Joseph G. Colonna, M.D.

PATIENT INFORMATION UPDATE

*Please complete this form with your current information. *

**REFERRING DR/PRIMARY CARE DR:_____
Patient Name:_____
Current address: _____
_____

CIRCLE: Marital status: * Single * Married * Separated * Divorced * *Widowed *

Telephone numbers: Home: _____/CELL_____
Work: _____EXT_____

Employer's name and address: _____
_____

Health Insurance UPDATE: ** (Need updated copy of all insurance cards)**

Primary_____	Secondary_____
_____	_____
_____	_____
ID #_____	ID #_____
Group #_____	Group #_____

Please indicate any changes in your health since your last visit:
Illness_____
Accident_____
Allergies_____
Surgery_____

PLEASE LIST MEDICATIONS:

1._____	6._____
2._____	7._____
3._____	8._____
4._____	9._____
5._____	10._____

_____ _____
Signature Date

Joseph G. Colonna, M.D., F.A.C.S.

BILLING AND PAYMENT INFORMATION

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

For patients without insurance, full payment is to be made at the time services are rendered.
For patients with insurance, payment of co-pay is to be made at the time services are rendered.
Whether or not your insurance company pays in full, a portion, or no portion of your medical bill is a matter between you and your insurance carrier.
Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment.
Payment is accepted in the form of cash, check, charge, or Money Order.

I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient, _____.

NO SHOW POLICY

APPOINTMENTS: Patients must call to cancel any scheduled appointment they are unable to keep, prior to their appointment time. Patients may be charged a $25.00 FEE for any appointment not kept and/or not canceled in advance.

SURGERY: Patients must call to cancel any scheduled surgical services they are unable to keep, prior to their scheduled surgical time. Patients may be charged a $250.00 FEE for any appointment not kept and/or not canceled in advance.

COLLECTIONS POLICY

If your account becomes past due for failure to pay, the account may be turned over to an outside collections agency. A processing fee up to 50% of the balance due will be assessed to your account if an outside agency is needed.

My signature indicates that I read and understand the "POLICY CONCERNING PAYMENT OF MEDICAL BILLS", the "NO SHOW POLICY", and the "COLLECTIONS POLICY".

_____

_____ _____

Date Signature

RELEASE OF INFORMATION / PROTECTED HEALTH INFORMATION

_____I give permission for information regarding my Protected Health Information to be discussed with my spouse, significant other and children or other family members if I am unavailable. Please indicate name(s) and relationship: _____

_____

_____

____I do not give permission for information regarding my laboratory, pathology results to be discussed with anyone, but myself.

Authorized Methods of Communication

____Telephone: Residence
- ____Leave a call back number
- ____Leave a detailed message with person
- ____Leave a detailed message on answering machine

____Telephone: Work Number: _____
- ____Leave a call back number
- ____Leave a detailed message on personal voice mail

____Written Correspondence
- ____Mail/Delivery Service
- ____E-Mail @ residence _____
- ____Fax Number: _____

____Other (Specify)

_____

_____

_____ _____ _____

Date Signature Print Patient's Name

Office Use Only:

I have been provided with and/or have been offered access to the Notice of Privacy Practices for the office of Joseph G. Colonna, M.D.

_____ _____

Date Signature