

GREG A. CISNEROS, M.D.
Family Medicine
33 Old Kings Road North. STE #2
Palm Coast, FL 32137
Phone: 386-446-4141

CONSENT FOR TREATMENT I hereby give consent to Dr. Cisneros to render medical evaluation, treatment, perform necessary diagnostic testing, and procedures according to the provider's discretion. I understand that no guarantee will be made as to the result of examination and/or treatment.

NOTICE AND ACKNOWLEDGEMENT OF HIPAA: I acknowledge that I have read and/or have been offered the Notice of Privacy Practices for Dr. Cisneros.

Financial Policy:

We require payment **in full due at the time of service**, for Self-pay patients. We (do not balance bill. I understand I will not be filing to an insurance carrier. **Visa, MasterCard and Cash accepted.**

If we participate with your insurance company, we will collect all co-payments, deductibles, and/or other co-insurance amounts **at the time of service**. **Visa, MasterCard and Cash accepted.**

I fully understand if I do not pay for services upon check-out, that I **will not** receive any prescriptions written by Dr. Cisneros or the discharge instruction paperwork.

INSURANCE CHANGES You are required to notify us if your insurance changes, or if any information regarding your insurance identification or group number changes up subsequent visits.

RETURNED CHECKS Your account will be assessed a \$30.00 fee for all returned checks. We reserve the right to revoke check privileges at any time.

PAST DUE & LATE FEES

- Your account will be assessed 1.5% interest for balances over 30 days.
- Your account will be assessed a late fee of \$25 per month and/or 1.5% interest for balances due past 60 days.
- You will be responsible for any charges incurred if your account has to be handled by our collection Agency.

I understand that all fees, co-payments, deductibles, and co-insurance amounts are based on **(INITIALS)** estimated charges which may be subject to change after all documentation has been reviewed by our billing manager. I agree that I will be responsible for any additional charges.

Patient/Guarantor/Legal Guardian Signature

Date