

Release of Medical Information

I am requesting the release of my medical records from:

To be released to :

Family Integrative Healthcare Network

Greg Fihn, D.O

7455 W Azure Drive

Bldg C, Suite 140

Las Vegas, Nevada 89130

Patient Name

Date of Birth

Signature

Date

FAMILY INTEGRATIVE HEALTHCARE NETWORK

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We ask that all patients take a few moments and review our financial policy, initialing each item. Should you have any questions, please do not hesitate to request to speak with our staff.

_____ **Cash Patients:** payments for services are due at the time services are rendered. We accept cash, checks, Visa, Discover, American Express and MasterCard.

_____ **Insured Patients:** co-payments, co-insurances, and/or deductibles are due at the time services are rendered. We accept cash, checks, Visa, Discover, American Express and MasterCard. .

_____ If your insurance company does not pay your claim within 45 days, we ask that you contact your insurance company to assist in having your claim(s) for services paid.

_____ Returned checks are subject to a \$25.00 returned check fee. If a check is returned, unpaid, it is the patient or guarantors responsibility to pay the balance, including the returned check fee, within 10 days of notification to avoid further collection activity.

_____ There is a \$25.00 No-Show Fee if an appointment is missed without prior notification.

_____ Delinquent accounts will be turned over to a collection agency. Our billing service will send three (3) patient statements for balances due. The fourth (4th) patient statement will be a pre-collection statement. This will be the final notification prior to collection activity. In the event the account is sent to a collection agency, the patient or guarantor will be responsible for a \$50.00 collection fee and all reasonable collection costs.

I have read and understand this Financial Policy.

_____ Signature of Insured/Guarantor/Patient

_____ Date

ELIGIBILITY WAIVER

I _____ hereby certify that I am eligible for
Name of Patient

_____ as of _____
Name of Insurance Effective Date

I understand that if I am not eligible, I will be financially responsible for all services rendered to me, and as billed to this insured company. If I am not eligible for coverage, I agree to pay these services in full within thirty (30) days of notification.

_____ Signature of Insured

_____ Date

Family Integrative Healthcare Network (F.I.H.N.)

POLICY FOR LABS, IMAGING, OTHER MEDICAL TESTS, AND HEALTHCARE REFERRALS:

In order to provide the highest quality medical care, your attention to the following agreement is requested.

As patient of F.I.H.N, I agree to complete requested tests or requested referrals as discussed with Dr. Fihn or his staff members. I agree to notify Dr. Fihn within 7 days of requested due date if I fail to do requested testing or requested referral.

After all testing or referrals to a specialist or other healthcare provider recommended by Dr. Fihn, I agree to be seen by Dr. Fihn for a follow-up appointment within 1 month.

Failure to follow the above request may be cause for increased health risks. Consequently, undiagnosed or untreated health problems could result in potentially LIFE THREATENING CONDITIONS, or other ADVERSE HEALTH PROBLEMS.

Non-adherence with the above may also result in DISCHARGE from the FIHN practice.

Signature_____

Date_____

Printed name_____

FAMILY INTEGRATIVE HEALTHCARE NETWORK
Authorization for Release of Health Information

I authorize Family Integrative Healthcare Network to release health information to:

Name of Person or facility to receive health information

Street Address, City, State, Zip Code

TYPE OF RECORDS

MEDICAL

MENTAL HEALTH

INFORMATION TO BE RELEASED

Discharge Summary	Lab Reports	History & Physical
Billing Statements	Radiology Reports	EKG
Progress Notes	Diagnostic Testing	Consultations
Pathology Reports	Operative Reports	Drug & Alcohol Info
HIV/AIDS Test Results	Outpatient Records	Psychological Results

Other: _____

Specify the time period for information selected above: _____

I also authorize FIHN to leave messages on my voicemail re: test results and other medical information: YES NO

I understand this authorization is voluntary and I may revoke this authorization at any time, provided I do so in writing and submit it to the Family Integrative Healthcare Network. The revocation will take effect when FIHN receives it.

Expiration of Authorization

Unless otherwise revoked, this authorization expires _____ 12 months after signing this form if no other date is indicated.

Signature

Signature of Patient or Legal representative

Date

Relationship to patient

Witness if patient is unable to sign