MAXWELL LARWEH M.D.

1320 Galvin Rd
Bellevue NE 68005
Phone # (531)-201-2422
Fax # (531)-202-4242

We are pleased that you have chosen Maxwell Larweh, M.D. for your health care needs. This information regarding office procedures will be helpful to you. All patients must sign this policy before receiving treatment.

His office hours are Monday 1:00 pm to 5:00 pm and Friday 8:30 am to 1:00 pm. Call during business hours to refill prescriptions.

If you need to cancel your appointment, **call 4 hours before your appointment time** or a no show fee will automatically be added to the bill of $25.00.

Financial Policy:

1. Maxwell Larweh, M.D. practice will file insurance claims for patients as a courtesy. **Regardless if you have an insurance plan, you still have responsibility of payment of the bill monthly.** It is also the patient's responsibility to know if the provider he or she is seeing is a participating provider with his/her health plan.
2. **Co-payments are always due at the time of service.** Our contractual agreement with your carrier prevents us from waiving your required co-pay amounts.
3. The **"patient balance" is due within 15 days of the statement date** unless you have made other arrangements with the business office. We will collect all outstanding patient balances prior to each visit. You can call the business office at (402) 341-9519 to make other arrangements for a payment plan. **If monthly payments are not received the account will be sent to an outside collection agency. If you have an amount in collections you will not be allowed to make appointments or get medication refills.**
4. If you have **no insurance coverage**, a payment of $50.00 is due at the time of services, unless you have made a prior agreement.
5. We accept **CASH, CHECKS, VISA, MASTERCARD AND DISCOVER.**
6. **Call to correct any billing errors promptly.** If you ignore our billing statements or telephone calls, we can only assume that you do not intend to pay for the medical services that were provided in good faith and your account will be forwarded to an outside collection agency.
7. **Referrals** – some insurance plans require that a referral from the primary care physician be obtained prior to being seen. It is the responsibility of the patient to obtain this referral. If a referral has not been obtained you may be responsible for a larger portion of you bill.

I have read this policy and accept the terms as outlined above.

Signature: _____ Date: _____

Patient Authorization of Disclosure

Dr. Maxwell Larweh

In general, the HIPAA Privacy Rule provides individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (CHECK ALL THAT APPLY):

___Home telephone_____
(Area code and number)
___OK to leave message with detailed information
___Leave message to call-back number only

___Work telephone_____
(Area code and number)
__OK to leave message with detailed information
__Leave message with call-back number only

____ Written Communication
____OK to mail to home
____OK to mail work/office
____Other

___ Cell phone _____
(Are code and Number)

___Email_____

In a further effort to protect your health information and confidentiality of your health care, we ask that you designate below to whom the health care providers and staff at Dr. Larwehs' office may discuss your health care and scheduling needs as well as billing issues that may arise.

I allow you to give my clinical health care and or financial information to or answer questions from: (Check all that apply and provide names and contact information)

__Spouse_____
__Parent_____
__Child_____
__Other (specify) _____
__Only disclose information to myself.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization at any time by submitting a written revocation to Dr. Larweh's office. However, your written revocation will not affect any disclosure of your medical information that the person(s) and or organization(s) listed above have already made, in reliance of this authorization, before the time you revoke it.

Potential for Re-disclosure

The person or organization to which the health information is sent, may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Patient Name: _____ Patient signature_____

Date_____