WAIMEA PACIFIC ENTERPRISES, LLC/*Lyn M. Lam, M.D.*

Assignment of Benefits

Patient Name:____

All patients must complete our information and insurance form before seeing the provider.

The following is a list of the insurance carriers that we are participating with:

PPO'S: **Blue Cross/Blue Shield, HMSA, Medicare, HMAA, UHA (University Health Alliance) Tricare, HMA, Inc.**

****HMO's:** **Five Mountain, East Hawaii IPA** ****QUEST: HMSA**

****(Referral required for all visits except Annual exams) Please be sure to contact your PCP (primary care provider) for all visits with us.**

I hereby authorize payment from my insurance company directly to: Waimea Pacific Enterprises, LLC. I understand that my insurance policy is a contract between myself and my insurance carrier and that I am ultimately responsible for any **non-covered services** (Please refer to your insurance benefits booklet). The billing office of WPE, LLC will file my insurance claim only as a courtesy.

AUTHORIZE TO RELEASE INFORMATION

By signing below, I hereby authorize this office to release any information required to process my claim(s) and account.

All co-payments, deductibles and account balances are due prior to treatment, unless prior arrangements in writing have been made. If no payment is received for your account within 90 days, your account will automatically be referred to a collection agency. A monthly interest rate of 1% will be added to any outstanding balances over (30) days. All returned checks will be assessed a $25.00 return check charge. A service charge of $50.00 will be charged to you for all appointments missed without a 24 hours advanced notice. $100.00 for each procedure.

Non-Participating Insurance (not listed above)

You are required to pay for your visit in full at the time of service. We will be pleased to assist you in filing the claim form to your insurance for reimbursement. Please let us know if you have any questions in this regard.

HIPAA Privacy Practices Acknowledgement Form

We can only release information with your permission, the person(s) listed below are authorized to receive information as indicated.

**I have received the Notice of Privacy Practices and I have been provided an opportunity to review the content.

I give this office permission to speak with the following person(s) on my behalf:

Name:______________________________( )All information ( )Scheduling only ( )Billing only

Name:______________________________( )All information ( )Scheduling only ( )Billing only

Name:______________________________( )All information ( )Scheduling only ( )Billing only

We hope to always be able to reach you by phone but in the event we get your voicemail may we leave a message regarding non-medical issues like appointment confirmations? ( ) YES ( )NO

Signed:____Date:__________

By signing I have read this document in it's entirety and agree with these terms.

(Signature of patient or responsible party)