New Patient H&P

Name: _____
Age/Birthdate: _____
Referring Doctor: _____

Today's Date: _____

VS: HT: ____ **WT:** ____ **T:** ____ **BMI:** ____ **P:** _____ **R:** ____ **BP:** _____ **LMP:** ___/___/___

REASON FOR TODAY'S VISIT: _____

PMHx **PSHx** **Meds** **Allg** **SHx** **FHx**

Please tell us when you last had the following:

Colonoscopy (50-75): _____
Flu Shot: _____
Pneumonia Vaccine (>65) _____
Falls in Past 6 months (>65): _____

Name: _____
Age: _____
Referring MD/NP: _____
Other MD/NP: _____
Date: _____

REASON FOR TODAY'S VISIT: ***(Please check all that apply)***

	CURRENT	PRIOR		CURRENT	PRIOR
Breast lump (you/doctor can feel)	[ ]	[ ]	Nipple Symptoms	[ ]	[ ]
Abnormal mammogram/ultrasound/MRI	[ ]	[ ]	Breast Pain	[ ]	[ ]
Family history of breast cancer	[ ]	[ ]	Other	[ ]	[ ]

MENSTRUAL HISTORY: Do you still have menstrual periods? [ ] YES [ ] NO

Date your last menstrual period began: (LMP) ___/___/___

How old were you when you had your first period? _____

MENOPAUSE: Have you gone through menopause? [ ] YES [ ] NO

If yes, age you stopped having periods: _____

Are you currently experiencing menopausal symptoms? [ ] YES [ ] NO

Please describe: _____

Did you have a hysterectomy (removal of the uterus)? [ ] YES [ ] NO

If yes, please provide the reason _____

Age: _____ Date of surgery ___/___/___

Were your ovaries removed? [ ] YES [ ] NO

[ ] ONE [ ] BOTH [ ] UNKNOWN

If yes, please provide the reason _____

PREGNANCY & NURSING: Have you ever been pregnant? [ ] YES [ ] NO

How many pregnancies? _____ How many children? _____

Did you Breastfeed? [ ] YES [ ] NO

If yes, for how long? _____

How old were you when your first child was born? _____

Please list any multiple births: _____

HORMON MEDICATION USE: Have you ever used...

Birth Control Pills, Patch or Implant? [ ] YES [ ] NO

What type(s)? _____

Are you using any now? [ ] YES [ ] NO

Total years of use: _____

Infertility medicine? [ ] YES [ ] NO

Please describe type(s) and number of cycles (duration):

_____

Hormone Replacement Therapy? [ ] YES [ ] NO

What type(s): _____

Are you currently taking HRT? [ ] YES [ ] NO

Total years of use _____ **How long ago did you stop?** _____

PAST MEDICAL HISTORY: Please list all medical conditions that you have or have had in the past.

[ ] I have no significant medical problems

PAST SURGICAL HISTORY: Please approximate date and type of surgery:

[ ] I have never had surgery

PRIOR BREAST BIOPSIES

Have you had any breast biopsies? [ ] YES [ ] NO

If yes, what type? [ ] Surgical [ ] Core Needle [ ] Fine Needle Aspiration

Year and side(s): _____

Reason for the biopsy: _____

Result: _____

SOCIAL HISTORY: Please use the back of the page if you need more space

	NEVER	PRIOR	CURRENT	AMOUNT	HOW LONG?
Cigarettes/Cigars	☐	☐	☐		
Alcohol	☐	☐	☐		
Other (type?)	☐	☐	☐		

Occupation: _____ **Marital Status:** _____

Who do you live with? _____

FAMILY HISTORY: Please list all relatives who have had any type of cancer:

Relative	Mother's or Father's Side	Age at Diagnosis	Type of Cancer

[ ] **NONE KNOWN**

Please list any other diseases that run in the family, such as heart disease or diabetes:

[ ] **NONE KNOWN**

Please include any other history which you think is important:

Patient Signature: _____ **Date:** ____/____/____

As a courtesy, we will forward a letter to your PCP and 1 other physician.

Please list physician(s) here: _____

(name & address)

_____

(name & address)

Name: _____

Date: _____

If you are currently experiencing any of the following symptoms, please check all that applies

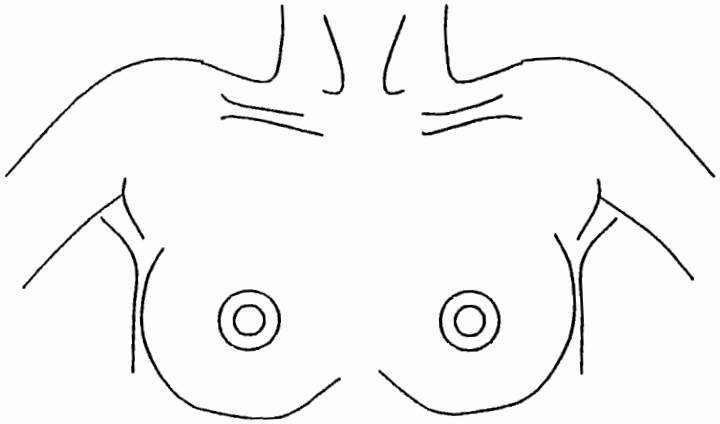
BREAST LUMP: Right Breast [ ] YES [ ] NO Left Breast [ ] YES [ ] NO

How long have you felt it: _____months _____weeks _____ days

Has it changed in size: [ ] YES ___pea ___dime ___nickel ___quarter [ ] NO

BREAST PAIN [ ] YES [ ] NO

If Yes, draw the location of the pain.



How long have you had the pain? _____months _____Weeks _____Days

What is the intensity of the pain between 1 (least) and 10 (worse)? _____

Any factors contributing to the pain? _____. Does it make the pain better or worse? _____.

Have you taken any medications to reduce the pain? _____.

NIPPLE DISCHARGE: Right Breast [ ] YES [ ] NO Left Breast [ ] YES [ ] NO

When was the first time you saw the discharge? _____

What is the color of the Discharge? _____

How often is the discharge _____Is it Spontaneous _____ Does it show in Bra _____

Patient Signature: _____ Date: ____/_____/_____

Name: _____

Date: _____

If you currently have the following symptoms, please place check mark beside it.

Breast:

( ) Breast Pain

( ) Breast Lump

( ) Nipple Discharge

( ) Change in Breast Size/Shape

General:

( ) Change in Appetite

( ) Chills

( ) Fatigue

( ) Fever

( ) Sleep disturbance

Lymphatic:

( ) swollen glands

( ) chronic arm or leg swelling

Ear, Nose, & Throat:

( ) Decreased hearing

( ) Difficulty Swallowing

( ) Sore throat

Skin:

( ) Blistering

( ) Redness or discoloration

( ) Rash or ulceration

( ) Skin lump

Endocrine:

( ) Cold intolerance

( ) Heat intolerance

( ) Weight gain

( ) Weight loss

( ) Irregular menstruation

( ) Last Period __/__/___ or Age_____

Respiratory:

( ) Cough

( ) Shortness of breath

Cardiovascular:

( ) Chest pain

( ) Irregular heartbeat

( ) Palpitations

Gastrointestinal:

( ) Abdominal pain

( ) Change in bowel habits

Genitourinary:

( ) Blood in urine

( ) Frequent urination

( ) Flank pain

( ) Pain with urination

Musculoskeletal:

( ) Joint stiffness

( ) Leg cramps

( ) Pain in shoulder

( ) Swollen joints

( ) Back pain

Hematology:

( ) Easy bruising

( ) Prolonged bleeding

Neurologic:

( ) Balance difficulty

( ) Difficulty speaking

( ) Headache

( ) Memory loss

( ) Seizures

( ) Numbness or tingling

( ) Short-term loss of vision

( ) Tremor

Psychiatric:

( ) Anxiety

( ) Depression

( ) Eating disorder

( ) History of mental abuse

( ) History of physical abuse

WOMEN'S HEALTH AND HEALING OF THE PALM BEACHES
PATIENT MEDICATION LIST

Patient Name: **Date:**

Patient Primary:

Patient OB/GYN: **Medication has NOT changed since my last visit** ☐

Patient Medical Oncologist: **Patient Initials:** **Date:** / /

Patient Radiation Oncologist: **Patient Initials:** **Date:** / /

List All Allergies: **Patient Initials:** **Date:** / /

	Drug Name	Amount	Frequency	Condition Reason For Medication	Notes
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
18					
19					
20					

PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sr. ☐ Jr. ☐

Patient Name	**Sex M ☐ F ☐**	**Age**	**Marital Status**
Social Security Number	**Date of Birth**	**Spoken Language English ☐ Spanish ☐ Other ☐**	
Home Address	**City**	**State**	**Zip**
Mailing Address if Different	**City**	**State**	**Zip**
Home Phone Number	**Work Phone Number**	**Cell Phone Number**	
Emergency Contact Name	**Contact Phone Number**		
Email Address	**PERMISSION FOR PHYSICIAN TO LEAVE VOICEMAIL WITH RESULTS YES ○ NO ○**		

Referred by: Please circle one

Consult a Nurse Healthgrades JFK (ER) Palms West (ER) PCP Other

Pharmacy:	**Phone Number:**
Primary Care Provider:	**Phone Number:**
Specialist/Other Doctor:	**Phone Number:**

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Primary Insurance Company		**Claim Address**
Name of Policy Holder if different from patient	**DOB**	**Social Security Number**
Secondary Insurance Company		**Claim Address**
Name of Policy Holder if different from patient	**DOB**	**Social Security Number**

I authorize Women's Health and Healing of the Palm Beaches to release my records, give any medical or financial information out to the following people

1. _____ **Relationship to you** _____
2. _____ **Relationship to you** _____
3. _____ **Relationship to you** _____
4. _____ **Relationship to you** _____

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge

_____ _____

Patient or Authorized Representative ***Date***

Women's Health and Healing of the Palm Beaches

Consent for Treatment and Payment Agreement

I hereby authorize Women's Health and Healing to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to; the administration and performances of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgement of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to; the authorization of payment directly to Women's Health and Healing of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurances payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance in not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms rom your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Women's Health and Healing, all insurance or third party payments that I receive for services rendered to me immediately upon receipt. **Patient Initials:** _____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to Women's Health and Healing. **Patient Initials:** _____

I request this authorization also apply to all other insurances. **Patient Initials:** _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Patient Representative Signature: _____

Date: _____ **DOB:** _____

FINANCIAL POLICY

As your physician, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding or our payment policy.

We ask that all services be paid at time of service. If you have insurance, please present your insurance card for verification. If you insurance changes, please notify us immediately,

BLUE CROSE BLUE SHEILD PPC (_____): as providers with **PPC** of _____, we ask that the co-pay and deductibles (if possible) be paid in full at the time of your visit. We accept assignment for services covered and will bill the insurance. Any balance outstanding following payment from the insurance, will be billed to you.

MEDICARE: We are participating Medicare providers, and we will file Medicare for you. Any service routinely not covered by Medicare (i.e. Preventative/Routine Exams) we will request that the services be paid at time of service. We request payment for the 20% of the allowable Medicare charges and any deductible (if applicable) that has not been met at the time of your visit.

PCA MANAGED CARE: We are **NOT** providers of Managed Care Programs except **PCA** managed care. If you are a member of a Managed Care Program, and choose to see us as your physician, please be prepared to pay for services at the time of your visit. Or, if your physician has referred you to us, please verify **BEFORE** your appointment that we have received the authorization for payment.

WORKERS COMPENSATION AND AUTO INSURANCE: We do not participate in the treatment of illnesses in Workers Compensation claims but each provider might choose to see a case on an individual level basis. Please call the office and verify before making an appointment.

FINANCIAL AGREEMENT: We will be glad to discuss your proposed treatment and the cost of those services. If you have questions, if your insurance will cover a medical service, we will be glad to try to find out if the insurance will cover for those services. **HOWEVER**, please be aware that you insurance is a **CONTRACT BETWEEN YOU, YOUR EMPLOYER (IF APPLICABLE) AND THE INSURANCE COMPANY.** We are not a party to your contract. Unfortunately, not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (***i.e., annual physicals***).

We must emphasize that as your physician, our relationship and concerns are with you and your health. Not with your insurance company. ALL CHARGES FOR SERVICES ARE YOUR RESPONSIBILITY AT THE TIME OF THE SERVICE. On any balance on your account after ninety (90) days, collection will be taken. We realize that emergencies do arise and may affect timely payment(s) of your account. If such extreme cases do occur, please contact our insurance office promptly for assistance in the management of your account.

If you have any questions regarding the above, or any uncertainty regarding insurance coverage or request for payment, please do not hesitate to ask. We are here to help you.

I HAVE UNDERSTOOD AND AGREED TO THE FINANCIAL POLICY OF WOMEN'S HEALTH AND HEALING OF THE PALM BEACHES.

_____	_____	_____
PATIENT PRINT NAME	SIGNATURE	DATE
_____	_____	
STAFF SIGNATURE	DATE	

WOMEN'S HEALTH AND HEALING OF THE PALM BEACHES
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorization

Patient Name:	Birth Date:	Social Security No (***Optional***):

Recipients' Name:	
☐**Julian Berrocal, MD**	4685 S Congress Ave. Suite 201 Lake Worth, FL 33461 Phone: (561) 548-8600 Fax: (561) 548-8650
Provider's Name:	**Phone:** **Fax:** **Address:** **City:** **State:** **Zip:**

This authorization will expire on the following (Fill in the Date or the Event but not both)
Date: Event: DISCHARGE/DEATH

Purpose of disclosure: EVALUATION & TREATMENT

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s)	Description:	Date(s)
☐All PHI in medical record ☐History & Physical ☐Consultation Reports ☐Progress Notes ☐Physicians Orders ☐Clinical Test		☐Operative Information ☐Pathology Reports ☐Specialist Test/Therapy ☐Laboratory tests ☐Clinical Test		☐Medication Record ☐Pathology Report ☐Nursing Information ☐Itemized Bill: ☐Other	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information _____ (Initial) if not applicable, ☐ check here

I understand that:
I may refuse to sign this authorization and that it is strictly voluntary.
My treat, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by
federal privacy regulations and may be redisclosed.
I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
I get a copy of this form after I sign it.

Section B: The request of PHI is for the purpose of marketing?
If yes, the health plan or healthcare provider must complete section b, otherwise skip to C ☐ ***NO***

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐Yes ☐No
If yes describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative Initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.
____ (Patient/Representative Initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email and/or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients.
Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information.
If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_(_____)_____-_____.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

OR

_____ (Patient/ Representative Initials) **I decline to receive communication via text.**
_____ (Patient/ Representative Initials) **I decline to receive communication via email.**

If you have previously consented to receive communication via text/email and wish to remove the consent Opt Out/Revocation of communications via email and/or text. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

__ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*
__ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____
Date: _____ *Time:* _____

Prescription Order Pick-up: There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ (Patient/Representative Initials) ***I wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/ Representative Initials) ***I do not want*** to designate anyone to pick-up my prescription order.

Patient/Guardian/Patient Representative Signature _____ **Date:** _____

Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

_____ (Patient/Representative initials) **Notice of Privacy Practices**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization at any time and that revocation or modification **must** be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

WOMEN'S HEALTH AND HEALING OF THE PALM BEACHES

MICHELLE BARLETTA, PA-C

STEPHANIE FERRER, PA-C

During your visit with our doctors, you may also be visiting our Physician's Assistant.

Our Physician's Assistant work very closely with the doctors during your office visit and throughout your hospital stay. The Physician's Assistant is an integral part of this practice.

Please acknowledge that you have been informed of the Physician Assistants and their role here at Women's Health and Healing of the Palm Beaches.

Should you have any questions, please let us know. Thank you.

_____ _____

PATIENT NAME **DATE**

Thank you for trusting us with your healthcare!

Thank you for choosing

Women's Health and Healing of the Palm Beaches

Comprehensive Breast Care

You are our most important priority and

We appreciate that you have trusted us with your medical care today!

In effort to keep your medical cost down, we ask that you pay your portion of the bill at the time of your visit.

HAVE A CO-PAY

- It is due in full at the time of service.

HAVE CO-INSURANCE

- Please pay $30 today and will bill you for the balance due.

HAVE A DEDUCTIBLE (*that is not met*)

- We will collect the following amounts today and we will bill you for any remaining balance:
  - $50 for established patients
  - $75 for new patients (*or patients who have not been seen in the last 3 years*)

DO NOT HAVE INSURANCE?

- We offer a 35% discount which requires a minimum payment as shown below and we will bill you for the remaining balance:
  - $88 for established patients
  - $132 for new patients

BALANCE DUE?

Please ask us to review your account.

- $100 or less, we expect you to pay it in full
- >$200 and unable to pay today; ask to speak with practice management to arrange a payment plan.

Thank you for allowing us the opportunity to serve you and for helping us keep your cost down!