DISCLOSURES OF MEDICAL INFORMATION TO FAMILY MEMBERS AND FRIENDS

☐ **I DO NOT GIVE PERMISSION** to disclose personal medical information about my treatment and/or financial account information to family members or friends.

☐ **I GIVE PERMISSION** to disclose financial account information and/or personal medical information about my treatment to the following individuals:

These are the additional persons I give my permission to disclose information about my medical treatment/account:

Name: _____ Relationship: _____ Phone #: (___) _____

Name: _____ Relationship: _____ Phone #: (___) _____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE?

☐ **YES** ☐ **NO**

PHARMACY INFORMATION (we transmit all prescriptions through the computer!)

Local Pharmacy Name: _____Phone #: (___) _____
Address: _____
Mail Order Pharmacy Name: _____ Phone #: (___) _____
Address: _____

FOR MEDICARE PATIENTS ONLY

Medicare Authorization: I request that payment for Medicare Benefits be made on my behalf to Dr. Eric Tondera, D.C, P.C. for any services provided to me by its Providers. I authorize Dr. Eric Tondera, D.C, P.C.to release to the CMS and its agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare benefits apply.

MEDICARE IS NOT ALWAYS THE PRIMARY INSURANCE. FEDERAL REGULATIONS REQUIRE THAT WE OBTAIN INFORMATION TO DETERMINE IF ANOTHER INSURER MAY BE PRIMARY TO MEDICARE:

1. Do you or your spouse now work in a company which has 20 or more employees and have insurance at the job? ___Yes ___No

2. Are you covered by an HMO/PPO which makes Medicare secondary? ___Yes ___No

3. Is this illness/injury covered by the VA? ____Yes ____No

4. Is this illness /injury covered by Federal Black Lung or End Stage Renal Disease Program? ____Yes ____No

5. Is this illness/injury due to an automobile accident? ____Yes ____No

6. Is this illness/injury due to work related causes? ____Yes ____No

ALL PATIENTS PLEASE READ AND INITIAL

- I hereby acknowledge that I have been provided with an opportunity to review the privacy notice of health information practices of Dr. Eric Tondera, D.C, P.C.
  - _____ Initial of Acknowledgement

FINANCIAL POLICIES

INSURANCE

As a courtesy, we will file your insurance if your insurance plan is one with which we are contracted. If your insurance has changed since your last visit, please inform us before your visit, and present us with your new card to be sure we are in that plan. **If you do not inform us of a change and we have not been able to collect from your previous insurance, you will be responsible for any unpaid balance. Please remember that all charges are your responsibility whether or not your insurance company pays. Any amount due after insurance pays is your responsibility and is due upon notice.**

- Payment is due at the time services are rendered. Your co-pay is to be paid each time you come to the office. We accept cash, credit/debit cards and personal checks with a valid Texas Driver's License.

- Fixed co-pays will be collected at the time of check in. Inability to make payment at that time may require us to reschedule your appointment. **Deductibles, co-pays, co-insurance and non-covered services must be paid at the time the service is provided. Medicare Patients: It can be considered Medicare fraud to waive deductibles and co-payments.** Therefore, you will be billed these amounts following Medicare reimbursement.

- **Referrals/Authorization:** I understand that if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of service, no services will be rendered until I obtain a referral or sign a waiver of financial responsibility. Payment in full is required at the time of service.

- **Assignment of Benefits/Release of medical information:** I request that payment for authorized Medicare or other applicable private insurance benefits be paid directly to Dr. Eric Tondera for services provided under his care. I also authorize Dr. Eric Tondera to release necessary medical information to my insurance company, its agents, or any third party in order to determine payable benefits for the services rendered.

- **Missed Appointments**: If you are unable to attend your appointment, notice needs to be given to us 24 hours in advance unless it is an emergency. If you miss two appointments without proper notification you will be subject to the charge for the office visit missed in the amount of $25.00. If your miss a third appointment, you will be charged a full office and/or possibly notified that you will need to find another physician.

- **Returned checks**: A fee of $35.00 will be charged for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order or check to prevent further action. If a check is returned on your account, we will no longer be able to accept personal checks as payments.

- **Medical Records:** There is a fee of $25.00 for the first 20 pages and $.50 cents thereafter for additional pages. If records are requested by another physician's office a courtesy copy of your records will be sent to the requesting physician.

Thank you for choosing Tondera Family Practice and Chiropractic to provide your health care. Our main concern is that you receive the proper and optimal treatment needed. In order to prevent any misunderstandings and to serve you better, we ask that all patients read and sign our financial policy. If you have any questions or concerns about policies, please do not hesitate to contact our business office.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we look forward to serving you.

Print Name:_____

Signature:_____ Date: _____