Luda Kamenetsky, M.D.
1315 St. Joseph Parkway Suite 1101, Houston, TX 77002
Phone: 713-659-3781 Fax: 713-659-6848

OFFICE POLICY-PLEASE READ CAREFULLY

Payment, copay, and/or any account balances remaining after insurance has paid, are due before you see the doctor. We accept cash, check, debit cards, and all major credit cards. There is a $25 charge for all returned checks plus a $25 bank charge. There is also a $25 penalty charge for missed appointments if the office is not notified 24 hours in advance of the scheduled visit.

Patients without insurance will be expected to pay the full cost of the visit before they leave the office unless previous payment arrangements have been made with the billing company.

Frequently insurance companies require additional information from the patient before processing a claim. If you receive such requests in the mail, please fill out the form and mail it to your insurance company as quickly as possible. Failure to do so will make you responsible for the entire bill regardless of your contract status.

If your insurance requires referrals for specialists, they must be requested at least 1 week prior to the appointment and you must have seen your primary care physician in this office within the last 6 months. Requests for symptoms which can be treated in this office will be referred to our appointment desk.

Luda Kamenetsky, M.D. will accept assignments for our Medicare patients. If you do not have a Medicare supplement and have not met your deductible +20%. Please sign below verifying that you have read this office policy and agree to it. If there is a question about payment, please speak to the business office before seeing the doctor.

_____ _____

Patient or Legal Guardian Signature Date

OFFICE POLICY-CONTINUED

HIPPA Policy of Compliance

Please be sure that you have received a HIPPA Policy and Compliancy Form and have read it over it completely. If you have any questions, please address with bookkeeping, the business office or your doctor prior to be seen. Please sign below stating that you have received the forms, read them, and understand them completely.

_____ _____

Patient/Guardian Signature Date

Release of Information

I hereby authorize Luda Kamenetsky, M.D. to furnish medical information concerning my present illness or injury, including HEPATITIS and HIV information to any specialist or insurance companies for the purpose of obtaining payments. I further authorize any specialist and other care providers to furnish all medical information concerning my present illness or injury to Luda Kamenetsky M.D. I agree to allow the faxing of this information when necessary.

_____ _____

Patient/Guardian Signature Date

Assignment of Benefits

I request payments of the medical benefits otherwise payable to me, be made to Luda Kamenetsky, M.D. for services provided by the doctor. I understand that I am financially responsible to Luda Kamenetsky, M.D. for charges not covered by the insurance.

_____ _____

Patient/Guardian Signature Date

Consent to Treatment

I hereby authorize evaluation and treatment by Luda Kamenetsky, M.D. I understand and agree that the signature and dates on this form will not expire without written notice, and that a photocopy of this form is considered valid as the original.

_____ _____

Patient/Guardian Signature Date

Luda Kamenetsky M.D.
1315 St. Joseph Parkway Suite 1101, Houston, TX 77002
Phone: 713-659-3781 Fax: 713-659-6848

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____

I hereby authorize Luda Kamenetsky, M.D., to use and disclose my individually and identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI from Luda Kamenetsky, M.D., and that it then may no longer be protected by federal privacy regulation. I voluntarily sing this authorization, and I understand that my health care will not be affected if I do not sign this form.

This authorization covers the following Protected Medical Information (PHI):

Medical Records	Claims/Billing Information	Mental Health Records
Drug/Alcohol Abuse	HIV & Hepatitis Results	Genetic Test Results

Amount of Protected Medical Information (PHI) authorized (option 1 or 2):

1. Entire PHI (entire chart) _____
2. Limited Disclosure _____ (ex: lab results from 2009)

The recipient of my PHI is: Luda Kamenetsky, M.D.
1315 St. Joseph Parkway #1101
Houston, TX 77002

I authorize my PHI to be used and disclosed at my request for all medical purposes. This authorization will expire at the patient's verbal or written request.

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying the office. I understand that my revocation or modification of this authorization will not affect any action taken by Luda Kamenetsky, M.D. in reliance of this authorization before Luda Kamenetsky, M.D. receives my request for revocation or modification. I must sign my written request and send it to the address above.

_____ _____
SIGNATURE DATE