS JUNE 9, 2021

PATIENT CONSENT AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician(s) regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance company declines to pay.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

H.M.O. DISCLAIMER: I certify that I am not presently enrolled in any Health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of this admission, due to current enrollment in an HMO plan will constitute responsibility for payment of claim on my part.

MEDICARE AND MEDICAID PATIENT CERTIFICATION – PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Date Signature

Printed Patient Name

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) TO PROVIDER/BILLING AGENT

I,_____(PATIENT/POLICY HOLDER) HEREBY AUTHORIZE _____ (INSURANCE CARRIER, LEGAL REPRESENTATIVE) IT'S AGENTS, EMPLOYEES AND ASSOCIATES, TO RELEASE THE PROTECTED HEALTH INFORMATION THAT IS DESCRIBED BELOW TO THE PROVIDER OFFICE OF OPTIMAL HEALTH CLINIC OR INTEGRATED MEDICAL CENTRE OF BONITA SPRINGS LOCATED AT 28315 S TAMIAMI TRL, SUITE 101, BONITA SPRINGS, FL 34134, OR THE BILLING AND COLLECTION AGENT/REPRESENTATIVE OF THE SAME.

MY INSURANCE CARRIER OR MY LEGAL REPRESENTATION (SHOULD CASE INVOLVE A LEGAL MATTER) IS DIRECTED TO MAKE AVAILABLE ALL OF MY INSURANCE INFORMATION INCLUDING COVERAGE INFORMATION AND ALL BILLING RECORDS SHOWING ALL CHARGES, EXPENSES, COSTS AND PAYMENTS. FAILURE TO PROVIDE SUCH REQUESTED INFORAMTION, OF WHICH I HAVE HEREBY AUTHORIZED THE RELEASE OF BY MY SIGNATURE, MAY HAVE ADVERSE AFFECTS ON MY PHYSICAL, MENTAL AND EMOTIONAL WELL BEING. I WILL HOLD ANY ENTITY LIABLE FOR SUCH NON-COMPLIANCE WITH MY AUTHORIZATION.

AT MY REQUEST, THIS INFORMATION WILL BE USED FOR THE PURPOSE OF ESTABLISHING COVERAGE; OR PAYMENT; OR BILLING; OR ESTABLISHING MY LEGAL CLAIM.

THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME BY GIVING WRITTEN NOTICE TO THE HEALTHCARE PROVIDER AND/OR BILLING AGENT A REVOKATION OF THE AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFURE TO SIGN THIS AUTHORIZATION AND THAT THE HEALTHCARE PROVIDER MAY NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENFITS ON WHETHER I SIGN THIS AUTHORIZATION.

IN UNDERSTAND THAT ONCE PHI IS DISCLOSED, IT MAY BE RE-DISCLOSED TO INDIVIDUALS OR ORGANIZATIONS THAT ARE NOT SUBJECT TO THE FEDERAL PRIVACY REGUALATIONS SUCH AS EXPERT WITNESS, LITIGANTS, INSURANCE COMPANIES, AND EVEN BECOME PUBLIC RECORD IF FILED WITH A COURT OF LAW.

A COPY OF THIS SIGNED AUTHORIZATION WILL BE PROVIDED TO ME AFTER IT HAS BEEN SIGNED.

THIS AUTHORIZATION WILL EXPIRE ON _____

DATE THIS _____DAY OF _____, 2021

PATIENT/POLICY HOLDER

_____

DATE OF BIRTH

OUT OF NETWORK INSURANCE POLICY

- We always call your insurance company to verify any benefits you may have and are willing to bill your insurance for your care. If we are out-of-network with your insurance company please keep in mind that your insurance is an arrangement between yourself and your insurance company, NOT between OPTIMAL HEALTH CLINIC and your insurance company.

- If we are out-of-network with your insurance, they may send payment directly to you, the patient. You are responsible for bringing the payment to the office with a copy of the Explanation of Benefits (EOB). If you do not bring payment into the office, we will attempt to collect by sending you a statement. If we have not received payment within 90 days of the charge being billed to your insurance, you could face your account being forwarded to a collection agency.

I understand and agree to all information written above

Date: _____

Patient Name: _____

Patient Signature: _____

OFFICE POLICY

IT IS POLICY OF THIS OFFICE TO COLLECT FOR ALL SERVICES AS THEY ARE RENDERED. THIS OFFICE ACCEPTS US CURRENCY, US CHECKS, MASTERCARD, VISA AND AMERICAN EXPRESS. IF YOU REQUEST THIS OFFICE TO ACCEPT ANY ASSIGNMENT, OR SPECIAL ARRANGEMENT, THEN YOU ARE RESPONSIBLE FOR OBTAINING ANY FORMS, AUTHORIZATIONS OR SIGNATURES THAT ARE REQUIRED, PRIOR TO TREATMENT.

1. HEALTH INSURANCE/AUTO INSURANCE WITHOUT AN ATTORNEY. MOST HEALTH INSURANCE POLICIES HAVE DEDUCTIBLES AND COPAYMENTS FOR WHICH THE PATIENT IS RESPONSIBLE. THESE MUST BE PAID IN FULL AS SERVICES ARE RENDERED. EVEN IF THE POLICY PAYS 100%, THERE ARE USUALLY LIMITS TO THE BENEFITS FOR WHICH A PATIENT IS ELIGIBLE. THEREFORE, IT IS OUR POLICY TO HAE THE PATIENT PAY THE INITIAL VISIT FEES ON THE INITIAL VISIT.
2. IF THE PATIENT REQUESTS THAT OUR OFFICE ACCEPT THE ASSIGNMENT OF THEIR INSURANCE BENEFITS THE PATIENT WILL NEED TO INSTRUCT THE INSURANCE COMPANY TO MAIL THESE BENEFITS TO OUR OFFICE TO BE APPLIED TO THE PATIENT'S BALANCE. THIS IS DONE BY SIGNING THE INSURANCE ASSIGNMENT FOUND IN OUR OFFICE. UPON RECEIPT OF AN INSURANCE CHECK, YOU WILL BE NOTIFIED OF ANY AMOUNTS UNPAID. WE ASK THAT YOU CLEAR UP ANY BALANCE OWED AT THAT TIME.
    - PRE-PROCEDURE VERIFICATIONS AND APPROVALS FROM INSURANCE DO NOT IN ANY WAY, CONSTITUTE A GUARANTEE OF PAYMENT BY THEM.
    - ALL DEDUCTIBLES (UNLESS PREVIOUSLY MET AND VERIFIED BY INS. CO) AND ANY PORTION NOT COVERED BY INSURANCE WILL BE DUE AT THE TIME OF SERVICE.
3. REGARDLESS OF YOUR INSURANCE COMPANY'S GUIDELINES, ALL UNPAID BALANCES WILL BECOME YOUR FULL RESPONSIBILITY 45 DAYS AFTER YOUR PROCEDURE.
4. WORKER'S COMPENSATION- ONCE WE HAVE BEEN INFORMED OF AN INJURY THAT HAS OCCURRED AS A RESULT OF YOUR EMPLOYMENT, WE ARE REQUIRED BY LAW TO REPORT IT. IF YOU WERE INJURED AS A RESULT OF YOUR EMPLOYMENT, YOUR TREATMENT WILL BE PAID FOR BY YOUR EMPLOYER OR THEIR INSURANCE CARRIER. YOU ARE REQUIRED TO REPORT THE INJURY TO YOUR EMPLOYER, FILL OUT NECESSARY FORMS AND REQUEST AUTHORIZATION FOR TREATMENT. WRITTEN AUTHORIZATION MUST BE PRESENTED PRIOR TO TREATMENT.
5. INJURY CASES WHERE YOU HAVE RETAINED AN ATTORNEY – WE WILL ACCEPT ASSIGNMENT ON ANY INSURANCE WHICH IS APPLICABLE (UPON VERIFICATION OF BENEFITS) AND WE WILL WAIT FOR THE INSURANCE COMPANY TO PAY US. ANY PORTION OF YOUR BILL, WHICH IS NOT PAID BY YOUR INSURANCE COMPANY IS YOUR RESPONSIBILITY. WE DO NOT ACCEPT ATTORNEY ON ASSIGNMENT. WE WILL BE HAPPY TO SUPPLY YOUR ATTORNEY WITH REQUESTED INFORMATION FOR MINIMAL COPYING CHARGES ONCE AUTHORIZATION IS GIVEN.
6. ATTORNEY'S NAME _____
7. MEDICARE - WE WILL SUBMIT INSURANCE CLAIMS TO MEDICARE ON YOUR BEHALF IF WE HAVE AGREED TO DO THIS UPON VERIFCATION OF YOUR BENEFITS AND CONSULATION WITH THE OFFICE MANAGER. THERE ARE MANY DIFFERENT TYPES OF SUPPLEMENTAL COVERAGE WITH MEDICARE AND WE MUST VERIFY YOUR COVERAGE ON A CASE-BY-CASE BASIS.

YOU REMAIN RESPONSIBLE FOR THE UNPAID BALANCE AFTER PAYMENT IS RECEIVED. ALL PROFESSIONAL SERVICES AND TREATMENTS, EQUIPMENT AND NUTRITIONAL SUPPLEMENTS THAT ARE PURCHASED AND RECEIVED ARE NON-REFUNDABLE. UNDER NO CIRCUMSTANCES ARE OPENED PRODUCTS SUCH AS EQUIPMENT AND SUPPLEMENTS REFUNDABLE.

PRINTED NAME_____

SIGNATURE_____DATE_____