PATIENT INFORMATION (Please Print) Date _____

Patient Name _____Date of Birth_____ Age_____ Sex M F

Mailing Address_____City_____State_____Zip_____

Home Address (if different)_____

Primary Phone (_____)_____ Marital Status_____

Other Phone (_____)_____ Full-Time Student: Yes No

Employer_____ Business Phone (____)_____

SPOUSE

Name_____ Date of Birth_____

Cell Phone (_____)_____

Employer_____ Business Phone (____)_____

IF DEPENDENT: **PARENT'S INFORMATION**

Mother's Name_____ Date of Birth_____

Address (if different than patient's)_____

Employer_____ Business Address_____

Business Phone (____)_____ Cell Phone (____)_____

Father's Name_____ Date of Birth_____

Address (if different than patient's)_____

Employer_____ Business Address_____

Business Phone (____)_____ Cell Phone (____)_____

INSURANCE INFORMATION

Primary Insurance_____Contract# _____
Policy Holder's Name _____ Date of Birth: _____

Secondary Insurance_____ Contract# _____
Policy Holder's Name _____ Date of Birth: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name_____Relationship to Patient_____
Home Phone (____)_____ Cell Phone (____)_____Work Phone (____)_____

HOW DID YOU SELECT OUR OFFICE

□ Referring Physician (Name)_____ Phone (____)_____
□ Hospital Referral Service □ Insurance Directory □ Internet Search □ Facebook □ Phone Book
□ Friend □ Other_____□ Relative (Name)_____

ALDO TROVATO, MD, PC PAYMENT POLICY AND AGREEMENT

This is an agreement between Aldo Trovato, MD, PC and the patient/guarantor named on this form. In this agreement the words, you, your and yours mean the Guarantor. The word Guarantor refers to the responsible party. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words, we, us and our refer to Aldo Trovato, MD, PC.

I hereby assign to Aldo Trovato, M.D., P.C. all payments for medical services rendered to patient and authorize the release of any medical information by mail, phone, or fax concerning my illness and/or treatment to insurance carriers and referring physicians.

Insurance is a contract between you and your insurance company. All professional services rendered are charged to the patient and payment is required for all services at the time they are rendered. The patient is responsible for all fees, regardless of insurance coverage. **I agree that I will be responsible for payment of charges not paid to Aldo Trovato, M.D., P.C. by my insurance company.** Copayments, coinsurance, and deductibles will be collected at the time of service. We accept payment in the form of cash, debit card, Master Card, Visa or Discover Card. As of May 1, 2009 we do not accept checks. If payment is not received, we reserve the right to refuse appointments on deliquent accounts. There may be a separate charge for laboratory tests and pathology tests. We will bill your Blue Cross Blue Shield (BCBS) or AETNA insurance as a courtesy to you. However in order to do so, we must be supplied proper insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire balance. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower or no payment from the insurance company and the balance is your responsibility. After filing your insurance, if you have a remaining balance, as a courtesy to you, your account balance can be charged to your credit card. If you have an insurance carrier other than BCBS or AETNA, you will be given the necessary paperwork to file a claim at the end of your visit. This does not guarantee reimbursement from your insurance carrier.

Scheduled Appointments/Surgery Appointments. As of December 1, 2010 we have implemented a "No Show Policy." The no show fee for a regular appointment is $25.00. You must provide 24 hour notice of cancellation or rescheduling to avoid this fee. Failure to give 24 hour cancellation notice, missed appointments, multiple cancellations, and rescheduling of appointments could relinquish your right to be a patient at this practice and may result in termination. There is a $100.00 fee for any surgery that is cancelled or rescheduled without 24 hour notice (except for medical reasons).

Non-Covered Services. PLEASE NOTE that insurance companies do not consider the removal of benign growths such as moles, skin tags, seborrheic keratoses and milia to be medically necessary and DO NOT pay for these procedures.

Past Due Accounts. I understand and agree that in the event that my account is placed with a collection agency, or an attorney for collection, I will be responsible for collection fees equal to 33.3% of the balance due in addition to the principal balance. I further understand and agree that if legal action is taken to collect the balance, I shall be responsible for any and all fees and costs associated with collecting, securing, or attempting to collect or secure this account including but not limited to collection agency fees, attorney's fees, publication fees, process server fees, and court cost whether suit is necessary or not. I hereby waive all rights of exemption under the U.S. and Alabama Constitution. If your account is past due more than 90 days or is referred to a collection agency you will forgo the patient/physician relationship. A $10 late fee will be charged to all past due accounts. A $35.00 fee will be charged for all returned checks.

In the event my account is 60 days past due, I authorize Aldo Trovato, M.D., P.C. and any of its officers, agents or employees to request a credit report on me. I also understand any past due balances may be reported to one or all of the national credit bureaus. I further authroize Aldo Trovato, M.D., P.C., its officers, agents or employees to contact me by phone, cell phone, text message, e-mail or any other universally used modes of communications as needed to confirm apointments, provide essential treatment information or secure payment of outstanding past due balances. This agreement shall apply to past, present and future services rendered and claims made by Aldo Trovato, M.D., P.C.. A copy of this agreement shall be equivalent to the original.

Forms. Should you require forms or papers to be completed, there is a $20.00 charge per set of paper work. Please allow 48-72 hours for these forms to be completed.

Medical Records. A medical records release form must be completed and signed for all medical records requests. Payment of the medical records fee is required. Please allow 72 hours for your request to be completed.

HIPPA. By signing below, you agree to and understand the Notice of Privacy Practices (copy available at front desk). 6/20/16

Signature _____ **Print Name** _____ **Date** ____/____/____
(Patient/Legal Guardian)