Alina Bouza MD, PLLC

11416 Slater Ave NE #202 C
Kirkland, WA 98033
(206) 393-7111

SERVICE AGREEMENT

Treatment
I authorize **Alina Bouza MD, PLLC** to give me reasonable clinical care and treatment by today's standards.

Initials _____

Release of Information
I consent to treatment by **Alina Bouza MD, PLLC** to release any and all information needed to determine insurance benefits to my insurance carrier(s), any of its agents, intermediaries or others it may designate, for purposes of review, benefit determination, & processing claims. I consent to benefits being assigned to **Alina Bouza MD, PLLC** for services rendered. I understand and agree that **Alina Bouza MD, PLLC** is not responsible for any dissemination or disclosure of my confidential medical information once such information is provided, at my request, to others.

Initials _____

Benefits and Fees
I understand that I am responsible for researching and understanding my medical and mental health benefits including, but not limited to: deductible, coinsurance/copays, visit limits, network providers, limits of coverage etc. I understand that I am wholly responsible for all incurred fees, regardless of the actions of the insurance company. I understand that any unpaid charges will be my responsibility and due within 30 days, including charges deemed noncovered by my insurance company. Fees may be changed at any time, without notice.

Initials _____

Appointments
I understand that I am required to give **2 business days (48 hours)** notice of cancellation. Business days do not include weekends or holidays. I understand that if I do not give the required notice, I will be charged a cancellation fee. The fee for cancellation less than 2 business days in advance or a missed appointment is $100. I understand that this fee is NOT covered by insurance. The no show/late cancellation fee is due immediately, and any outstanding balance will be referred to collection agency.

Initials _____

Payment
I understand that payment or copayment is due in full at the time of service.

Initials _____

Non-Sufficient Funds
I understand that there is a $40 fee for checks returned for non-sufficient funds (bounced check).

Initials _____

Balances
Regardless of the actions of the insurance company (including delayed claims, claims under review, denied claims etc.), unpaid balances beyond 60 days are my sole responsibility and will incur a $10/month service charge. Unpaid balances beyond 90 days, *or refusal to respond to requests to pay balances,* will be referred to collections & may result in negative credit report. I understand and agree that information necessary to ensure debt collection will be released to the guarantor, your other providers, the collection agency and their partners or intermediaries. I understand and agree that any collection, legal fees, court or other costs necessary to collect unpaid balances will be my sole responsibility.

Initials _____

Document Preparation
Preparation of documents for a third party will be charged a fee. Fees available upon request.

Initials _____

Disclosure of Confidential Matters in Legal or Administrative Proceeding
If a legal or administrative entity requests my mental health records or testimony from **Alina Bouza MD, PLLC** and I (or the agent legally acting on my behalf) wish to contest/refuse (if contesting/refusal is allowed by law), I/agent agree to pay all legal costs, court expenses, fees for physician time, and administrative expenses incurred for **Alina Bouza MD, PLLC** - *regardless* of the outcome of the release.

Initials _____

Communication
In order to best protect private health information, I understand that **Alina Bouza MD, PLLC** does not interact with patients on social media or networking sites.

Initials _____

Email Communication
If you choose to communicate Patient Identifiable Information by email, you are consenting to associated email risks. Please note that email is not secure and I cannot guarantee that information transmitted will remain confidential. Email can be limited to initial inquiries/scheduling. **Alina Bouza MD, PLLC** is the only person who reads the email. I give permission to exchange email communication regarding appointments and scheduling.

Initials _____

I have read these policies, understood the contents, and agree to the terms. I have had my questions regarding this policy satisfactorily answered. This authorization will remain in effect indefinitely.

Printed name _____

Signature_____Date_____

Notice of Privacy Practices Acknowledgment

Alina Bouza MD, PLLC has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints. We may change the Notice of Privacy Practices at any time, and you may contact **Alina Bouza, MD** at 206-393-7111 to obtain a current copy of the Notice of Privacy Practices or to ask questions. A copy of the Notice of Privacy Practices can also be found at **http://www.AlinaBouzaMD.com/Privacy/**.
By my signature below, I agree that I have received the Notice of Privacy Practices of **Alina Bouza MD, PLLC**.

Printed name _____

Signature_____Date_____