DANIEL BENDETOWICZ, MD, PA
INTERNAL MEDICINE

ACKNOWLEDGEMENT OF OFFICE POLICIES

LATE CANCELLATIONS – NO SHOW APPOINTMENTS

1) I understand and I have been notified that I will be charged a fee in the event that I do not give a minimum of 24 hours cancellation/reschedule notice by phone to Dr. Bendetowicz's office.

The notification should be done during regular working hours. A message left on the answering machine or to the on call physician is not considered a 24 hour notice.

There may be exceptions that will be considered in exceptional situations.

Initials _____

2) I acknowledge that I have been notified that in case that my account goes to a collection agency due to lack of payment, I will be responsible for the collection agency's fees. This is 25% of the debt amount.

Initials_____

AUTHORIZATION TO RETRIEVE EXTERNAL MEDICATION HISTORY

I authorize Daniel Bendetowicz, MD, PA to retrieve my external medication history. I understand that this may include medication history prior to getting established as a patient of Daniel Bendetowicz MD PA. This medication history may include substance controlled medication, psychiatric drugs, antiviral drugs (for example those ones used in the treatment of HIV/AIDS) and medications used in the treatment of pain.

Initials_____

AUTHORIZATION TO RETRIEVE MEDICAL RECORDS FROM PRIOR HOSPITALIZATIONS THROUGH WEB SITE PORTALS (INTERNET)

I authorize Daniel Bendetowicz, MD, PA to retrieve my medical history through website portals. I understand that this may include history prior to getting established as a patient of Daniel Bendetowicz MD PA. This history may include substance controlled medication, psychiatric drugs, antiviral drugs (for example those ones used in the treatment of HIV/AIDS).

Initials_____

NON COVERED SERVICES

There is a charge for non-covered services, payable out of pocket and not billable to insurances. For example a phone consultation.

Initials_____

Signature _____

Name _____

Date _____