Pompano Beach Internal Medicine

Eugenio Menendez, D.O., P.A.

d/b/a **Pompano Beach Internal Medicine**

Office of **Eugenio L. Menendez, D.O., F.A.C.P.**

Board Certified -- Internal Medicine

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PATIENT NAME(FULL FIRST, MI, LAST NAME):_____

PATIENT AUTHORIZATION FORM

HMO/PPO DISCLAIMER: I certify that I am not enrolled in any Health Maintenance Organization (H.M.O.), Preferred Provider Organization (P.P.O). Subsequent rejection of a claim as a result of this consultation, due to current enrollment in an H.M.O. plan will constitute responsibility for payment of claim on my part. **INITIALS: _____**

H.M.O./P.P.O. ACCEPTANCE: I certify that I am enrolled in _____ Health Maintenance Organization (H.M.O.)/Preferred Provider Organization (P.P.O.). I understand that if I change H.M.O./P.P.O. enrollment I must notify: *Eugenio Menendez, D.O., P.A. immediately.-SEE CONFIDENTIAL MAILING ADDRESS/AND OR EMAIL ADDRESS ABOVE.* Subsequent rejection of a claim as a result of this consultation, due to changing H.M.O./P.P.O plan will constitute responsibility for payment of claim on my part. **INITIALS:_____**

FEE CONSENT: In consideration of the provision of medical services rendered by **Eugenio Menendez, D.O., P.A.** to the above named patient. I assume full responsibility for all physician charges for such medical services rendered to the above named patient, derived from deductible and co-insurance amounts as well as any amounts not covered by my insurance carrier, from the actual physician charges. I have been advised that, pursuant to 42 C.F.R., Section 405.420, the physician is authorized and obligated to undertake reasonable collection efforts, such as submitting follow-up letters, and engaging in personal and telephonic amounts due and owing pursuant to the rendering of medical services to the above named patient. Further, I agree that, I will be responsible for all collection costs, attorney fees and court costs should this account be referred to an attorney or collection agency. In the event that I am financially unable to pay my bill, I will report in writing to the physician my inability to pay prior to services being rendered. **INITIALS:_____**

SIGNATURE:_____

WITNESS:_____Date:_____

IT IS THE POLICY OF THIS OFFICE

THAT PAYMENT IS EXPECTED AT THE TIME SERVICE IS RENDERED