Thank you for choosing Bey Health Solutions LLC. We look forward to providing you with high level care and are committed to your treatment being successful.
We accept the following forms of payment:
Cash, Checks, Visa, MasterCard and American Express.

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION, AUTHORIZATION FOR INSURANCE PAYMENT AND FINANCIAL RESPONSIBILITY POLICY

1. I, the undersigned or legal guardian grant permission as indicated below to undergo all necessary tests, treatments and other procedures or studies required for the diagnosis by the medical staff and other employees of Bey Health Solutions LLC.
2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment and examination by Bey Health Solutions LLC
3. I consent to the release of medical information to other institutions or agencies accepting the patient for medical or institutional care, and consent to the release of medical information to patient's insurer and give permission to release data (both medical and personal) to such government agencies as is required of Bey Health Solutions LLC by law, rules, regulations, or by consent.
4. I consent to the release of medical and financial information for auditing purposes.
5. I hereby authorize payment to Bey Health Solutions LLC of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS, otherwise payable to me, but not to exceed the health center and/or physician regular charges for this period of treatment. I agree that a copy of this authorization is as valid as the original. I understand that if my insurance does not approve the charges for this visit, I am fully responsible Bey Health Solutions LLC for payment.
6. HMO Plans (with which we are contracted): All co-pays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting co- pays at every visit. You are responsible for obtaining authorization and approval for treatment with your Medical Group or PCP prior to treatment. If you have not received an authorization prior to your arrival at our office, unfortunately we will need to reschedule or you will be financially responsible for your visit. All payments: visits, co-pays, balances are required prior to pt being seen that day. If pt does not have sufficient funds, the visit will be rescheduled. No exceptions will be made.
7. PPO Plans (with which we are contracted): We have negotiated rates with your insurance company. Your co- insurance and unmet deductible is your responsibility and payment is due at time of treatment.
   In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductibles or coinsurance amounts.
8. Out of Network Patients If your insurance company is out of network for Bey Health Solutions LLC, you will be responsible for 70% of the estimated charges at the time of service. The balance of the fees charged will be submitted to your insurance for payment according to your policies out of network guidelines. Any amount that remains unpaid after payment by your insurance company will be your responsibility.

9. Cash Patients All services must be paid in full at time of treatment. Our office can provide you with a rough estimate of the cost of treatment prior to your visit with the Physician.
10. Returned Checks a $35.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter.
11. Administrative Fee, Bey Health Solutions LLC charges only for professional services provided by your physician. There will be additional billing directly to you from the hospital/facility where your procedure is performed, the anesthesiologists and other assistants that your surgeon may require. Once a decision for surgery is made, our surgery scheduler will contact your insurance carrier to confirm eligibility of benefits. At this time, the Surgery Scheduler will provide you with an estimated cost of the Physician's professional services along with your estimated responsibility. The estimate patient responsibility will be collected as a deposit at the time of your pre-op appointment.
12. Medical Records, Misc. Letters and Forms, All Medical Records request for personal use are subject to an administrative fee of $25.00 - $199.00. If Medical Records are requested by a third party, the fee is determined on a case by case basis. If medical records are requested for continuing care, we will be happy to fax them directly to a physician at no charge. Processing of disability documents/FMLA, juror letter, airline letters, etc., are each charged at a fee of $25.00.
13. We will bill your insurance company as a **courtesy**. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60-days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form. If you are unable to make payment in full, contact the billing department at 954-225-5237 immediately to make payment arrangements. If the account is referred for collections, you will be responsible for the balance of your account plus a collection agency charge and reasonable attorney's fees and costs. If your account becomes delinquent or is referred for collections, your provider and/or any collection agent of your provider has authorization to obtain your credit report to assist them in the collection of your bill.
14. BY SIGNING THIS DOCUMENT, I ATTEST THAT ALL INFORMATION IS TRUE AND CORRECT AND I WILL NOTIFY BEY HEALTH SOLUTIONS LLC OF ANY CHANGES TO MY INSURANCE, INCOME OR CONTACT INFORMATION.

---------- **Date:**

"Patient's Bill of Rights and Responsibilities/Advanced Directives"

As a patient, you have many "Rights", as having certain "Responsibilities" which may help us serve you more promptly and efficiently. This is a mutual partnership established between you, our patient (parent or custodian of our patient) and us, our professional care team of Bey Health Solutions LLC this agreement is called the :PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES."

Your Rights

1. Be treated with courtesy and respect, with appreciation for your dignity, and your need for privacy.
2. A prompt and reasonable response to questions and requests for services.
3. Choose your health care providers and know who is responsible for your care by being given proper identification by name and title of everyone who provides health care or other related service to you.
4. Know what patient support services are available, including whether interpreter is available if you are unable to speak English.
5. Know what rules and regulations are applicable regarding your conduct.
6. Be given complete and current information by Bey Health Solutions LLC concerning your diagnosis, treatment, alternative treatment, risk, and prognosis as required by your physician's legal duty to disclose in terms and language that you can reasonably be expected to understand.
7. To refuse any treatment, expect as otherwise provided by law.
8. Be given upon request, full information and necessary counseling on the availability of know financial resources for your care.
9. Know, upon request if advance treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
10. Receive, upon request, prior to treatment, a reasonable estimate of changes for medical care.
11. Receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
12. Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
13. Treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
14. Know whether medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
15. To express grievance regarding any violation of your rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility, which served you and to the appropriate state-licensing agency.
16. To be given information about formulating an advanced directives.
17. To discuss alternate options regarding pain management.
18. Patient/guests have the right to appropriate assessment and management of their pain.

Your Responsibilities

As a patient of Bey Health Solutions LLC, you are RESPONSIBLE for:

1. Providing the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
2. Reporting unexpected changes in your condition to your health care provider.
3. Reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you.
4. Following the treatment plan recommended by the health care provider.
5. Keeping appointments and when unable to do so for any reason, notifying the health care provider.
6. Your action if you refuse treatment or do not follow the health care provider's instructions.
7. Assuring that financial obligations of your health care are fulfilled as promptly as possible.
8. Following the health care facility rules and regulations affecting patient/guest care and conduct.
9. Patient/guests will be expected to work with their provider to develop a pain management plan and assist in the assessment of their plain to assure that effective pain relief becomes an important part of their treatment.

Verification of Receipt of Copy of Patient's/Guest's Rights, Responsibility and Advanced Directives:

I have received written information concerning my rights to concept or refuse medical treatment and my right to formulate Advanced Directives from the care team of Bey Health Solutions LLC. After reading this document, I had the opportunity to ask questions and I believe that I understand what this document means, what I might expect from this health care facility, and what is expected of my family member (s) and me.

---------- Date:

PATIENT ACKNOWLEDGMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

THE ATTACHED NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE NOTICE CAREFULLY.

SUMMARY

- Your personal health information may be released to other healthcare professional within our Network for the purpose of providing you with quality healthcare.
- Your personal health information may be released to your insurance provider for the purpose of Bey Health Solutions LLC receiving payment for providing you with needed healthcare services.
- Your personal health information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your personal health information may be released to other healthcare providers in the event you need emergency care.
- Your personal information may be released to public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your personal information may not be released for any other purpose that that which is identified in the attached notice.
- Your personal information may be released only after receiving written authorization from you. You may revoke your permission to release personal healthcare information at any time.
- You may be contacted by Bey Health Solutions LLC to remind you of any appointments, healthcare treatment options or other health service that may be of interest to you.
- You may be contacted by the Bey Health Solutions LLC for the purpose of raising funds to support Bey Health Solutions LLC operations.
- You have the right to restrict the use of your personal health information. However, Bey Health Solutions LLC may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes regarding the information that you have provided.

- You have the right to know who has accessed your personal healthcare information and for what purpose.
- You have the right to possess a copy of our Notice of Privacy upon request. A copy of the notice will be provided in the form of a paper document.
- Bey Health Solutions LLC is required by law to protect the privacy of its patients and clients. We will keep confidential any and all patient healthcare information and will provide patient with a list of duties or practices that protect confidential healthcare information.
- Bey Health Solutions LLC will abide by the terms of the notice. Bey Health Solutions LLC reserves the right to make changes to the notice and continue to maintain the confidentiality of all healthcare information. We will post a copy of our current notice in all of our sites. Our notice will indicate the effective date on the first page. We will also give you a copy of our current notice upon request.
- You have the right to complain to Bey Health Solutions or secretary of the department of health and human service if you believe your rights to privacy have been violated. All compliant will be investigated. No personal issue will be raised for filing a complaint with Bey Health Solutions LLC. If you feel your privacy rights have been violated or you want further information about our Notice of Privacy Practices, please write or call Bey Health Solutions LLC privacy contact person at:

Attn: Privacy Officer
Bey Health Solutions LLC
1200 E Broward Blvd,
Fort Lauderdale, FL., 33304
Tel. 954-225-5237

UNIVERSAL PATIENT AUTHORIZATION FORM FOR

FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:
OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider):

Person/Organization Name:

PURPOSE: To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.
EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the day I withdraw my permission.

WITHDRAWING MY PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization named above in “To Whom.”

_____

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of what": includes ALL YOUR HEALTH INFORMATION, INCLUDING:
1. All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:
a. Drug, alcohol, or substance abuse
b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
c. Sickle cell anemia
d. Birth control and family planning
e. Records which may indicate the presence of a communicable disease or non-communicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
f. Genetic (inherited) diseases or tests
2. Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.
3. **Information created before or after the date of this form**.

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give your health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Withdrawal": You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form for Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Note to recipient(s) of the information disclosed under this permission: *This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part 1). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2 (e.g., certain medical emergencies) or 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.*

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 ("HIPAA"); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) §13405 ("HITECH Act"); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code §1232g ("FERPA"); 34 CFR parts 99 and 300; Florida Statute 408.051(4) ("Universal Patient Authorization Form"); and all other Florida Statutes, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statutes §456.057(7)(a), §395.3025(4), §394.4615(2)(a), §381.004, §397.501(7), §760.40(2), §392.65(1), §384.29(1), and §385.202(3)).

No-Show and Cancelation Policy for Bey Health Solutions LLC

Our goal is to provide quality medical care in a timely manner. Your providers want to make sure that you and other area residents have access to high-quality medical care when you need it. To ensure maximum access to medical services for all of our patients, please be aware of the following appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

No-Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show", there will be no charge to the patient. Any additional "no-show" will result in a fee of $50.00 billed to the patient's account.

Medical Appointment Cancellation Policy:

In the event that you need to reschedule your appointment, we request that you please give our office a 24 hour notice. If a patient misses an appointment and does not contact us with at least 24 hour notice, we consider this to be a missed appointment. A $50.00 “no show” fee will be charged.

Scheduled Appointments:

Although we will make every effort to remind you of your upcoming medical appointment by phone or by mail, you are ultimately responsible for remembering your appointment date and time.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Bey Health Solutions LLC promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and **your early cancellation** will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 954-225-5237. If you do not reach the receptionist you may leave a detailed message on the voice mail or you can go into your web portal and send a secure message, if you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

Late Cancellations:

Late cancellations will be considered same as a "no-show".

Cancellation of Surgery:

Any surgery cancellation within 1 week of surgery date will be charged a $300.00 cancellation fee. If a deposit for surgery is required and collected this amount will be deducted from the deposit paid, the remaining balance will then be refunded to the patient.

ACKNOWLEDGEMENT AND AUTHORIZATION:

• I have read and understand the HIPAA/Privacy Policy for BEY HEALTH SOLUTIONS LLC

Signed_____Date:_____

• I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed_____Date:_____

• I authorize BEY HEALTH SOLUTIONS LLC to release medical information required to process my claim

Signed_____Date:_____

• I have read and understand the Financial Policy for BEY HEALTH SOLUTIONS LLC

Signed_____Date:_____

• I authorize BEY HEALTH SOLUTIONS LLC to obtain/have access to my medication history

Signed_____Date:_____

• I authorize my provider's office to contact me by mobile phone

Signed_____Date:_____

• I have read and understand the No-Show and Cancelation Policy for BEY HEALTH SOLLUTIOS LLC
Signed_____Date:_____

• I have read and understand the Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care for BEY HEALTH SOLUTIONS LLC
Signed_____Date:_____

Check one to describe the relationship of Legal Representative to Patient (if applicable):
Parent of minor
Guardian
Other personal representative explain:
_____

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it

In addition:

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

I understand that there are some circumstances in which this information may be re-disclosed to other persons [See page 2 for details].

I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or

permission.
I have read both pages of this form and agree to the disclosures above from the types of sources listed.

• I have read and understand the Patient's Bill of Rights and Responsibilities/Advanced Directives for BEY HEALTH SOLUTIONS LLC

Signed_____Date:_____

ACKNOWLEDGMENT

Advanced Directive/Living Will

Have you formulated a "Living Will" which contains your personal instructions about life-prolonging treatment? Yes ____No___ if Yes, did you bring a copy with you? Yes____ No____
Have you selected someone to be your health care surrogate? Yes____ No____
If yes please provide the name and relationship
First Name_____ Last Name_____Relationship_____
Telephone_____ __
Street _____City/State _____ Zip Code_____