Desai Medical Center
3290 N. Ridge Rd., Suite 100
Ellicott City, MD 21043
(P) 410-313-9292 (F) 410-313-9293
(E) DrDesai@desaimedicalcenter.com

Patient Document Processing Policy

Today's Date: _____   **Due Date:** _____

Last Name		First Name	
DOB		**Email**	
Document Type		**Document Recipient**	
Method of Dispatch		**Dispatch Contact Info**	

1. A $10.00 Document Processing Fee is due <u>at the time of submission</u>. No exceptions.
2. Any outstanding balances more than 61-90 days past-due must be settled by: payment in-full OR a monthly payment plan <u>before</u> any processing can begin.
3. Documents will not be processed unless a dispatch method and appropriate contact information is provided.
4. All documents must have the patient's portion completed before Desai Medical Center can begin processing.
5. Documents will be processed based on the available information and medical records on-file at Desai Medical Center.
6. Typical processing time is 7-10 business days, <u>ONLY</u> if all document criteria is met by the patient.
   a. Processing may take longer if: the patient needs a more current Office Visit, if the patient needs to be referred to a specialist, additional information is required by the patient, additional information is required by another healthcare provider, etc.
   b. Desai Medical Center is not at fault for any delays or missed deadlines if it is deemed that additional information is required to complete the requested document.
7. Pending/stagnant Document Processing Requests will be held for 3 months. After which, patients must submit a brand new Document Processing Request, all policies and fees apply.

By signing below, I agree to abide by Desai Medical Center's Document Processing Policy and also authorize Desai Medical Center to release any PHI that is deemed pertinent to completing my requested document. I understand that it is my responsibility to notify Desai Medical Center at the time of submission if any of my PHI should <u>not</u> be disclosed to the document recipient.

Signature: _____   Date: _____

DMC STAFF ONLY

Amount Paid		Method		Date	
DMC Staff			**Signature**		