Amistad Medical Clinics
Ajar G. Meka M.D. Inc

Meena K. Meka M.D **Aruna Krishnaswamy M.D**

All Primary Services **Senior/Medicare Clinic Only**

606 S. Euclid St	2740 S. Bristol #208	1510 E. 7th St	3325 Tyler Ave.	201 S. Broadway
Anaheim, CA 92802	Santa Ana, CA 92704	Long Beach, CA 90813	El Monte, CA 91731	Santa Ana, CA 92701
P: (714)635-8570	P: (714)979-5734	P: (562)590-9800	P: (626) 416-5822	P: (714) 571-4941

Financial Policies: Updated: June 20, 2017

Regarding Payment:

- Payment for services is due at the time of your doctor's visit. We accept cash, credit cards, debit cards and money orders. If other special arrangements become necessary or you are experiencing a financial hardship please discuss this with us prior to your office visit.

Regarding Insurance:

- Medical services offered through this office are provided directly to you and not to an insurance company or some other third-party payer. Our Office may be able to bill your insurance company directly for you, provided that you are eligible for services and you bring us your health insurance card and other related information. You must sign the **Assignment of Benefits** below.
- If your medical services are related to a personal injury suit you will be required to sign an **Attorney's Lien**.
- You are responsible for submitting any additional information that your insurance company may request from you in order to issue a payment to our office for services rendered.
- You are responsible for any amounts that your insurance does not cover or if you have not met you deductible. You are responsible for paying all co-pays. If you choose to pay for services and bill your insurance company directly, payment is due at the time the services are rendered. Please request a Superbill.

Regarding Confidentiality and Disclosure of Medical Information:

- HIPPA Privacy Policy Statement: This medical office understands the importance of privacy and is committed to maintaining the confidentiality of your medical information. We make a record of the medical care that we provide and may receive such records from others. We use these records in order to provide or enable other health care providers to provide quality medical care, to obtain payment for services allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. Except in cases where prohibited by law or in cases we have reasonable belief that notifying you could place you at risk, we will not use or disclose your personal medical information without your written consent. In the event of an emergency and if you are unable or unavailable to agree or object, our health professionals will use their best judgement in communicating with your family and others.
- By signing the Assignment of Medical Benefits below you or an authorized person has given our Office permission to release any medical or other information necessary to process your insurance claims or to obtain payment from another type of third party payer.
- Any questions or concerns about how this medical practice handles your health information should be directed to our Designated Privacy Office.

Regarding Appointments:

- Whenever possible, please notify our office as soon as possible if you are unable to make your scheduled appointment. This way we can allow another patient to use the time that had been set-aside for you. A 24-hour notice is appreciated.

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE OFFICE OF AJAY G. MEKA M.D. INC. OTHERWISE PAYABLE FOR CHARGES FOR MEDICAL SERVICES RENDERED BY THE MEDICAL GROUP. I HAVE READ THE FINANCIAL POLICIES LISTED ABOVE AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY THIS AUTHORIZATION. I ALSO AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM FOR PAYMENT. I ACKNOWLEDGE THAT A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION IS AS IF SUCH COPY WERE THE ORIGINAL. IF IT BECOMES NECESSARY FOR THE ACCOUNT TO BE REFERRED TO AN ATTORNEY OR COLLECTION AGENCY FOR COLLECTION OR SUIT, I MAY BE RESPONSIBLE TO PAY REASONABLE ATTORNEY FEES AND COLLECTION EXPENSES.

Patient's Name ____ Patient's Date of Birth: __________________

Guardian's Name (if applicable): __________________________________ Relationship: _______________________

Signature: : ____