TROY LAMAR, M.D. INC.
51 NORTH FIFTH AVENUE, SUITE 202
ARCADIA, CA 91006
PHONE: (626)445-0600
FAX: (626)574-8654

PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE RECORD

Authorized Methods of Communication (Circle all that apply)

Home/Cell phone number:

- Leave detailed message with person? Yes No
- Leave call back number only? Yes No
- Leave detailed message on voicemail? Yes No

Work phone number:

- Leave detailed message with person? Yes No
- Leave call back number only? Yes No
- Leave detailed message on answering machine? Yes No

Fax Number: ______________________________

Email address: ______________________________

List of people we are authorized to speak with regarding your medical care (including billing).

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Signature Date

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GENERAL OFFICE POLICIES

We are committed to providing you with the best possible care, and we 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. Please ask if you have any questions about our fees or financial policy.

1. All patients must complete the "Patient Information Forms" before seeing the Doctor.
2. You will be asked to update your information forms annually.
3. If there are any changes (e.g. address, phone, insurance) you are responsible for providing this information to the office.
4. Depending on your insurance, full payment may be due at the time of service.
5. Full payment is due at time of service for all uninsured patients.
6. Co-payments must be made at the time of service.
7. We accept most credit cards for charges over $25.00.
8. There is a $25.00 fee for NSF checks.
9. It is the patient's responsibility to verify our participation with their insurance.
10. We are happy to file insurance claims for you.
11. This office is not participating with straight Medi-cal.
12. We will complete EDD forms for you at no cost.
13. There is a $15.00 fee for any other form (e.g. FMLA – AFLAC).
14. There is a $25.00 fee for copies of medical records.
15. Missed appointments may result in a charge of a normal office visit, unless cancelled 24 hours in advance.
16. If you are requesting pharmacy refills, we ask that you have your pharmacy submit a request via fax.

I, the undersigned, acknowledge the receipt of Troy LaMar, M.D. Inc. financial policy. I will adhere to the policies set forth by Troy LaMar, M.D. Inc.

Print name ______________________________

Signature ______________________________ Date ______________

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I,___________________________________, hereby certify that I am eligible for insurance coverage

with: ____.

I have chosen Troy LaMar, M.D. to be my medical provider. I understand if the above information is not True, I am responsible for all charges related to services provided to me. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from Troy LaMar, M.D. Inc.

____
Print name

____
Signature Date