GEOFFREY M. KWITKO,, M.D., F.A.C.S., F.I.C.S, F.A.A.O., F.N.O.S.S, F.I.S.O.D.

CURRENT OFFICE POLICY

1) ***I understand that I am financially responsible for all charges not covered by my insurance company.***
2) If we cannot verify your insurance on your first office visit, you are responsible for payment in full at the time of the visit.
3) If you are on an HMO, you must have prior authorization for your visit or reschedule your appointment. If you do not wish to reschedule to appointment you must pay in full at the time of the office visit.
4) Any insurance copays must be paid at the time of office visit. Also any patient's portion of the bill i.e. 20% of the bill must also be paid at the beginning of visit.
5) Workman's comp patients must be prepaid before the time of visit.
6) Self-pay patients must pay in full at the time of the office visit, unless prior arrangements have been made.
7) If there is any balance owed for an extended period of time there may be a monthly finance charge added to your outstanding balance. If you default on your payments it will be sent to a billing company which will add more fees onto the balance.
8) If your insurance company requests any information i.e. second policies, injury reports, etc the responsible party must cooperate with the insurance company in a timely matter or be fully responsible for the bill.
9) There is a $50.00 return check fee for any returned checks.
10) We do not give any medical information out on the phone as required by the law.
11) Minor children must have guardian or parent present during visit or a witnessed note giving permission for the doctor to see the patient without the parent or guardian.
12) We will file your secondary insurance per your request, though be aware it is not done automatically.
13) There may be a medical student present during the office visit examination unless you specifically refuse it.

I_____ hereby have read and fully understand these policies and will abide by it.

_____ Date: _____ _____

Patient's Signature/Parent Signature (if patient is a minor) ***Witness***

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance company to make any payable benefits to Dr. Geoffrey M. Kwitko, and a photocopy of this assignment shall be considered as effective and valid as the original.
I authorize the doctor to initiate any complaints to the Insurance Commissioner for any reason on my behalf.

SIGNATURE OF POLICYHOLDER:_____
DATE:_____

RELEASE OF MEDICAL RECORDS

I, the undersigned, agree to allow Dr. Geoffrey M. Kwitko, to release a copy of my medical records, if so requested by me either now in the future, to another party to be designated by me at the time of my request.
I, the undersigned, hereby authorize any physician who has examined and/or treated me, to release any and all medical information and records concerning diagnosis and treatment to Dr. Geoffrey M. Kwitko, M.D., F.A.C.S., F.I.C.S., F.A.A.O.

SIGNED:_____ DATE:_____