JOSE M BAEZ, MD, LLC

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND INFORMATION RELEASE

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and other medical professionals and institutions that I may be referred for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to JOSE M BAEZ, MD, LLC for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, coinsurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: X_____
Date: _____

FINANCIAL AGREEMENT

I understand that I'm directly responsible for all the charges incurred for medical service for myself and my dependents regardless of insurance coverage. I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date. I furthermore agree to pay legal interest, collection expense, and attorneys' fees incurred to collect any amount I owe.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable.
AGREEMENT: This above information is for the purpose of obtaining credit and is warranted to be true.
CANCELLATION POLICY: If you are unable to keep your appointment please call us at least 24 hours before your appointment in order to reschedule it. **Our No-Show fee will be $50**, to be paid prior to your next appointment.
RETURNED CHECKS: Your account will be charged $30 fee for each returned check in addition to check amount.

Signature: X_____
Date: _____

CONSENT FOR TREATMENT

I understand that by signing below that I am authorizing consent for treatment by Dr Jose M Baez and my signature is valid unless revoked by writing. I authorize the office staff to perform the care ordered by my physician. I understand that I have the right to be informed by my physician of the nature of any proposed procedure and any available alternative methods or treatment, along with an explanation of the possible risk associated with each procedure. This form is not a substitute for such explanations, which is the responsibility of my physician to provide according to recognized standards of medical practice.

Signature: X_____
Date: _____

CONSENT FOR MEDICAL RELEASE OF INFORMATION TO INDIVIDUAL/FAMILY

I also authorize the following individuals to be able to access my medical records/history either verbally or copy:

Name_____ Name_____

Signature: X_____
Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of our Internal Medicine practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.
Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:
• The right to request restrictions on the use and disclosure of your protected health information.
• The right to receive confidential communications concerning your medical condition and treatment.
• The right to inspect and copy your protected health information.
• The right to amend or submit corrections to your protected health information.
• The right to receive an accounting of how and to whom your protected health information has been disclosed.
• The right to receive a printed copy of this notice
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

PRIVACY OFFICER
MARISOL BAEZ
11181 HEALTH PARK BLVD
SUITE 1180
NAPLES, FL 34110

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices for JOSE M BAEZ, MD, LLC. Our Notice of Privacy Practice provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change.

X_____
Signature Patient's/ Parent/ Guardian

_____
Name of Patient or Representative (Print please)

_____
Date

_____
Relationship to Patient

Office use:

We attempted to obtain written acknowledgement, but couldn't be obtained for the following reason:

- Patient or Representative Refused to Sign
- Emergency Situation Prevented Signature -Initials of employee: _____
- Other: _____

This notice is effective March 20, 2017.