

PRIVACY POLICY & INSURANCE AUTHORIZATION

Patient: _____ Date Completed: ___/___/20___

Your **Marital Status**: Single Married Divorced Separated Widowed

Your Employer: _____ Your Spouse's Name: _____

Your Spouse's Cell #:(____) _____ Your Spouse's Employer: _____

Your **Primary Care Physician**: _____ Location: _____

APPOINTMENT REMINDERS

Home Phone: _____ Cell Phone: _____ E-Mail: _____

We will be sending appointment reminders by email & text messages to your cellphone. If you would also like to be called with a reminder, please check the box next to the phone you would like called.

IF YOUR PROBLEM IS DUE TO AN INJURY, PLEASE BE SURE TO COMPLETE THIS SECTION.

Is your problem due to an injury? _____? If yes, was it due to: ___ Auto Accident ___ Work ___ Slip & Fall

What part of your body was injured? _____ State/Country that injury occurred in? _____

Do you have an open claim? _____ If yes, what is your claim #? _____

Insurance Co. _____ Phone # :(____) _____

Adjuster / Claim Representative's Name: _____

Date of Injury: _____

IN CASE OF EMERGENCY, CONTACT

Name (Must be someone not living with patient) _____ Relationship: _____

Telephone: () _____

Your **PREFERRED PHARMACY** is: _____ Location: _____

Cross Streets: _____ Phone Number: _____

LATE CANCELLATION / NO SHOW POLICY AGREEMENT:

I acknowledge that a **Late Cancellation** is when I have cancelled an appointment with less than 24 weekday hour notice and that a **No Show** is when I do not show for my appointment. I further acknowledge that David S. Weingarden, M.D. & Assoc. PC provides **1 free** "No Show" or "Late Cancellation" per calendar year. For each additional "Late Cancellation" or "No Show" (beyond the 1st free one) during the same calendar year, there will be a \$25 charge for all visits except a new patient visit which will be a \$50 charge, that I am responsible for. If I feel the late cancellation / missed appointment was unavoidable and I have the documents to prove it and I wish to have the charge waived, I will request a "Request to Waive the Late Cancellation / No Show Charge" form from the office of David S Weingarden MD & Associates PC. I understand that the completed form & accompanying documentation will be reviewed by the Practice Manager, for their sole determination of a waiver of the fee or not.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I authorize David S Weingarden MD & Assoc. PC to furnish information to insurance carriers for the purpose reviewing my medical coverage and/or for the processing of claims for services rendered to me or my dependent. I assign to David S Weingarden MD & Assoc. PC all payments for medically related services rendered by them, to myself or my dependent. This authorization and assignment will remain in effect until revoked by me in writing. I understand and agree that I am responsible for any amount not covered by my insurance. I also agree to reimburse David S Weingarden MD & Assoc. PC the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, incurred in such collection efforts. I will also be responsible for any charges for returned checks due to insufficient funds.

NOTICE OF PRIVACY AND TEXTING PRACTICES: I acknowledge that I have received and read a printed copy of the Notice of Privacy Practices. I am aware that the Notice of Privacy Practices is available on the Practice web page at www.dswmd.com. I also agree to allow the Practice to send me automated text messages to the number I provide for appointment reminders and/or communications from David S Weingarden & Associates P.C.

My signature below attests to my authorization & acknowledgement of all the sections above

(Late Cancellation / No Show Policy, Insurance Authorization & Assignment, Notice of Privacy and Texting Practices)

Name & Signature: _____ Date: _____