**Nia K. Terezakis, M.D.**

**Patricia R. Hickham, M.D. Elizabeth B. Grieshaber, M.D.**

Information for Patients:

* Insurance carriers require regular updating of patient information and medical history; please help us to maintain these standards by completing the required paperwork when you are asked to do so by our staff.
* We will submit insurance claims to the plans with which we participate if you desire (including MEDICARE and some OTHER INSURANCE companies), only if we have the insurance information at the time of visit. Your signature below gives us permission to submit these claims and release any information and records the insurance carrier may request to process your claim.
* We are unable to submit insurance claims for those plans which we are not participating providers.
* You are responsible for updating your insurance information at every visit; if you do not give us your updated information at the time of your visit you are responsible for any unpaid bill due to timely filing limitations imposed by insurance companies. Your signature below indicates that you are aware and accept this responsibility.
* Some diagnoses, discussions, and treatments may be considered **COSMETIC** by your insurance carrier; the patient/insured is responsible for any balance that is not covered by the insurance for cosmetic or experimental reasons. We will always try to inform you before any noncovered services are rendered; however, the insurance carriers may change their policies at any time, in which case, we may not be aware that the visit, a procedure, or portion thereof is not covered. In this case you (the patient, insured, or guarantor) are always responsible for any unpaid balance. Your signature below indicates that you are aware and accept this responsibility.
* All **COPAYS** are to be paid at the time of the service and any subsequent patient responsibility is to be paid immediately once determined. Secondary insurance is the sole responsibility of the patient/insured and expected to be paid by the patient/insured if not received by our office within 30 days of the Primary Insurance’s payment.
* If any overdue payment is not received in full by 60 days, the patient will automatically be assessed a surcharge of $10.00 or 30% of the total bill, whichever is greater, in addition to the outstanding balance. Medicare guidelines will be followed for all patients with Medicare coverage. Failure to pay a balance may result in other actions to collect the unpaid balance. Any unpaid balance including surcharge may be transferred to a collection agency if not received by 75 days after the patient’s initial bill date, and the patient may be discharged from our practice.
* There is a $25.00 fee for all NSF checks.
* There is a $25.00 fee for any visits not cancelled 24 hours before the scheduled appointment. Multiple failures to cancel scheduled appointments my result in discharge from the practice.
* **If the patient is a minor** (less than 18 years),a parent or designated guardian must accompany the patient or give written permission for the patient to be seen and treated in their absence. **Sign here if you consent to your minor child being seen and treated by our staff without your presence: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* We do not participate in Worker’s Compensation cases or cases which my involve litigation for other purposes. Please notify our staff if you are involved in such, as you may need to make other arrangements for your medical evaluation.
* HIPAA requires that each patient be offered a copy of our Privacy Policy. Your signature below indicates you have received or have been offered a copy of our Notice of Privacy Practices.

Your signature below indicates that you have read the above information and accept these terms for current and future medical care by our office.

Patient/Guardian Signature (including relationship) Date Staff Initials

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