

Boyd W. Flinders, M.D.

2701 West Alameda Suite 403

Burbank, CA 91505

818-848-9807

Financial Agreement:

We are non-participating providers with most insurance carriers.

We ask that a deposit toward your account be made at the time of service.

As a courtesy, we will bill your insurance carrier.

You will be responsible for the balance your insurance carrier does not cover.

We are participating providers with:

Medicare -- Industry Health Net Work -- Regal Medical Group

Co-pays, and deductible are due at the time of service.

Authorization is not a guarantee of payment. If you are

not eligible with the above named insurance carrier services rendered

will be your responsibility. This may included durable medical supplies i.e. braces, and splints.

A service charge will apply for filling out the following forms: (Charges do not apply to Medicare insured)

Handicap	\$10.00	Jury Duty	\$15.00
Private Disability	\$25.00 per page	Auto Med	\$15.00 per page
Disability	\$25.00	Turned over to collection	\$25.00
Disability Extension	\$15.00	Phone Refills *	\$25.00
To review x-rays or MRI by CD/DVD \$25.00 (except HMO members)		* No phone refills after hours or weekends. All narcotic refills require an office visit.	

MEDICAL RECORDS

How Protected Health Information May be used or Disclosed:

- The Law permits us to use or disclose health information for the following purpose without a patients written authorization
 - Purpose of treatment with other providers
 - Operations/Surgeries
 - Payments

Communication:

Yes, it is ok to disclose information to any individual, who states they are a family member or a friend, if not, be specific: No one , Family , Friend :

Family or Friend's Name

HIPAA:

I acknowledge of receipt of the Notice of Privacy Practice (HIPAA) form.

Your signature indicates you understand the office policies and procedures.

Patient's Name: _____
Print

Signature: _____ Date: _____

As the responsible party or guardian of the minor listed above, my signature indicates I understand the office policies and procedures.

Signature: _____ Date: _____