Angela Intili, M.D., Ltd.

Patient Signature Form

(Please initial at all the corresponding *)

*_____ Privacy Notice

I hereby acknowledge that I have received the Notice of Privacy Practices from Angela Intili, M.D. LTD.

_____ *In lieu of the patient signature, I _____, a staff member of Angela Intili, M.D. Ltd., state that this patient has been given our current Notice of Privacy Practices*.

*_____ Authorization to Discuss My Account

I hereby give my authorization to the staff of Angel Intili, M.D. to discuss my account and/or medical information with the person whose name appears *printed* on the line below. If I do not wish to designate anyone, I will check the appropriate box below.

Designated person: _____

(name) (date of birth) (relationship to patient)

I do not want my account or medical information discussed with anyone but me.

*_____ Consent to Treat:

I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments which my physician and I agree are necessary. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications given to me. This consent shall remain in effect until I choose to revoke it in writing.

*_____ Release of Information and Assignment of Benefits:

I understand that I am responsible for any fees for services rendered for myself and/or for my children (if applicable). I hereby authorize Angela Intili, M.D. Ltd. to furnish information to my insurance carrier concerning all conditions including those that may reference drug abuse, alcohol abuse, or mental illness. I hereby assign to Angela Intili, M.D. LTD payments made by my insurance carrier until such time as I revoke this in writing.

*_____ Patient Financial Responsibility

I understand that Angela Intili, M.D. Ltd. will, as a courtesy to me, submit the charges for my visit to my primary and secondary insurance carriers. If there is any question regarding coverage, benefits, or payment for services provided, I understand that it is my responsibility to resolve this. I also understand that I am financially responsible for any covered or non-covered services which are not paid by my primary or secondary insurance and that any unpaid charges over 60 days old will become my responsibility, with payment due from me plus processing costs. In the event my account is placed with an agency for collection purposes, I understand that I am responsible for all collection agency fees (up to 35% of the balance placed for collection). In addition, I will be responsible for all court costs, filing fees, and attorney fees should this account require litigation.

Additional charges will apply for the following:

Failing to cancel your appointment at least 24 hours ahead --- $25.00
Failing to cancel your surgery at least five days prior to surgery date --- $75.00
Non sufficient bank funds (check bounces) --- $35.00
FMLA, insurance forms, work forms, school forms, etc. --- $30.00

My signature in the box above indicates my knowledge of and agreement with all of the above. Further, I understand and agree that my consents/assignments remain in effect until I choose to revoke them in writing.

******* *Please complete other side* *******

*_____ Practice Policies

My signature above indicates that I have been given a copy of Dr. Intili's Practice Policies. I understand that the office will follow these policies with regard to my care and the processing of charges to my insurance company. I also understand that if I have any questions, the staff will be happy to answer them for me.

My signature in the box below indicates that I have read and understand the information on the front side of this paper.

********** ***For Medicare Patients Only*** **********

Medicare Assignment of Benefits

I request that payment of authorized Medicare benefits be made on my behalf to Angela Intili, M.D. LTD for services provided to me by the above physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

_____

(Beneficiary/Patient signature) (Date)

Medi-Gap Assignment of Benefits (Medigap = Secondary Insurance)

I request that payment of authorized Medi-Gap benefits be made on my behalf to Angela Intili, M.D. LTD for services provided to me by the above physicians. I authorize any holder of medical information about me to release to my Medi-Gap insurer any information needed to determine these benefits or the benefits payable for related services. This assignment of benefits is to remain in effect until I choose to revoke it in writing.

_____

(Beneficiary/Patient signature) (Date)