Weston OB/GYN and Endocrine Associates LLC
Rahil Malik MD; Ayesha Malik MD
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Welcome to the practice of **Dr. Ayesha Malik (Endocrinologist)** and **Dr. Rahil Malik (Ob/Gyn)**. To assist you on planning for your health care cost, we would like to inform you of our office and financial policies, which we request that you read and sign prior to any treatment. Our office policies are in place to ensure quality and efficient healthcare services and patient care, patient comfort and respect.

INSURANCE / FINANCIAL RESPONSIBILITY: If our doctors are contracted with your insurance, we will submit your claim to your insurance carrier. Your insurance will pay all or part of the payments based on your insurance policy. Patient financial responsibility is collected PRIOR to your visit. The amount due is determined by your insurance company and is detailed on your **"EOB" or explanation of benefits**. Any questions pertaining to the amount you owe can be addressed with your insurance company. I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. Overpayments, if any, will be maintained on your account as credit and can be applied to future appointments _____**INITIALS**

CREDIT CARD ON FILE POLICY: Weston OB/GYN and Endocrine Associates is committed to making our billing process as simple and easy as possible. **We require that all patients provide a credit card on file to our office when making an appointment**. We will scan your card with a card reader or accept it over the phone into our secure system. It will store your card number in a secure, compliant location in your electronic medical record. Credit cards on file will be used to pay copays, coinsurance and/or deductibles when you are scheduled to be seen in the office, **Patient financial responsibility will be collected PRIOR to the visit.**

I give Weston OB/GYN and Endocrine Associates permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged for my responsibility towards the appointment. _____**INITIALS**

CANCELLATION/NO SHOW POLICY: We send notifications to patients via text/email to confirm appointments. **You must confirm via text/email your appointments**. You can also reschedule/cancel the appointments and avoid cancellation fees. We understand that unforeseen circumstances can lead to missed appointments, at the same time, missed appointments take time away from other patients that need to be seen for their medical issues. If you cancel your appointment less than 48 hours of your appointment or no show for an appointment, **our policy is to charge a fee of $65.00** regardless of insurance status. **Insurance does not cover this charge and this will be your responsibility.** Please help us serve you better by keeping scheduled appointments or rescheduling them in a timely manner (**48 hour notice**). _____**INITIALS**

REFERRALS: It is the responsibility of the patient to obtain all referrals that are needed for any treatment given in this office. **It is your responsibility to obtain and know that you need a referral to see a specialist.** If that referral is not received by the day of your appointment you may have to reschedule. If you elect to be seen by the Doctor without a referral, you will be charged the self pay rate for the office visit. _____**INITIALS**

Name: _____ **Date:** _____ **Signature:**_____

ACCESS TO HEALTHCARE RECORDS/LABORATORY RESULTS: Your patient health information (PHI) is available to you at no cost via the **Healow App**. You can review results any time**. A valid email & phone are required for access**. We use a HIPAA compliant email (**WestonObgynEndo@Femwell.com**) to receive PHI securely. You are permitting us to contact you via text/email. You must maintain your information securely and take measures to protect your privacy. We will notify you as soon as the results are reviewed by the physician who may recommend medications/referrals as indicated. For non-emergent results, we require an appointment (in-person or via televisit) to review your results and to determine the best medical care for your health needs. . _____**INITIALS**

MEDICINE PRESCRIPTIONS AND PRIOR AUTHORIZATIONS: Medicine refills requests greater than 14 days from date of last appointment require a NEW appointment and reevaluation in office. **For medicine refills, please make appointment PRIOR to having a lapse in your medication supply**. It is the patient responsibility to call their insurance and to identify medications that are covered for their medical treatment. The office does NOT have the capability to call insurances to identify individual medication coverages for policy holders. Once a medication is covered by your insurance and formulary plan, the doctor can prescribe those medications.

_____**INITIALS**

TELEMEDICINE: Telemedicine refers to any encounter between a physician and patient that does not occur in person. **Dr. Ayesha Malik offers Audio only and Audio/visual visits to patients for a fee**. These visits are not processed through insurance. Televisit appointments can be made with the front desk staff. Medical problems and lab/test results will not be reviewed or addressed on the phone unless payment has been made prior. All patients have the option to schedule an in-person visit to address their concerns and labs based on doctor's availability. _____**INITIALS**

STUDENT/MEDICAL RESIDENT/CHAPERONE CONSENT: Medical students may shadow/rotate with your physician to gain valuable educational experience. A chaperone is present for sensitive examinations. However, patient and comfort are of utmost importance. If you want to speak to your physician privately, please indicate to the medical assistant so that we can make an effort to accommodate your request. _____**INITIALS**

PRIVACY PRACTICES: I have received and read a copy of Weston OB/GYN and Endocrine Associates' Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Weston OB/GYN and Endocrine Associates has a link to the Notice of Privacy Practices on the practice website located at Westonobgynendo.com_____**INITIALS**

TELEPHONE AND TEXTING COMMUNICATION: The Telephone Consumer Protection Act (TCPA) has an exemption for non-telemarketing healthcare calls, allowing healthcare providers to contact patients for appointment reminders, lab results, and other healthcare-related messages**.** I give consent to Weston Ob/Gyn and Endocrine Associates to opt/in to this service and allow them to call me via telephone / text messaging / Email (**WestonObgynEndo@Femwell.com**) and communicate directly with me or my delegated representatives. I consent to receiving text messages to confirm appointments and communicate with staff at the office. _____**INITIALS**

Name: _____ **Date:** _____ **Signature:**_____

Card On File Authorization Form

CREDIT CARD INFORMATION

Type [ ] VISA [ ] AMEX [ ] MASTERCARD [ ] DISCOVER [ ] FSA [ ] HSA

EXPIRATION DATE: _____ CVV:_____

3% Credit card processing charges may apply

CREDIT CARD NUMBER (ONLY THE Last 4 digits of Credit card)	**NAME ON CREDIT CARD**

Disclaimer

A valid credit card is required to be on file at all times in order to receive care at Weston Ob/Gyn & Endocrine Associates LLC.

I authorize WESTON OB/GYN & ENDOCRINE ASSOCIATES, LLC to charge any outstanding balances on my account, including co-pays, deductibles, coinsurance, fees for late cancellation of appointment and no-show fees to the credit card information I have provided below. Overpayments will be maintained as a credit on my account and can be utilized towards payments for future appointments.

I understand that this authorization will remain in effect indefinitely. I understand that WESTON OB/GYN & ENDOCRINE ASSOCAITES, LLC must be notified immediately of any changes/updates to my credit card information

I hereby assign, transfer and set over to Dr Ayesha Malik and Dr Rahil Malik DBA WESTON OB/GYN & ENDOCRINE ASSOCIATES, LLC. All of my rights, title and interest to my medical reimbursement benefits for my medical evaluation appointments/visits under my insurance policy.

I authorize the release of my medical information to insurance entities, imaging centers, credit card vendors if needed to determine benefits, coordinate care and to validate proof of services. I understand that I am financially responsible for all charges if they are not covered by my insurance.

By submitting this signed and dated form, I fully acknowledge that I am the card holder and hereby authorize WESTON OB/GYN & ENDOCRINE ASSOCIATES, LLC to charge the credit card provided and apply any charges related to my visit that I am responsible for.

The authorization shall remain valid until written notice is given by me revoking such authorization.

Name: _____ Date: _____ Signature:_____

Our office is PCI-DSS Our compliant, and all staff are thoroughly background checked as a condition of employment. Your card data will be securely stored in a PCI-DSS compliant database in which your full card details will not be accessible.