Dr. Fern Taisenchoy-Bent MD
&
Colleen Bianco ARNP
2964 N State Rd 7
Suite #320
Margate, Fl 33063

# NOTICE OF PRIVACY ACKNOWLEDGEMENT

Care Center: Dr. Fern Taisenchoy- Bent, M.D.

☐ I have read and understand the notice of Privacy Practices

_____
Patient's Name Printed

_____ _____
Patient's Signature Date

**Dr. Fern TaiSenChoy-Bent, MD, LLC**
**Financial Policy**

**Thank you for choosing our office. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require for you to read and sign prior to any treatment.**

FULL PAYMENT IS DUE AT TIME OF SERVICE ALL. COPAYMENTS AND DEDUCTIBLES ARE DUE PRIOR TO YOUR VISIT. WE ACCEPT: CASH, CHECK, VISA, MASTER CARD, AND AMERICAN EXPRESS.

**INSURANCE:** We will bill your insurance company for your visit as a courtesy to you. Due to difficulty of obtaining payment from your insurance plans, we may ask for your assistance in getting your claim paid. Please be advised that it is the patient's responsible to verify that we are a participating provider of your insurance plan.

**HMO/REFFERRALS:** It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires it for your visit. It is the patient's responsibility to know and understand the requirements of their insurance plan. Our office is not responsibility to obtain referrals for patients on HMO plans. If you arrive without a referral for your visit and you are required to bring one, your appointment will be rescheduled.

**MINOR PATIENTS:** The parent or guardian accompanying the minor is responsible for payment of the bill.

**MISSED APPOINTMENTS**: Unless cancelled 24 hours in advanced, our office policy is to charge a $25.00 fee for missed appointments. Please help us serve you better by keeping your scheduled appointment. Or, if you need to cancel an appointment and the office is closed please leave a message on our voice mail system.

**RETURNED CHECKS: $30.00 FEE**

**COLLECTION POLICY:** Should your account becomes a collection problem, the patient assumes all cost of collection including but not limited to collection agency fee, court costs, interest and legal fees. All unpaid accounts will be reported to a collection bureau.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY AND ALL MY QUESTIONS HAVE BEEN ANSWERED. I HERBY AGREE TO RENDER PAYMENTS IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET ABOVE.

_____ _____
PATIENT/ RESPONSIBLE PARTY SIGNATURE DATE

_____
PATIENT'S NAME

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TO ALL PATIENTS WHO RECEIVE LAB REQUEST/ BILL

Your physician has chosen the diagnosis code she has determined best fits your medical condition. This decision is based on her medical knowledge and not on insurance coverage. If your health plan does not cover the lab tests you have done, the lab will direct the bill to you. Our physician cannot change your diagnosis based on insurance, as this would be fraud. Should you receive a bill from the lab, please deal directly with the lab-billing department.

_____ _____
Patient's Signature Date