MERINO MEDICAL & WELLNESS, LLC – PAMELA MERINO, M.D., P.A.

6705 Red Road, Suite 512. Coral Gables, FL 33143
305-663-1266- Office – 305-663-8928-Fax

GENERAL AND FINANCIAL OFFICE POLICY

Our office is dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

- **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. Self-Pay patients are responsible for the full amount of services rendered and payments are due at the time of service. **MERINO MEDICAL & WELLNESS, LLC – PAMELA MERINO, M.D., P.A.** does not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service.
- **INSURANCE** We are participating providers with several insurance plans. As a courtesy to our patients, we will file all of these insurance claims and send them. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. Any charges not paid by your insurance, for whatever reason, will be the responsibility of the patient and payment is expected promptly. If our doctors are not listed in your plan's network, you may be responsible for full payment. If you are insured by a plan with which we have no prior arrangement, we will provide an itemized bill of all charges so you can submit a claim to your insurance. All charges are due at the time of service. Patient is responsible to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage.
- **ASSIGNMENT OF INSURANCE BEBEFITS:** I hereby assign, transfer, and set over directly to **MERINO MEDICAL & WELLNESS, LLC - PAMELA MERINO, M.D., PA.** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said facility. I authorize **MERINO MEDICAL & WELLNESS, LLC - PAMELA MERINO, M.D.,** P. A. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to **MERINO MEDICAL & WELLNESS, LLC - PAMELA MERINO, M.D., P.A.** I authorize **MERINO MEDICAL & WELLNESS, LLC - PAMELA MERINO, M.D., P.A** to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.
- **RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. No more checks will be accepted after a returned check instance.
- **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.
- **FORMS FEES: P**re-payment for completing forms, copying medical records, or for extra written communication by the doctor. Forms are $20.00 and request will be processed after payment is received. Printing fees for Medical Records is $1.00 p/page for the first 25 pages and $0.25 per additional page. **MERINO MEDICAL & WELLNESS, LLC - PAMELA MERINO, M.D., P.A.** will have 30 business days in which to copy records before making them available for patient to pick up, and these 30 days will commence after payment has been received and after patient has signed this form authorizing records' release.
- **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 business hours before, or if you no-show, we will assess you a $50.00 missed appointment fee.
- **RELEASE OF INFORMATION:** I hereby authorize the and direct **MERINO MEDICAL & WELLNESS, LLC - PAMELA MERINO, M.D., P.A.** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
- **COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.
- **REFERRAL/AUTHORIZATIONS:** Any referrals or Authorizations needed for an specialist or a procedure needs to be requested at least 48-72 hours prior to your appointment. We will do all in our power to get the approval as soon as possible but we do not guarantee same day or next day approvals.
- **REFFILS:** Refills will be filled within 72 business hour after the request is placed. Please, do not wait until you run out of medication to place a refill request.
- **SERVICE FEE:** There is a $20.00 Service Charge not billable to insurance if we draw your blood here to be sent to the lab. If you rather go to another lab facility, please, let us know and a requisition will be provided.

I have read and understand the practice's General & Financial Policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Patient's Name & DOB

Notice of Privacy Practices

MERINO MEDICAL &^ WELLNESS LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

6705 Red Road, Suite 512
Coral gables, FL 33143

Office: 305-663-1266
Fax: 305-663-8928

Attn: Paola Merino

Please sign the accompanying "Acknowledgement" form

MERINO MEDICAL & WELLNESS, LLC – PAMELA MERINO, M.D., P.A.
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MALPRACTICE NOTICE

Under Florida Law, physicians are generally required to carry Malpractice Insurance or otherwise demonstrate Financial Responsibility to cover potential claims for medical malpractice. You doctor has decided not to carry malpractice insurance. This is permitted under Florida Law subject to certain conditions.

Florida Law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.

I, _____, have read this notice and acknowledge that my physician, Pamela Merino, MD, is not carrying Malpractice Insurance.

_____ _____

Patient Signature/Firma del Paciente Date/Fecha

Bajo la ley del estado de la Florida, el medico practicante es generalmente requerido a tener una poliza de Seguro de Malapractica, o por el contrario, demostrar responsabilidad economica de cubrir potenciales reclamos por mala practica medica. Esto es permitido bajo la ley del estado de la Florida, sujeto a ciertas condiciones.

La ley del estado de la Florida impone penalidades contra aquellos medicos sin seguro de mala practica que no cubren sus obligaciones economicas que provienen de sentencias adversas en casos de mala practica medica.

Este aviso es provisto de acuerdo a la ley del estado de la Florida.

Yo, _____, he leido esta carta y entiendo que mi medico, Pamela Merino, MD no tiene seguro de mala practica medica.

_____ _____

Patient Signature/Firma del Paciente Date/Fecha

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TO ALL PATIENTS

DR. PAMELA MERINO is a **NON PARTICIPANT** provider with Medicaid.

As of January 18th, 2010, all patients that have Medicaid as Primary insurance will be financially responsible for all charges at the time of the visit.

All patients that have Medicaid as Secondary insurance will be financially responsible for any deductible, co-insurance or non covered charges after Medicare process the claim.

All payments are due at the time of service with no exceptions.

I have read the above statement and I fully understand that, regardless of any insurance coverage, I will be responsible for any and all payment at the time of service.

_____
Print Name & Date

_____
Patient or Guardian Signature

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MEDICAL INFORMATION RELEASE FORM

Full Name:_____

Address: _____

_____

Telephone #: _____ **Date of Birth:** ____/____/____

Sex: Male ___ **Female:** ___

I hereby give permission to **MERINO MEDICAL & WELLNESS, LLC - PAMELA MERINO, M.D., P.A.** to release medical information to:

1- **Name:** _____
Relationship: _____
Address & Phone nbr: _____
_____

2- **Name:** _____
Relationship: _____
Address & Phone nbr: _____
_____

3- **Name:** _____
Relationship: _____
Address & Phone nbr: _____
_____

I understand that I sign this form voluntarily and that I may change my decision at any time. Although I understand that I cannot do anything about information previously authorized and released, I am aware that I must notify **MERINO MEDICAL & WELLNESS, LLC - PAMELA MERINO, M.D., P.A.** in writing if I would like to revoke this release. A copy of this form is as valid as the original.

_____ ___/___/___ _____ ___/___/___
Authorizing Signature (Date) Witnessss Signature (Date)

MERINO MEDICAL & WELLNESS, LLC
6705 Red Road, Suite 512. Coral Gables, FL 33143
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information:

- ☐ Mental health records
- ☐ Disclose Alcohol/drug abuse treatment records
- ☐ Other: _____
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Genetic information

Form of Disclosure:

☐ Electronic copy or access via a web-based portal ☐ Hard copy

Section III – Reason for Disclosure

Please detail the reason(s) why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s)listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

- ☐ From _____ to _____, or
- ☐ The date of the signature in section VI until the following event: _____
- ☐ All past, present, and future periods, or

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section VI – Signature

_____	_____	_____
Print Patient Name	Patient Signature	Date

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____ Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____

_____

INTEGRITY
HEALTH SPA MIAMI

PAMELA MERINO, M.D., P.A.

Aesthetic Patient Self-Assessment

Patient Name: _____ Date of Birth: _____

Phone Number: _____ Email Address: _____

At **Pamela Merino, MD PA**, we are dedicated to providing you with **ex**cellent medical care and also the newest and most effective procedures and products to enhance the appearance of your skin, face and body.

Aesthetic Products, Treatments and Procedures

Please let us know which of the following aesthetic products, treatments and procedures interest you. Please check all that apply.

- ☐ HALO
- ☐ BBL Forever Clear - Acne
- ☐ BBL Forever Young - Skin Rejuvenation
- ☐ BBL Forever Bare - Hair Removal
- ☐ BBL Phototherapy - Sun damage, freckles, age spots, rosacea
- ☐ Botox
- ☐ PRP Treatments
- ☐ Dermal Fillers - Juvederm, Voluma, Vollure, Volbella
- ☐ Facials & Peels
- ☐ Massage Therapy
- ☐ Skin Care Products

Would you be interested in having any of these products and/or services done today? Y N

If not today, What's your time-frame for getting any of these products and services done?

_____.

Ask us about sales and specials...

Patient Signature: _____ Date: _____

MERINO MEDICAL & WELLNESS, LLC
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E-mail Consent Form

Patient Name _____ Date _____

Patient E-mail address _____ Patient phone number _____

The LLC and its Staff Members shall be referred to throughout this consent form as "Provider".

1. RISK OF USING E-MAIL TO COMMUNICATE WITH YOUR PROVIDER:

Provider offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail has a number of risks that patients should consider before using e-mail communication. These include, but not limited to, the following risks:

a. E-mails can be circulated, forward, and stored in numerous paper and electronic files.
b. E-mails can be immediately broadcast worldwide and be received by unintended recipients.
c. E-mail senders can easily type in the wrong email address.
d. E-mail is easier to falsify handwritten or signed documents.
e. Backup copies of e-mail may exist even after the sender or recipient has deleted his or her copy.
f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their system.
g. E-mail can be intercepted, altered, forward, or used without authorization or detection.
h. E-mail can be used to introduce viruses into the computer system.
i. E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL:

Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the patients must consent to the use of email for patient information. Consent to the use of e-mail includes agreement with the following conditions.

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record will have access to those e-mails.
b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c. The patient is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the patient or any third party.
d. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.
e. It is the patient's responsibility to follow-up and/or schedule an appointment.

3. **PATIENT RESPONSIBILITIES AND INSTRUCTIONS:**

To communicate by e-mail, the patient shall:
a. Limit or avoid using his/her employer's computer.
b. Inform Provider of changes in his/her e-mail address.

c. Confirm that he/she has received and read the e-mail from the Provider.
d. Put the patient's name in the body of the e-mail.
e. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g. billing and questions).
f. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password.
g. Withdraw consent only by e-mail or written communication to Provider.

4. TERMINATION OF THE E-MAIL RELATIONSHIP

The Provider shall have the right to immediately terminate the e-mail relationship with you if determined in the sole Provider's discretion, that you have violated the terms and conditions set forth above or otherwise breached this agreement, or have engaged in conduct which the Provider determines to be unacceptable.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have discussed with the Provider or his/her representative and I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between the Provider and me, and consent to the conditions herein. I agree to the instructions outlined herein, as well as any other instructions that my Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Name (print) _____

Patient Signature _____ Date _____

HOLD HARMLESS

I agree to indemnify and hold harmless the Provider and its trustees, officers, directors, employees, agents, information providers and suppliers, and website designers and maintainers from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider, and any breach by me of these restrictions and conditions.

Patient Name (print) _____

Patient Signature _____ Date _____