Dr. Christopher Stalberg M.D.PLLC

14418 W. Meeker Blvd #210
Sun City West, Az 85375

Thank you for choosing Dr. Christopher Stalberg's office. We are committed to providing quality care. In effort to avoid confusion and misunderstanding, we have adopted the following Financial Policy and require you to read and sign it prior the commencement of pay treatment.

Insurance- all patients

Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy to you, we file claims for those plans with which we have an agreement. Please be advised that you are ultimately financially responsible for payment of medical services rendered by this clinic. All health plans are not the same, and they do not always cover the same services. In the event your health plan determine a service to be "not covered" you will be responsible for the complete charge. Dr. Stalberg's office does not bill any third party insurers. If you received services that are payable by a third-party insurer you will be charged the appropriate amount from our standard fee schedule, and are responsible for payment at the time of service. If you have an HMO plan Dr Stalberg's name needs to be listed as the PCP or you will be required to reschedule your appointment.

Non-insured patients

If you have insurance coverage with a plan with which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. We offer a competitive cash fee schedule for our patients with no insurance, if paid in full at the visit we offer a 20% discount.

Deductibles

Our insurance contracts require us to collect deductibles and co-pays at the same time of service if you have on.

Paperwork Services

Any paperwork filled out by our providers such as short term disability, or FMLA are subject to a $50.00 charge.

This financial policy surrenders all prior written financial policies, contracts, or verbal agreements.

Patient Name: _____ Date: _____

Assignment of benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE TO DR. CHRISTOPHER STALBERG MD FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN(S). I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICADE SERVICES) AND ITS AGENTS ANY INFORMATION NEED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

Patient Name: _____ Date: _____

Christopher Stalberg M.D., PLLC

14418 W. Meeker Blvd. Bldg B Ste. 210
Sun City West, AZ 85375

Patient Name: _____
(First) (MI) (Last)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Marital Status: _____ Health Care POW Living Will? _____ DNR Status? _____

Employer: _____ Occupation: _____

Spouse/Partner's Name: _____ Phone: _____

Emergency Contact: _____

Phone: _____ Relationship to Patient: _____

Previous Primary Physician: _____ Phone: _____

Referring Physician or Friend : _____ Phone: _____

Patient Email: _____

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

Pharmacy Information

Primary Pharmacy: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I authorize my previous doctor to release copies of my medical records to:

Dr. Christopher Stalberg M.D.

14418 West Meeker Blvd #210
Sun City West, AZ 85375
P: 623-544-8400
F: 623-544-8989

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication. This consent will remain in effect for the time that I am under Dr. Christopher Stalberg's care, or until I revoke at any time by written notice to the medical office. I also understand that my medical records may include mental health information, drug/alcohol information and/or HIV information.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

The information to be released is for: Continued Care

Patient Name (Print): _____

Date of Birth: _____

Address: _____

Phone: _____

Patient Signature: _____

Christopher Stalberg M.D.

14418 W. Meeker Blvd. Bldg B Ste. 210
Sun City West, AZ 85375
623-544-8400

Release for Disclosure of Health Information

☐ I have no restrictions regarding the disclosure of my medical information to family members, other relatives, close personal friends or other.

☐ Please limit disclosures of my medical information to the following persons:

_____ _____

_____ _____

☐ Do not disclose my medical information to anyone. (Family, Friends, or Others)

Print Patient Name: _____ Date: _____

Patient Signature: _____

Christopher Stalberg M.D.

14418 W. Meeker Blvd. Bldg B Ste. 210
Sun City West, AZ 85375

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient to this practice) may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the health insurance portability and accountability act of 1996 (HIPPA).

Our Commitment to your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and Disclosure of your Health Information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request, however, if we do agree we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Stalberg, 14418 W Meeker Blvd. Ste 210, Sun City West, AZ 85375.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Stalberg, or contact our office at 623-544-8400. You must provide us with a reason that supports your request for an amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, you may contact us at 623-544-8400. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the office at 623-544-8400 hereby acknowledge that I have been presented with a copy of Dr. Stalberg's Notice of Privacy Practices.

Signature: _____

Date: _____

Name of Patient: _____