Purpose of visit today: _____

PHYSICIAN INFORMATION:
Referring Physician: _____
Phone: _____
Primary Physician: _____
Phone: _____

FINANCIAL DISCLOSURE:
I understand that I am financially responsible for all medical expenses associated with my treatment, or the treatment of my dependent. I understand that such treatment may or may not be covered by my insurance policy. I authorize Art Armenta, M.D.P.A., to release my medical records to my insurance company, and to file with my insurance carrier to obtain payment. I assign all payments to Art Armenta, M.D.P.A., for any covered expenses.
I realize that any insurance deductible and insurance co-payment must be paid prior to the performance of elective surgery. I understand that pre-certification or pre-authorization of any procedure is not a guarantee of payment, and that I am ultimately responsible for all expenses not covered by insurance.
I realize that all returned checks are subject to a $25.00 returned check fee. I understand all of my financial responsibilities as explained above.

_____
Signature of Patient

PRIVACY NOTICE AND CONSENT
We are required by law to protect the privacy of your health information. The attached Notice of Privacy explains our practices and your rights. Please sign below to signify that you have read the notice and that you allow us to disclose your health information to your family members (i.e., giving lab or appointment information to a family member answering you phone or in an emergency situation). If this concerns you in anyway, please discuss it with Art Armenta, M.D.P.A.

_____
Signature of Patient

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be paid to Art Armenta M.D.P.A...

_____
Signature of Patient Date

PHOTO CONSENT: I authorize Dr.Armenta to take pre-operative, intra-operative, and post-operative photographs.

_____
Signature of Patient Date