Catalina Medical Center

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by request.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name_____

Patient/Guardian Signature_____

Date_____

CATALINA MEDICAL CENTER
1919 S. Catalina Avenue, Redondo Beach, CA 90277
(310) 378-7246

OFFICE FINANCIAL POLICY

It is our sincere desire to avoid any misunderstanding about our credit and collection policy.

For our patients with Health Insurance, please be advised that you are responsible for your deductible and any co-payments. These items are due and payable at the time service is rendered. We will bill your insurance company for the remaining balance. We bill insurance every week.

If you have a **PERSONAL INJURY CASE** (Auto Accident, Slip or Fall) and you anticipate your insurance carrier will cover the doctors' services, payment must be made within 30 days unless other arrangements are made with the Office Manager.

If you have a **WORK RELATED INJURY** (Worker's Compensation) and we accept your case; all fees for health care services will be paid by your employer.

If you have **MUSCLE THERAPY**, it is our policy that you pay on the day the treatment is given. Our Muscle Therapists are independent contractors and must be paid in full for the service rendered. We will, as a courtesy, bill your insurance and reimburse the patient upon request for any amount that results in a credit balance. **THE PATIENT WILL BE BILLED FOR MUSCLE THERAPY APPOINTMENTS IF A 24-HOUR CANCELLATION NOTICE IS NOT GIVEN.**

If you have any questions, please feel free to discuss them with our Office Manager. Thank you in advance for your understanding in our efforts to control health care costs for our patients.

I UNDERSTAND THE POLICY OF THIS OFFICE AND AGREE THAT MY ACCOUNT WILL BE PAID IN FULL WITHIN 30 DAYS OF RELEASE BY THE DOCTOR OR 10 DAYS IF I DISCONTINUE CARE.

NAME _____ DATE _____

Catalina Medical Center
1919 South Catalina Ave
Redondo Beach, CA 90277
310-378-7246 FAX 310-373-9618
Tax ID# 330800100

ADVANCE MEDICAL DIRECTIVE / LIVING WILL

To our adult patients:

Like all adults, you have the right to accept or refuse any medical treatment your doctor recommends to you. But what if you are in a coma, through illness or injury, or are otherwise unable to communicate, and a medical decision must be made about your medical care? In such a circumstance, if you have signed an **advance directive** the doctor and your family can refer to it and honor your wishes. Thus, through the directive you make decisions about your medical treatment. If you have already signed a living will or durable power of attorney for healthcare and they have been properly prepared and signed they continue to be valid. Please furnish a copy of your directive to this office so we can keep it in your chart. You need not re-do them unless there are changes you want to make.

Patient signed new directive/living will ___

Patient declined ___

Patient furnished copy of previous signed directive ___

Today's date:_____

Patient's
Signature:_____