PRIVACY POLICY & INSURANCE AUTHORIZATION

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

Please complete the following and sign where indicated below. Thank you.

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:_____

Your Primary Care Physician: _____Phone # _____

Address:_____

IN CASE OF EMERGENCY, We should contact:
Name (Must be someone **not living with patient)** _____

Relationship: _____ Telephone: (____)_____-_____

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

Spouse's name:_____ Spouse's Work #: (____)_____-_____

Name of Spouse's Employer: _____

Your Employer:_____ Position: _____

Address: _____

WINTER ADDRESS: _____

Dates From / To (estimate): _____

INSURANCE AUTHORIZATION & 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.

LATE CANCELLATION / NO SHOW POLICY: 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.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received & read a copy of the Notice of Privacy Practices. I am aware that the Notice of Privacy Practices is also available on the Practice web page at www.dswmd.com.

My signature below attests to my authorization & acknowledgement of the 3 sections above (Insurance Authorization & Assignment, Late Cancellation / No Show Policy & Notice Of Privacy Practices).

Name & Signature: _____ **Date:** _____