Conditions of Service at Hosseinion Family Medicine, LLC.

Consent for Treatment: As the patient or authorized representative of the patient, I consent to inpatient and outpatient medical services and procedures performed by Hosseinion Family Medicine, LLC. and its employees.

Office and Billing Policies: I acknowledge receipt of the "Hosseinion Family Medicine LLC Office and Billing Policies" document and agree to these policies.

Patient Rights and Privacy Practices:
I acknowledge receipt of the Notice of Privacy Practices and information regarding Patient Rights. We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Dr. Shahram Hosseinion, Hosseinion Family Medicine, LLC.

No guarantees: I am aware that medicine is not an exact science, and acknowledge that no guarantees or promises have been made to me concerning the outcome or results of any of the procedures, treatment, examination, or care authorized by this consent.

Confirmation and assignment of insurance benefits: During this period of medical care I authorize direct payment to Hosseinion Family Medicine, LLC. any third party, insurance, Medicare, Medicaid or liability benefits otherwise payable to me.

Financial Agreement: By signing below I agree that I am responsible for payment for any medical services not covered by my insurance, and for my assigned portion of covered services. Payment is due within 30 days of billing. I understand that if this account is sent to an attorney or a collections agency, I will be obligated to pay reasonable attorney fees, interest at the legal rate, and collection expenses. Further medical care may not be provided until accounts are up to date.

I have read and understood the above information, have asked questions about anything not clear to me, and am satisfied with the answers that I received. The information I have given is true and accurate to the best of my knowledge.

Patient (or legally authorized individual) Signature: _____

Patient Name: _____ Patient Birth Date: _____

Patient Address: _____

Date: _____

*due excessive missed appointments without prior cancellation which has compromised access to services,
-there will be a $60 charge for missed appointments not cancelled 24 hours in advance
(unless there are extenuating circumstances)
*to respect the timeliness of others
-arrival for an appointment late by 20 minutes or more will be considered a missed appointment