VIRGINIA ENDOCRINOLOGY

Ben Phillips MD • Cynthia Ryan MD • Akta Mukherjee MD • Kristin Fabiato MD
Elizabeth Wallace MD • Maria Iuorno MD • Anita Prakash MD • Samantha Hudson MD
Alexander Millis MD • Sarah Bearer MD • Laura Harris PA • Marsha Di Peppe FNP
Alejandra Lozada MD • Erin Myers PA

2384 Colony Crossing Place | Midlothian, VA 23112
3460 Mayland Court, Suite 100 | Henrico, VA 23233

(804) 423-3636 (tel) (804) 423-3637 (fax)
WWW.VIRGINIAENDO.COM

FORM #3: AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION TO VIRGINIA ENDOCRINOLOGY

Patient's Name:		Date of Birth:	
Previous Name:		Social Security #:	
I request and authorize (Primary care doctor or referring physician)			
To release healthcare information of the patient named above to:			
Virginia Endocrinology **2384 Colony Crossing Place** **Midlothian, Virginia 23112** **(804) 423-3636 phone** **(804) 423-3637 fax**			
This request and authorization applies to:			
☐	All healthcare information		
☐	Healthcare information relating to the following treatment, condition, or dates:		
SIGN IN THE SPACE BELOW			
Patient Signature:		**Date Signed:**	
THIS AUTHORIZATION EXPIRES 12 MONTHS AFTER IT IS SIGNED			

- **UPON COMPLETION OF THIS FORM, IF POSSIBLE, PLEASE FAX TO (804) 423-3637.**
- **IF YOU ARE UNABLE TO FAX PRIOR TO YOUR VISIT, PLEASE COME 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME AND BRING THIS TO THE FRONT DESK. THANKS!**

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION FROM VIRGINIA ENDOCRINOLOGY TO FAMILY MEMBERS

Patient's Name:			
Date of Birth			
I authorize the Virginia Endocrinology to release medical and billing information, either in person, over the phone, or in writing, to the following people:			
Name:		Name:	
Home Phone #:		Home Phone #:	
I understand that the person(s) that I have named above to receive private health information may be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect it			
SIGN IN THE SPACE BELOW			
Patient Signature:		**Date Signed:**	
THIS AUTHORIZATION EXPIRES 5 YEARS AFTER IT IS SIGNED			

CANCELLATION AND MISSED APPOINTMENT POLICY

Our practice philosophy is to provide comprehensive patient care by reserving dedicated blocks of time for each patient. Therefore, if you are not able to keep your appointment, we request that you **call as soon as possible** to let us know. This will allow us to provide more timely care to other patients who could be scheduled into your reserved time slot.

At least 24 hours notice is required for the cancellation of all appointments. A $25 charge will be added to your account if 24 hours notice is not received prior to a missed appointment. Insurance will not pay for this charge.

We reserve the right to end the physician-patient relationship in the case of a missed initial or multiple follow-up appointments.

FINANCIAL POLICY

As a courtesy to its patients, Virginia Endocrinology will file insurance claims upon the receipt of a current insurance card. If coverage is denied, you will be billed and payment in full is due upon the receipt of the bill. You will also be responsible for all co-payments (co-pays) at the time of the visit, as well as deductibles and balances due following insurance payments.

It is your responsibility, with the help of Virginia Endocrinology, to ensure that all referrals and authorizations are obtained prior to receiving medical care. If the referral/authorization is not obtained and your claim is denied, you will be responsible for the balance.

In the event that your account, following insurance payments and the normal billing cycle of Virginia Endocrinology, is not paid in full within thirty days from the date of service, you will be responsible for any additional special handling fees should your account fall into past due status.

Past due amounts that are **greater than 90 days overdue are subject to being turned over to a collection agency**. You are strongly encouraged to pay all past due amounts promptly or set up a payment plan with us.

There is a **$25.00 charge for returned checks**. If two (2) checks are returned, you will no longer be able to write checks in our office. Payments must then be made either by cash, credit card, money order, or certified check.

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INSURANCE AUTHORIZATION

You authorize any holder of medical or other information about you to be released to the insurance payor or other secondary insurance, as listed in your file, any information needed for the insurance claim(s). You permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to you or to Virginia Endocrinology, who accepts assignment.

SIGN IN THE SPACE BELOW		
Patient Name (printed):		
Patient Signature:	x	**Date Signed:**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (NOPP) provides information about how we may use and disclose personal health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I have reviewed a copy of the Virginia Endocrinology Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to the Virginia Endocrinology if I do not understand any information contained in the Notice of Privacy Practices.

Patient's Printed Name	
Patient's Signature	x
(if applicable) Patient's Personal Representative & Relationship	
(if applicable) Patient's Personal Representative's Signature	
Date	

The following section is for use by Virginia Endocrinology personnel if unable to obtain a written acknowledgement of receipt of the NOPP from the patient.

I have made a good faith effort to obtain a written acknowledgement of receipt of the Virginia Endocrinology & Osteoporosis Center's Notice of Privacy Practices from the above named patient, but was unable to for the following reason(s):

- ☐ Language Barrier
- ☐ Patient Cannot Read
- ☐ Patient Objects
- ☐ Read Later and Return
- ☐ Unable to Sign
- ☐ Other:

Employee Name and Date: _____