MASTER REGISTRATION

DATE: _____ _____

PATIENT INFORMATION

PATIENT NAME: _____ HOME PHONE #: _____

ADDRESS: _____ CELL #: _____

CITY: _____STATE_____ZIP_____ WORK #: _____

PT'S SSN: _____ _____ E-MAIL: _____

DATE OF BIRTH: _____ PREFERRED METHOD OF CONTACT:

MARITAL STATUS: _____ _____

POLICY HOLDER/RESPONSIBLE PARTY NAME (if different from above):

_____

POLICY HOLDER/RESPONSIBLE PARTY ADDRESS: _____

_____

POLICY HOLDER DATE OF BIRTH: _____ POLICY HOLDER SSN: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

RELATIONSHIP TO PATIENT: _____ EMERGENCY PHONE #: _____

ALLERGIES: _____

PREFERRED PHARMACY: _____

PLEASE READ:

I AUTHRORIZE TREATMENT OF THE PERSON NAMED ABOVE AND AGREE TO PAY ALL FEES AND CHARGES FOR TREATMENT.

I UNDERSTAND IF I HAVE INSURANCE AND HAVE PROVIDED ACCURATE AND COMPLETE INFORMATION REGARDING MY INSURANCE, MY CHARGES WILL BE FILED WITH MY INSURANCE CARRIER, HOWEVER, THE FINANACIAL RESPONSIBILITY FOR SERVICES RENDERED T A PATIENT ULTIMATELY RESTS WITH THE PATIENT OR RESPONSIBLE PARTY. I UNDERSTAND THAT MY COPAY AND/OR COINSURANCE PAYMENTS ARE DUE AT THE TIME OF SERVICE. IF I DO NOT HAVE INSURANCE OR MY CHARGES ARE NOT TO BE FILED WITH INSURANCE, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.

I UNDERSTAND THAT ANY PROFESSIONAL CHARGES INCURRED ARE MY RESPONSIBILITY. AFTER 90 DAYS OF NONPAYMENT ANY BALANCE DUE WILL BE TURNED OVER TO COLLECTIONS AND WILL BEGIN TO ACRUE A FINANCE CHARGE. THIS RATE IS COMPUTED BY A "PERIODIC RATE" OF 1.5% PER MONTH, WHICH IS AN APR OF 18% APPLIED TO THE PREVIOUS BALANCE WITHOUT DEDUCTING CURRENT PAYMENTS AND/OR CREDITS APPEARING ON ANY GIVEN BILL. THE PATIENT OR RESPONSIBLE PARTY FURTHER AGREE TO PAY ANY AND ALL COLLECTIONS FEES INCURRED AND LEGAL EXPENSES, INCLUDING BUT NOT LIMITED TO ALL COLLECTION AGENCY AND ATTORNEY FEES(33.3%), ALL COURT COSTS, SERVICE AND FILING FEES, INTERROGATORY AND GARNISHMENT FEES, AS WELL AS ANY INTEREST THAT MAY BE ADJUDICATED FOR THE COLLECTION OF PAST DUE DEBTS.

I HEREBY AUTHORIZE ASSIGNMENT AND PAYMENT OF MAJOR MEDICAL BENEFITS DUE ME TO FAMILY MEDICINE INC., FOR SERVICES PROVIDED BY THEM.

_____	_____	_____
PATIENT SIGNATURE	**SIGNATURE OF AUTHORIZED PERSON**	**DATE**

HIPPAA STATEMENT

I HAVE RECEIVED/READ FAMILY MEDICINE INC.'S, *NOTICE OF PRIVACY PRACTICES*.

I HEREBY AUTHORIZE FAMILY MEDICINE INC., TO FURNISH, TO MY INSURANCE COMPANY OR AUTHORIZED AGENT, INFORMATION REGARDING MY PROTECTED HEALTH INFORMATION, FOR THE PURPOSE OF TREATMENT, PAYMENTS OR HEALTHCARE OPERATIONS. I FURTHER AUTHORIZE THE PHYSICIAN(S) OF FAMILY MEDICINE, INC., TO CONSULT AS NEEDED IN THEIR SOLE DISCRETION WITH OTHER MEDICAL PROVIDERS REGARDING MY MEDICAL CARE.

I WISH TO PLACE THE FOLLOWING RESTRICTIONS CONCERNING THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION:

_____

FAMILY MEDICINE INC. CAN DISCLOSE MY MEDICAL CONDITION/INFORMATION WITH THE FOLLOWING:

	YES	NO		YES	NO
SPOUSE	____	____	**CHILDREN**	____	____
PARENTS	____	____	**FRIENDS**	____	____

PLEASE SPECIFICALLY LIST THE NAMES OF FAMILY MEMBERS/FRIENDS THAT WE MAY TALK TO:

_____

_____	_____	_____
SIGNATURE OF PATIENT	**SIGNATURE OF AUTHORIZED PERSON**	**DATE**

PAYMENT POLICY

THANK YOU FOR CHOOSING US AS YOUR PRIMARY CARE PROVIDER. WE ARE COMMITTED TO PROVIDING YOU WITH QUALITY AND AFFORDABLE HEALTH CARE. BECAUSE SOME OF OUR PATIENTS HAVE HAD QUESTIONS REGARDING PATIENT AND INSURANCE RESPONSIBILITY FOR SERVICES RENDERED, WE HAVE DEVELOPED THIS PAMENT POLICY. PLEASE READ IT, ASK US ANY QUESTIONS YOU MAY HAVE, AND SIGN IN THE SPACE PROVIDED. A COPY WILL BE PROVIDED TO YOU UPON REQUEST.

1. **INSURANCE.** WE PARTICIPATE WITH MOST INSURANCE PLANS, INCLUDING MEDICARE. IF YOU ARE NOT INSURED BY A PLAN WE DO BUSINESS WITH, PAYMENT IN FULL IS EXPECTED AT EACH VISIT. IF YOU ARE INSURED BY A PLAN WE DO PARTICIPATE WITH, BUT DON'T HAVE AN UP-TO-DATE INSURANCE CARD, PAYMENT IN FULL FOR EACH VISIT IS REQUIRED UNTIL WE CAN VERIFY COVERAGE. KNOWING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY. PLEASE CONTACT YOUR INSURANCE COMPANY WITH ANY QUESTIONS YOU MAY HAVE ABOUT YOUR COVERAGE.

2. **COPAYMENTS AND DEDUCTIBLES.** ALL CO-PAYMENTS AND DEDUCTIBLES MUST BE PAID AT THE TIME OF SERVICE. THIS ARRANGEMENT IS PART OF YOUR CONTRACT WITH YOUR INSURANCE COMPANY. FAILURE ON OUR PART TO COLLECT CO-PAYMENTS AND DEDUCTIBLES FROM PATIENTS CAN BE CONSIDERED FRAUD. PLEASE HELP US IN UPHOLDING THE LAW BY PAYING YOUR CO-PAYMENTS AT EACH VISIT.

3. **NON-COVERED SERVICES.** PLEASE BE AWARETHAT SOME-AND PERHAPS ALL-OF THE SERVICES YOU RECEIVE MAY BE NONCOVERED OR NOT CONSIDERED REASONABLE OR NECESSARY BY MEDICARE OR OTHER INSURERS. YOU MUST PAY FOR THESE SERVICES IN FULL AT THE TIME OF VISIT.

4. **PROOF OF INSURANCE.** ALL PATIENTS MUST COMPLETE OUR PATIENT INFORMATION FORM BEFORE SEEING THE DOCTOR. WE MUST OBTAIN A COPY OF YOUR INSURANCE CARD AND A VALID DRIVER'S LICENSE OR GOVERNMENT ISSUED IDENTIFICATION CARD TO PROVIDE PROOF OF INSURANCE. IF YOU FAIL TO PROVIDE US WITH THE CORRECT INSURANCE INFORMATION IN A TIMELY MANNER YOU MAY BE RESPONSIBLE FOR THE BALANCE OF THE CLAIM.

5. **CLAIMS SUBMISSION.** WE WILL SUBMIT YOUR CLAIMS AND ASSIST YOU IN ANY WAY WE REASONABLY CAN TO HELP GET YOUR CLAIMS PAID. YOUR INSURANCE COMPANY MAY NEED YOU TO SUPPLY CERTAIN INFORMATION DIRECTLY. IT IS YOUR RESPONSIBILITY TO COMPLY WITH THEIR REQUEST. PLEASE BE AWARE THAT THE BALANCE OF YOUR CLAIM IS YOUR RESPONSIBILITY WHETHER OR NOT YOUR INSURANCE COMPANY PAYS YOUR CLAIM. YOUR INSURANCE BENEFIT IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, WE ARE NOT PARTY TO THAT CONTRACT.

6. **COVERAGE CHANGES.** IF YOUR INSURANCE CHANGES IF YOUR INSURANCE CHANGES, PLEASE NOTIFY US BEFORE YOUR NEXT VISIT SO WE CAN MAKE THE APPROPRIATE CHANGES TO HELP YOU RECEIVE YOUR MAXIMUM BENEFITS. IF YOUR INSURANCE COMPANY DOES NOT PAY YOUR CLAIM IN 45 DAYS, THE BALANCE WILL AUTOMATICALLY BE BILLED TO YOU.

7. **NONPAYMENT.** IF YOUR ACCOUNT IS OVER 90 DAYS PAST DUE, YOU WILL RECEIVE A LETTER STATING THAT YOU HAVE 15 DAYS TO PAY YOUR ACCOUNT IN FULL. PARTIAL PAYMENTS WILL NOT BE ACCEPTED UNLESS OTHERWISE NEGTIATED. PLEASE BE AWARE THAT IF A BALANCE REMAINS UNPAID, WE MAY REFER YOUR ACCOUNT TO A COLLECTION AGENCY AND YOU AND YOUR IMMEDIATE FAMILY MEMBERS MAY BE DISCHARGED FROM THIS PRACTICE. IF THIS IS TO OCCUR, YOU WILL BE NOTIFIED BY REGULAR AND CERTIFIED MAIL THAT YOU HAVE 30 DAYS TO FIND ALTERNATIVE MEDICAL CARE. DURING THAT 30 DAY PERIOD, OUR PHYSICIAN WILL ONLY BE ABLE TO TREAT YOU ON AN EMERGENCY BASIS.

8. **MISSED APPOINTMENTS.** OUR POLICY IS TO CHARGE $35 FOR MISSED APPOINTMENTS NOT CANCELLED AT LEAST 24 HOURS BEFORE APPOINMENT. THESE CHARGES WILL BE YOUR RESPONSIBILITY AND BILLED DIRECTLY TO YOU. PLEASE HELP US SERVE YOU BETTER BY KEEPING YOUR REGULARLY SCHEDULED APPOINTMENTS.

9. **RETURNED CHECKS.** IF YOUR CHECK IS RETURNED FOR INSUFFICIENT FUNDS YOU WILL BE BILLED OUR BANKS CHARGE FOR PRESENTING THE CHECK, AND WE WILL THEREAFTER ACCEPT ONLY CASH, CREDIT, OR MONEY ORDERS FOR FUTURE VISITS.

OUR PRACTICE IS COMMITED TO PROVIDING THE BEST TREATMENT TO OUR PATIENTS. OUR PRICES ARE REPRESENTATIVE OF THE USUAL AND CUSTOMARY CHARGES FOR OUR AREA.
THANK YOU FOR UNDERSTANDING OUR PAYMENT POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF '<u>NOTICE OF PRIVACY PRACTICES</u>'

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE RECEIVED AND OR BEEN OFFERED A COPY OF FAMILY MEDICINE INC'S '<u>NOTICE OF PRIVACY PRACTICES</u>'

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____

IF SIGNED BY A LEGAL REPRESENTATIVE,
RELATIONSHIP TO PATIENT

ADVANCE DIRECTIVE

IF YOU ARE OVER THE AGE OF 21:
DO YOU HAVE A LIVING WILL OR MEDICAL POWER OF ATTORNEY ESTABLISHED?

YES _____ NO _____