Majed Jandali, MD FACS
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JANDALI SURGICAL ASSOCIATES
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FINANCIAL POLICY
We are committed to providing you with the best care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

Charges for office visits and surgery are determined by the time spent and vary with the severity and complexity of the problem. Please do not hesitate to discuss our fees if you have any questions. Please be aware that we can only discuss our professional fees. Surgical procedures are often undertaken in the hospital and this will incur fees from the hospital, anesthesiologist, pathologist, and others.

Insured Patients: Your co-payment is expected and due at the time of service.

Self-Pay Patients: You are required to pay a fee of $150 towards the office visit at the time of service. Payment in full is expected prior to any elective procedures. In the event of emergency surgery, please ask to speak to our financial department.

For your convenience, we accept Cash, Checks, Visa, MasterCard, and Discover. If you have insurance, please understand that this is an agreement between you and your insurance company. We will inform you if we are a participating provider with your insurance company and will handle your claims according to our agreement with the insurance company.

Insurance plans vary, and your insurance may cover anywhere from 0 to 100% of your medical and surgical costs. We file insurance claims as a courtesy to you, but you are *responsible for the timely payment of your account regardless of any dispute between you and your insurance company*. If your insurance company has not paid within 60 days from the date of service, you have 30 days to make arrangements to pay the balance.

I, the undersigned, certify that I have insurance coverage with the company listed on the Registration Form and assign directly to Jandali Surgical Associates, SC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. It is also my responsibility to inform the office of any insurance changes.

I hereby authorize the physician indicated to release to your insurance company any information including diagnosis and records of any treatment and/or examination rendered to me. I authorize the physician to initiate a complaint to the Insurance Commissioner for any reason on my behalf or to file an appeal to my insurance company on my behalf.

HIPPA NOTICE
The HIPAA Privacy Rule (Health Insurance Portability and Accountability Act) provides individuals with the right to request confidential communications or that a communication of PROTECTED HEALTH INFORMATION be made by other means, such as sending correspondence to the individual's office instead of the individual's home.

CONSENT TO TREATMENT AND FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
This form gives consent to Jandali Surgical Associates, SC to use and disclosure of your protected health information to carry out treatment, payment, or other healthcare related operations. By signing below, you also give consent to obtain your medication history from your pharmacy. Your records may be released to disability, FMLA, or workmen's compensation. For a more complete description of such uses and disclosures, please refer to our Notice of Privacy Practices.

You have the right to review our Notice of Privacy Practices prior to signing this consent. However, we reserve the right to change our privacy practices and change the terms of this notice. Any new notice provisions will be effective for all protected health information that we maintain. Should you wish to obtain a revised notice, you may contact our privacy officer or office manager.

You have the right to request that Jandali Surgical Associates, SC restrict how we use and disclose your protected health information. We are not required to agree to such a restriction, but if we do, the restriction will be binding on us. If we do agree, we will restrict our use and disclose to the extent we document such in writing and notify you of the same.

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatments or procedures after knowing the risks and hazards involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below , you are indicating that you intend that this consent is continuing in nature ever after a specific diagnosis has been made and the treatment recommended, and you consent to treatment at our practice, you also recognize that medicine is not an exact science and that your diagnosis and treatment may involve risk of injury or even death. Further I acknowledge that no guarantees can be made to me as to the results of examinations or treatments during my episodes of care. I also understand that no experimental or investigational treatment will be rendered to me without my expressed consent. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

It is important that you comply with the medical treatment recommendations provided by your doctor. If you are unable to comply, please notify your doctor immediately. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and health benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

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

Signature _____ Date: _____

Printed Name _____ Relationship to Patient _____
(if someone other than patient is signing)