MAURICE COLLADA, JR., M.D., P.C.

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FINANCIAL POLICY AND AUTHORIZATION ASSIGNMENT AGREEMENT AND RED FLAGS RULE

PLEASE SIGN AND RETURN

FINANCIAL POLICY AGREEMENT

I have read the financial policy and credit policy for the office of Maurice Collada Jr., M.D., P.C. and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a credit reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

Signature: _____ Date_____

AUTHORIZATION/ASSIGNMENT INFORMATION

I authorize Maurice Collada Jr., M.D., P.C. to perform all necessary and advisable medical procedures for diagnosis and treatment. I understand that I will be informed of all proposed medical procedures or treatment prior to commencement, except in case of emergency. I also understand that I have the right to refuse any proposed medical procedure or treatment. I authorize Maurice Collada Jr., M.D., P.C. to disclose my medical records to my insurance company. I assign to and approve direct payment to Maurice Collada Jr., M.D., P.C. of any insurance benefits otherwise payable for patient's treatment. However, I fully understand that I am financially responsible to Maurice Collada Jr., M.D., P.C. for charges not covered by this assignment.

Signature: _____ Date_____

(Authorization must be signed by the legal guardian if the patient is mentally or physically unable)

RED FLAGS RULE

In compliance with the **Federal Trade Commission "Red Flags Rule"** 16 C.F.R. and in continued compliance with the Federal Privacy Act HIPPA; **we are requiring our patients to provide us with a personal password to protect each patient's privacy as well as health and financial safety**. This individual password will be kept in your secure patient chart. This password will be created by you, the patient, and can be given at your discretion to individual(s) that you would like to also have access to your medical financial information. This **password will be required in all instances when the patient or designated individual(s) calls, writes, emails, or walks in to obtain any and all medical or financial information from our staff.** In addition staff may ask for personal identification at our discretion. **We hold your privacy and financial security in the highest regard and feel this will help us protect you as best we can. Thank you** for your understanding and your proactive stance on these matters.

Password: _____ Date_____

Password Hint: _____

Patient Name: _____

Patient Signature: _____