

Nonnie M Estella MD, PC
295 Varnum Avenue
Lowell, MA 01854

RELEASE OF MEDICAL INFORMATION

I authorize Nonnie Estella, MD, to release the medical Records concerning .my son/daughter/self to any physician, hospital, or agency involved in the Care of the patient listed.

ASSIGNMENT OF MEDICAL BENEFITS

I authorize my insurance carrier to assign all surgical and or medical benefits, if applicable, to Nonnie Estella, MD. I also authorize release of medical Information necessary to process all medical insurance claims.

PAYMENT POLICY

Co-payments are to be collected at the time services are received. There will be an additional \$5.00 fee if copayment is not collected at the time service is rendered. We accept cash, checks, Visa, MasterCard, and American Express. All medical services provided are directly charged to the patient or responsible party. If our physician is contracted with your insurance carrier, we will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed as patient responsibility/non-payable/non-covered by your insurance and billed accordingly. Payment is expected in full upon receipt of statement or payment arrangements must be made with our billing office.

CANCELLATION POLICY

Our office requests that if an appointment needs to be cancelled that we receive notice no later than 24 hours prior to the appointment. We reserve the right to charge \$25.00 for a no-show appointment, to be collected on or before your next appointment.

REFERRAL POLICY

I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

I HAVE READ, UNDERSTOOD, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _____ Date:

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