David Bub, MD, PC, FACS, FASCRS

Patient Authorization/Policy Form

Patient name: _____ Date of Birth: _____

Authorization must be given to our Practice to submit a claim to your insurance:
By my signature below, I am authorizing my insurance company, either commercial or Medicare/Medigap to release payment for services I received to the practice of David Bub, MD, PC. I authorize any holder of medical information regarding me to release to the Health Care Financing Administration (including secondary coverage) needed to determine benefits payable for related services. I hereby authorize my insurance carrier to furnish David Bub, MD, PC any information regarding my claims under Title XVIII of the Social Security Act. I am also authorizing release of information necessary to file my claim with my insurance carrier and I assign benefits payable to David Bub, MD, PC as indicated on submitted claims. I understand that I am financially responsible for any balance not covered by my insurance company. A copy of my signature is valid as the original if requested

Signature of Patient or representative: _____ Date: _____

NOTICE OF PRIVACY PRACTICES: I am aware of the Privacy Practices of David Bub, MD, PC and any associates which describe the use and disclosure of protected health information and how I may access my protected health information and exercise my rights concerning protected health information. I may review the current practice policy prior to signing this acknowledgement/consent. (NOTE: The Practice reserves the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health records that we maintain including information created or obtained prior to the date of the effective date of change. The Notice of Privacy Practices is displayed in the office.) I authorize the office to use my health information for treatment, payment, and healthcare operation purposes consistent with the Notice of Privacy Practices

Signature of Patient or representative: _____ Date: _____

CANCELLATION POLICY: Due to the nature of our specialty of care we reserve a specific block of time and staffing for each patient, and it is important that you make every effort to keep your appointments whether they are scheduled in our office or at an outside medical facility. Upon scheduling each patient's appointment/procedure a significant amount of paperwork, staff scheduling, equipment reservation, etc. go into preparing for that treatment. Last-minute cancellations cause disruptions within our office and/or at the medical facility where you have been scheduled and prevent other patients from receiving needed treatment. We do understand that there are valid reasons for rescheduling, such as family emergencies. However, we do want to make you aware that re-scheduling may result in a $100 fee not payable by your insurance. If you have any questions, please speak to the office staff.

Signature of Patient or representative: _____ Date: _____