Release of Medical Records and Information

This office is HIPAA compliant. We make every effort to protect your privacy. We feel it is important that you understand your patient rights to confidentially. If you have any concern, please feel free to discuss them with our office manager.

Medical Records Information Release

I understand the by signing this document I am authorizing the release of my medical information to my insurance carrier(s) needed for this or any related medical insurance claim. I authorize any holder of medical information or other information about me to release to the social security administration and the health care financial administration, its intermediaries, carriers and information needed for this or any related claim.
____________________ Initials

Medical Record Release to Hospitals/Physicians

I, the undersigned, authorize the release of my medical information to other physicians needed to provide my care. I further authorize release to hospitals and/or healthcare facilities as pertaining to my care. I understand that my records may be faxed to hospitals and/or physicians and that all reasonable efforts will be made to maintain confidentially.
____________________ Initials

Medical Records Release to Family

I authorize Lily Pan Perkins, D.P.M. to release information pertaining to my illness and or treatment to______________________________. I authorize Dr Pan Perkins to leave medical information on my answering machine. I also authorize information to be given to my spouse.
_____________________Initials

Patient Rights to Confidentiality

I understand that Dr Pan Perkins office complies with HIPAA regulations. All medical records are confidential and cannot be disclosed without the written consent of the person to whom they pertain. I further understand that under Florida law I have the right to my medical records. I further understand that I may request that my records be released to a physician and/or medical facility; however, this request must be in writing. I understand that by law this office may only release medical records that were generated by Dr Lily Pan Perkins. We cannot release medical records from other physicians, hospital or facility. I agree to accept responsibility for a copying fee as provided by Florida statues. I understand that employees have no responsibility or liability regarding any aspect of this authorization. Furthermore, I have the right to complain to the practice or the State of HHS if I feel that my privacy rights have been violated. It is the policy of this office that no retaliation of any type will be taken against any patient that files a complaint.

Patient Name________________________________ Signature________________________

Financial Policy

Payment of Benefits to the Physician/Provider

I, the undersigned, understand that Lily Pan Perkins, D.P.M. has agreed to accept Medicare and/or Health Insurance for payment of my medical bills. By my signature below, I acknowledge and understand that I am fully responsible for any yearly deductible and/or coinsurance balance after Medicare or my health insurance payment which is paid to Dr Lily Pan Perkins. I understand that I am financially responsible for any charges that are not covered by my insurance plan. If I fail to give updated or current information and the claim is denied, I will be totally responsible for the entire balance.

Signature ____ Date______________

Method of Payment

Payment is required at the time of service is rendered. Please present your insurance card(s) to our office staff for photocopying and benefit eligibility verification. You will be responsible for any copay or coinsurance amount at the time of your visit.

In the event your check is returned for any reason, your account will be charged $25. In the event it is necessary for your account to be placed with an outside collection agency or attorney, you will be assessed an additional 30% of the balance to recover the collection charges. We file your medical insurance as a courtesy. If your claim is not paid within 90 days, the claim will be transferred to patient responsibility. If timely payment is not received, the account may be referred to a collection agency or attorney.

For your convenience, we accept MasterCard, Visa, American Express and Discover, as well as cash and checks.

Thank you for taking the time to review our financial policy. Your cooperation is greatly appreciated. If you should have any questions, or require any assistance, we will be pleased to be of service.

I have read this financial policy and understand my rights and responsibilities.

Medical Records

One copy of your medical records will be provided upon request at no charge. A pre-paid charge is required for **any additional** copies. There will be a charge of $1.00 per page. Please allow 10 days for copying all medical records. There is an Xray copy charge of $5.00.

Signature____Date___________________