Practice Policies

Thank you for choosing Ocean Pulmonary Associates. We are committed to the treatment of your condition. In order to provide your care, we require both treatment and financial compliance.

If you have HMO coverage, it is your responsibility to obtain the necessary referral for your visit or procedure and forward a copy of this referral to our office prior to your visit.

All patients are expected to pay their copay and/or any balance due. We accept check, money order, Master Card, Visa and Discover. Self-pay patients are required to pay in full at the time of service.

If you present without the copayment you will be asked to reschedule your appointment. If for any reason a payment is dishonored by your bank, there will be a $40.00 service fee added to your bill and you will be required to pay by cash, certified check, money order or credit card for all future services.

We are participating providers with most insurance plans. You will be required to show your insurance card and a picture ID at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay in full for services rendered to you that day. If your insurance coverage terminates or changes you are responsible for notifying us of this change immediately so that we canassist you in receiving your maximum reimbursement. In the event that your insurance carrier issues payment directly to you, it is your responsibility to forward that payment along with the explanation of benefits for appropriate posting of the payment to Ocean Medical Associates.

If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care and refer your account to collections. **You are responsible for any interest, agency and legal fees associated with collections, which could total up to 50% of the balance owed.**

Disability Forms Reports, Etc.

Requests for completion of disability forms, reports or other paperwork will require a minimum fee of 15.00 paid in advance, related to the amount of the preparation involved. Please allow 5 business days.

Appointments

Please be sure to provide a telephone number where you may bereached. If you have voice mail on your contact telephone number, you will receivea message including the time, date and location of the appointment.

We require 24 hours' notice if you intend to cancel your appointment. Should you cancel, reschedule or no show for an appointment twice without 24 hour notice, we reserve the right to charge a no show fee.

If you are late for your appointment, we reserve the right to reschedule your appointment or see you as/if the schedule permits.

HIPPA PRIVACY

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the offices of Ocean Medical Associates. This policy explains your rights including your right to see and copy your records, to limit disclosure of your protected health information and to request an amendment to your record. You may revoke in writing any consent for release of your health care information except to the extent the practice has already made disclosures with your prior consent. Because of the privacy regulations we are not at liberty to discuss your treatment with anyone unless you specifically designate your permission to do so. If you wish to allow access to your protected health information to any individual, ask our receptionist for an Access to Medical Records form. By signing this release, you allow us to discuss your care with the specified individual(s). If a family member has concerns about your care, we may not discuss these concerns without your written permission. Or Notice of Privacy Practices provides information on your rights and is available on our website. We encourage you to read it in full. If you have any questions regarding our notice and if we change our notice, you may obtain a copy of the revised notice by contacting us at 732-341-9247 or visiting our website at www.oceanpulmonary.com.

AUTHORIZATION TO RELEASE INFORMATION AN ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Blue Shield, HMO's and Commercial Insurance to Ocean Pulmonary Associates. I hereby authorize assignee to release any information necessary to secure payment on my behalf.

Patient Name:

Patient Signature:_____ Date_____