Family Allergy
Asthma, Immunology & Sinus Center

Maryam Zarei, M.D.

IMPORTANT OFFICE POLICIES & PROCEDURES

Patient: ____ D.O.B:____________

_____**HIPPA NOTICE OF PRIVACY PRACTICE:** I hereby acknowledge that I was offered a copy of HIPPA notice. A copy is available upon my request, and any amended notices will be available at each appointment.

_____**CONSENT FOR TREATMENT / RELEASE INFORMATION:** I grant FAAISC, P.C. permission to administer medical treatment and perform procedures as deemed necessary and I authorize the release of medical information, to process insurance claims.

_____**ELECTRONIC COMMUNICATION CONSENT:** I hereby consent to HIPPA compliant, secure, electronic communication through http://family_allergy.myupdox.com, to be used for non-emergency communication. A username and password will be automatically assigned; you will need to log-in, and set-up your account. Please indicate your preferred method.

Email __________________________/ Mobile # __________________________ Text __ Voicemail__

_____**TEST RESULTS**
We take your medical care seriously, and will schedule an appointment to review all results.
A copy will be available at your visit and via portal, after discussion with MD.

_____**FINANCIAL POLICY (NET 60 DAYS)** Copay is due at the time of service. For all past due balances (> 60 days from Date of Service) you will receive a courtesy phone call and letter. If we are unable to settle the claim the account will be sent to collections (additional 18% interest rate/annum). It is your responsibility to contact your insurance and inquire about your coverage. This will provide full transparency and speed up your visit. Our staff will inform you of the services required on the day of your visit. By initialing here you acknowledge responsibility for payment.
$50 missed appointment fee (48hr. notice to reschedule) A.P./N.R.M/B.L.
$25 returned check fee.
A 3% convenience fee applied to all credit card transactions.

_____**FORMS: SCHOOL/CAMP, FAMILY LEAVE, COURT TESTIMONY, EXPERT WITNESS**
The completions of forms are NOT a part of your routine medical service. We are happy to assist you, but we reserve the right to charge appropriately for our time and effort. Be aware that your insurance provider may not wish to pay for these services.
$15 for simple 1-3 page School/Epi-Pen forms.

_____The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.
https://openpaymentsdata.cms.gov/
For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here.

_____**ASSIGNMENT OF BENEFITS:** I have read and understand the office policies and I authorize all benefits payable by my insurance company to FAAISC, P.C.

Signature:____ Date: _________________

15725 Pomerado Rd. Suite# 218, Poway, CA 92064 Tel. (858) 521-0806 Fax. (858) 521-0808 **Rev. 07/24/2020**