# Rodney L. Ellis, M.D., P.C

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you must provide **more than** a **24 hour notice**. This will enable for another patient who is waiting for an appointment opening to be scheduled in that appointment slot. With appointment cancellations made **less than** a **24 hour notice** we are unable to offer that appointment slot to other patients.

Office appointments which are cancelled **less than 24 hours** the following notifications will be presented out to the patient. A call from the office which will notify the patient stating the following "Sorry we missed you today we have not received any notification that you would not attend your appointment with us due to the fact that you have missed your appointment it will be a **$50.00 No Show fee"**. **Internal Medicine visits** and **Rosebud visits** are required to have **24 hour advance notice.**

The **Cancellation** and **No Show fees** are the **sole responsibility** of the patient and must be **paid in full** before the patient is able to make any other appointment here in the office. We understand that **special unavoidable circumstances** may cause you to cancel within the 24 hours. Fees in this instance may be waived but only with **management approval**.

Our practice firmly believes that good physician and patient relationship is based upon understanding and good communication. Any questions about cancellation and no show fees should be directed to our **billing department** (703)-403-7392.

Please sign below that you have read, understand and agreed to this cancellation and no show fee policy.

_______________________________________ ______________________

Patient Name (Please Print) Date

**RODNEY L. ELLIS, M.D., PC.**

PATIENT CONSENT FOR USE AND DISCLOSURE OR PROTECTED HEALTH INFORMATION

With my consent, Rodney L Ellis, M.D., P.C. (RLE), may use and disclose Protected Health Information (PHI) about me to carry out Treatment Payment and healthcare Operations (TPO). Please refer to RLE's Notice of Privacy Practices for a more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing this consent. RLE, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to RLE.'s Privacy Officer at 9811 Greenbelt Rd., Suite 104 Lanham, MD 20706.

With my consent, RLE may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, RLE may e-mail to my home or other designated location any items that the practice is carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that RLE restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to RLE's use and disclosures of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, RLE may decline to provide treatment to me.

____________________________________ ______________________
Signature of Patient or Legal Guardian Date

__________________________________ __________________________
Print Patient's Name Legal Guardian

Rodney L. Ellis, M.D., P.C.

**Patient Registration (Please Print)**

| REFERRED BY |
|---|
| |

| PATIENT NAME First Middle Last | | | | | PLEASE CHECK THE NUMBER AT WHICH WE MAY LEAVE A DETAILED MESSAGE. |
|---|---|---|---|---|---|
| SEX ☐ Male ☐ Female | DATE OF BIRTH | AGE | MARITAL STATUS ☐ M ☐ S ☐ W ☐ D | SOCIAL SECURITY NUMBER | HOME PHONE NO. ( ) ☎ ☐ |
| ADDRESS Street City State Zip | | | | | DRIVER'S LICENSE St. # |
| ARE YOU ☐ Employed ☐ Full-Time Student ☐ Part-Time Student | | | OCCUPATION OR, IF STUDENT, GRADE | | WORK OR SCHOOL PHONE NO. ( ) ☎ ☐ |
| EMPLOYER OR SCHOOL NAME AND ADDRESS | | | | | CELL PHONE NO. ( ) ☎ ☐ |
| E-MAIL ADDRESS | | | | | PHARMACY PHONE NO. ( ) ☎ |

**All Contact information given above authorizes RLE M.D. P.C. to use that information for contact and informational purposes.**

**PRIMARY INSURANCE** **If no insurance please check ☐**

| INSURANCE COMPANY | INSURED (If other than patient please complete) | | |
|---|---|---|---|
| INSURANCE COMPANY NAME OR MEDICARE INFORMATION | POLICY IN NAME OF (Insured) | | HOME PHONE NO. |
| POLICY /ID NUMBER/MEMBER ID NUMBER GROUP NUMBER | INSURED'S ADDRESS Street | | |
| INSURANCE COMPANY ADDRESS Street | City State Zip | | |
| City State Zip | PATIENT'S RELATIONSHIP TO INSURED | DATE OF BIRTH | SEX ☐ M ☐ F |
| INSURANCE COMPANY PHONE NUMBERS Verifying: ( ) Claim: ( ) | EMPLOYER'S NAME &PHONE NUMBER | | SOC. SEC. NO. OF INSURED |

| EMERGENCY CONTACT NAME | RELATIONSHIP TO PATIENT | PHONE NO. ( ) |
|---|---|---|
| FAMILY DOCTOR | | PHONE NO. ( ) |

SECONDARY INSURANCE (If Applicable)

| **INSURANCE COMPANY** | **INSURED (If other than patient please complete)** | | |
|---|---|---|---|
| INSURANCE COMPANY NAME OR MEDICARE INFORMATION | POLICY IN NAME OF (Insured) | | HOME PHONE NO. |
| POLICY /ID NUMBER/MEMBER ID NUMBER GROUP NUMBER | INSURED'S ADDRESS Street | | |
| INSURANCE COMPANY ADDRESS Street | City State Zip | | |
| City State Zip | PATIENT'S RELATIONSHIP TO INSURED | DATE OF BIRTH | SEX ☐ M ☐ F |
| INSURANCE COMPANY PHONE NUMBERS Verifying: ( ) Claim: ( ) | EMPLOYER'S NAME &PHONE NUMBER | | SOC. SEC. NO. OF INSURED |

If patient is under 18 years of age, please complete the following:

| ACCOMPANYING ADULT'S NAME | RELATIONSHIP TO PATIENT | SIGNATURE |
|---|---|---|
| | | |

***INSURANCE AUTHORIZATON AND ASSIGNMENT*** *I authorize Rodney L. Ellis, MD, PC to release medical information that may be necessary to request claim reimbursement from my insurance company to whom claims have been submitted. I certify that the information I have reported regarding my insurance coverage is correct. I also assign the claim payment to be made payable to Rodney L. Ellis, MD, PC directly and I understand that any overpayment will be refunded to me from the doctor's office. I understand that I will be responsible for any unpaid balance. I further understand that, if I have insurance with which Rodney L. Ellis, MD, PC participates, I will be responsible for any unpaid balance remaining after 45 days. I understand that if any unpaid balance necessitates legal action (attorney/court fees/collection agency fees) to collect this balance, I will be responsible for all attorney, court costs and collection agency fees.*

**Signature**________________________________________ **Date** __________________________

**(Insured or authorized person)**