



**Meyer
Internal
Medicine**

Robert M. Meyer, M.D.

Diplomate, American Board of Internal Medicine

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, a federal law. Administrative Simplification section of this Act is of concern to our practice and requires us to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals and employers
- Healthcare Transactions & Code Sets for transmitting electronic data
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services and will become final in a staged manner.

It will be the policy of Meyer Internal Medicine to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail, e-mail, cellular phones, pager and/or fax. Whenever returning telephone calls and an answering machine picks up, we will not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer your telephone.

If you would like to have your medical information released to someone other than yourself, please complete the following:

I authorize Meyer Internal Medicine to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Answering Machine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Work Telephone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Voice Mail	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cellular Phone	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pager	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list authorizations:

Spouse/Fiancé: _____

Parent: _____

Brother/Sister: _____

Son/Daughter: _____

Friend: _____

Date

Patient signature in full



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PATIENT REGISTRATION

PATIENT NAME: _____
Last First Initial

HOW DID YOU HEAR ABOUT US: _____?

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Male/Female: _____ Social Security Number: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Employer: _____

Occupation: _____ Work Phone: _____

Friend or Relative not Living With You:

Name: _____ Relationship: _____

Address: _____ Telephone: _____

Medical Insurance Information:

1. Primary Insurance: _____ Policy Holder: _____

2. Secondary Insurance: _____ Policy Holder: _____

Name of Spouse or (if a minor) parent: _____

Spouse's/Parent's Employer: _____

Telephone: _____

Authorization and Assignment

I hereby authorize my insurance carrier, attorney or any third-party payor to pay directly to Meyer Internal Medicine all charges submitted for service incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Meyer Internal Medicine to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the providers at Meyer Internal Medicine which may be due me from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. This authorization and assignment shall be valid until I notify Meyer Internal Medicine in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

Signature Date Signature (Witness) Date

FINANCIAL POLICY

In order for us to be able to continue to deliver high quality of care, it is necessary to provide a financial policy. PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. Please present your insurance card(s) at each visit. It is your responsibility to provide us with the correct information so that we may submit to your insurance.
2. We will collect your deductible, co-payment or for non-covered services along with any balance due after insurance on your account at the time of your visit. We accept cash, checks, Visa, MasterCard and Discover.
3. If we do not participate with your insurance, we will file your claims as a courtesy and ask that you follow-up to make sure payment is made to us in a timely manner. If we do not receive payment from them within 45 days, you will be billed for any unpaid balance. Balances are expected to be paid in full within 30 days. If payment on your account is not done in a timely manner, your account may be referred to a collection agency and reported to the credit bureau. We will assess a 1% monthly interest charge on unpaid balances over 60 days old.
4. **MEDICARE PATIENTS:** We are participating providers with Medicare and we will submit to Medicare for all your covered services. If you have supplemental insurance, we will also submit that for you. If payment is not received from your supplemental insurance within 30 days of being submitted, we will ask for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
5. **MEDICAID PATIENTS:** We are not participating providers with Medicaid. We ask that you pay for your services at the time of your visit.
6. **HMO-PPO PATIENTS:** If we participate with your plan, we will submit your services to your insurance for you. Your co-payment will be collected at the time of service-no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has the physician you are seeing in our offices as your PCP. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from our office prior to seeing the specialist. We cannot obtain retroactive referrals. If we do not participate with your plan, we will verify your out-of-network benefits, file your services, and we expect payment of your portion of the services at the time of your visit.
7. **SELF-PAY PATIENTS:** Patients without insurance coverage will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our business office prior to seeing the doctor to make payment arrangements.
8. **No show or missed appointments –** We understand there may be times when you are unable to keep an appointment and request a 24-hour notice of cancellation of your appointment. If two appointments are missed without cancellation, you will be charged \$25.00 fee.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your services. If you have any questions regarding our financial policy, please contact our business office at 407-297-DOC 'M' (3626).

I have read and acknowledge the about financial policy of Meyer Internal Medicine.

Signature (Patient or Guardian)

Date



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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ hereby authorize

(Phone and Fax number)

To release medical, psychiatric, alcohol and/or drug abuse, HIV testing, ARC and/or AIDS diagnosis, eating disorders information or any other records of sensitive nature to:

Robert M. Meyer, M.D.
Meyer Internal Medicine
1781 Park Center Drive
Suite 120
Orlando, Florida 32835
Phone: (407) 297-3626
Fax: (407) 297-3772

For the purpose of _____
(Specific purposes for the disclosure of records.)

The specific reports to be disclosed shall include _____

I understand that this consent is revocable upon written notice to Dr. Meyer except to the extent that the action has already been taken on this authorization. This authorization shall remain in force until _____ or for a reasonable time to accomplish the purpose for which it is given. Alcohol and drug abuse information, if present, will be disclosed from records whose confidentiality is protected by Federal law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations.

Date of Authorization

Patient Signature in Full

Date of Birth

Parent, legal guardian, power of attorney