Information for Patients

\*Please initial each statement and sign at the bottom\*

\_\_\_\_\_\_If you are an **HMO** participant, your insurance company requires that you bring your pre-authorization form with you when you have an appointment with Dr. Egan. **If we do not have an authorization on the day of your visit, we will be forced to reschedule your appointment or you will be responsible for the fees incurred.**

\_\_\_\_\_\_ If you have a **PPO** insurance, it is your responsibility to ensure that Dr. Egan is a provider. Your insurance company may require pre-authorization for surgery, CT scans, MRIs or any other special tests. It is your responsibility to determine what your policy requires as all policies vary from patient to patient.

**\_\_\_\_\_\_** You are responsible for determining what your co-payments and deductibles are since all fees are required at the time of service. **If, at the time of your visit, your insurance informs us that you have not met your deductible, you will be asked to pay for the services rendered.**

\_\_\_\_\_\_ **There will be a $25 charge for any returned checks, plus $25 in collection fees. There will be a $50 charge for all appointments missed or cancelled with less than 24 hours notice.**

**\_\_\_\_\_\_** In order to ensure pertinent Lab, X-ray and other personal data are communicated to you in a professional way; it is our policy not to discuss such results over the telephone. This policy insures patient confidentiality and guarantees that test results are accurately communicated to you.

\_\_\_\_\_ Please be aware that any services such as x-rays, labs, hearing or balance studies are separate and distinct from any charges incurred by services rendered by Dr. Egan.

\_\_\_\_\_ I have read and received Patient Privacy Rights and consent to the use and disclosure of my health information for the treatment, payment, and healthcare operations as described therein.

**\_\_\_\_\_Photographs**: I further consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs shall be taken with the consent of and by my physician or a photographer approved by my physician
2. These records may be used for medical records, promotional or publicity purposes and may be published in mass media publications, on Dr. Kristin Egan’s internet sites, or shown on television or video presentations.
3. The photographs may be modified or retouched in any way that my physician, at their discretion, may consider desirable.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_