ELIZABETH A. LIOTTA, MD, LLC
77 THOMAS JOHNSON DRIVE, SUITE C
FREDERICK, MD 21702
301-668-3004

# PATIENT AGREEMENT FORM

Thank you for choosing us as your health care provider. To ensure that all of our patients are treated fairly and openly, we have instituted the following Patient Policies. **Please read and sign this statement prior to treatment**.

**1. Consent for Treatment:** I, or my representative, agree to have Elizabeth A. Liotta, MD, and associate Health Care Providers evaluate and treat my condition. I understand that, for certain treatments, I may be asked to sign an additional informed consent form.

**2. Payment for Services:** I understand that Elizabeth A. Liotta, MD may bill my health insurance plan for the care I receive. I agree that payments from my health plan may go directly to Elizabeth A. Liotta, MD. If I should receive the payments, I understand that I will be responsible for paying Elizabeth A. Liotta, MD.

I understand that I must pay any co-payment or other part of the bill that my health plan says I must pay. I know that I may need to pay this before I am treated. Payment on all statements I receive is due upon receipt, and all outstanding balances, insurance deductibles, and co-pays are expected to be paid in full prior to treatment.

I understand and agree that if my insurance plan does not pay for the services provided, I will have to do so. If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed a 1.5 percent late charge per month on the unpaid monthly balance.

A fee of $30.00 will be imposed for any checks returned due to insufficient funds.

**3. Notice of Privacy Practices:** I have received a copy of Elizabeth A. Liotta, MD, LLC Notice of Privacy Practices.

**4. As a patient of Elizabeth A. Liotta, MD, LLC I understand it is my responsibility to**:

- provide accurate and complete information regarding my medical needs, medical history, medications, demographics, and health insurance, and to report any related changes in these areas to the physician and/or staff.

- provide proof of identification (driver's license) and current insurance information prior to or upon arrival for my appointment (parent's information if the patient is a minor).

- provide a valid referral (if required by your insurance company) prior to or at the time service. If a valid referral is not available at the time of my appointment, I may be required to pay the full amount of the visit or reschedule my appointment until a valid referral can be obtained.

**5. Missed Appointment Policy**: I understand and agree that I must provide 24 hours' notice when canceling an appointment (exceptions are made for emergencies). I understand that I may be charged a cancellation fee if I do not provide 24 hours notice.

After checking in for a scheduled appointment, should I have to leave before being seen I must notify the reception desk or I may be charged a cancellation fee. If the provider is running more than 30 minutes late, the cancellation fee may be waived; however I still must notify the reception desk that I am leaving.

**6. Telephone Consumer Protection Act:** I agree that by providing my landline or cellphone number(s), I am giving express consent for Elizabeth A. Liotta, MD, LLC its staff, employees, and independent contractors and agents to contact me at these numbers, or, at any number that is later acquired for me and to leave pre-recorded messages regarding scheduling or scheduled appointments or my account.

I have read, understand, and agree to the items as defined in the above Patient Agreement Form:

(SEAL)_____ _____ _____
Signature of Patient or Responsible Adult | Printed Name | Date