

FAMILY MEDICINE CENTER PATIENT INFORMATION

Date _____ Primary Physician _____ Pharmacy _____

PATIENT NAME _____ Male _____ Female _____
Last First Middle Initial DATE OF BIRTH

MAILING ADDRESS _____
City State Zip

Phone _____ Marital Status _____
Home Cell Work

SOCIAL SECURITY # _____ EMPLOYER _____

RESPONSIBLE PARTY

NAME _____ Relationship to Pt _____
Last First Middle Initial Date of Birth

ADDRESS _____
Street City State Zip

Phone _____ Martial Status _____
Home Cell Work

SOCIAL SECURITY # _____ EMPLOYER _____

EMERGENCY CONTACT _____
(NOT IN HOUSEHOLD) Name Phone : Home Cell

INSURANCE PRIMARY _____ SECONDARY _____

**PLEASE GIVE RECEPTIONIST COPY OF CARD or CARDS
CLINIC POLICY**

All Professional Services Rendered are charged to the patient. Necessary Forms will be completed to help expedite Insurance Carrier Payments however the patient is responsible for all fees regardless of insurance coverage.
All payments will be due at time of service unless arrangements are made in advance.
For patients with no insurance a 20% discount for any services over \$100.00 will be given when paid in full on the date of service.

We accept Cash, Checks and Major Credit Cards

PATIENT AUTHORIZATION

I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of an original.

I authorize FAMILY MEDICINE CENTER OF PAMPA, PLLC to apply for benefits on my Behalf for services rendered by them or by this order. I request payment from my insurance be paid directly to FAMILY MEDICINE CENTER OF PAMPA, PLLC.

I certify that the information I have reported with regard to my insurance coverage is correct and I will pay any unpaid balance by my insurance company 10 days after receiving a bill from FAMILY MEDICINE CENTER OF PAMPA, PLLC.

Family Medicine Center may leave messages on my home phone _____ Yes _____ NO Work Phone _____ Yes _____ NO

You have my permission to give my medical information to the following persons or persons.

Signature of _____ Date _____
PT/Parent/Guardian

FINANCIAL POLICY

Family Medicine Center of Pampa

Welcome to Family Medicine Center of Pampa! We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

PARTICIPATING PROVIDER

We are providers for a select group of major PPO networks and the Medicare program. However, due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. Therefore, it is **your responsibility** to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list before making an appointment. You will be responsible for payment in full for services rendered by your physician if he/she is not a provider in your plan. We will try our best to inform you of changes in our provider status as they occur.

For Non-PPO plans or traditional "80/20" plans, we will file a claim as a courtesy, however, the contract with your insurance company is between you and the company. Family Medicine Center is not a party to that contract. You are ultimately responsible for your bill, regardless of any non-payment by the insurance carrier. If within 45 days, payment is not received by your insurance company; payment will be due by you, regardless of the status of your claim.

CO-PAYMENTS

We require your co-payment at the time of service. The co-payment specified on your card will be collected. If the co-pay amount is not listed on your card, or you have a standard "80/20" plan, we will collect 20% of the services rendered.

YOU MUST PRESENT A VALID INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.

DEDUCTIBLE

If you have a high deductible and it is likely that the services rendered will go toward your deductible, payment in full is due at the time of service unless special financial arrangements are made.

PRECERTIFICATION OF HOSPITAL ADMISSION OR SPECIAL SERVICES

Precertification of hospital admissions and other special services is an area we strive to help you with. With the exception of some HMO plans, it is ultimately the patient's responsibility to inform us when precertification is a requirement of your plan. Due to the varying policy provisions of all of our patient's plans, it is impossible for us to know each patient's specific plan provisions. If you fail to disclose precertification requirements PRIOR to services being rendered, you will be responsible for payment of all related fees in full.

FOR OUTPATIENT AND INPATIENT SERVICES PROVIDED OUTSIDE OF OUR OFFICE, IT IS YOUR RESPONSIBILITY TO BE AWARE OF AND INFORM US OF WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN, THIS INCLUDES X-RAY, LABORATORY, DIAGNOSTIC AND REHABILITATION FACILITIES.

SECONDARY INSURANCE

We do not file secondary insurance for office visits. However, if you have Medicare, we will file one Medicare supplement for you. We will gladly file on ONE insurance plan for you. (If your secondary plan is an HMO—we are required to file a secondary claim). If you require extensive services resulting in a larger than average account balance, please speak to one of our patient account representatives.

RESPONSIBLE PARTY (GUARANTOR)

The guarantor of the account is the patient who comes in for treatment or the adult who brings in a minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings a minor child in, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of Family Medicine Center to become involved in medical bill payment disputes resulting from divorce, etc.

LIABILITY OR AUTO ACCIDENT CLAIMS

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to be reimbursed.

WORKER'S COMPENSATION CLAIMS

If you have been injured on the job, we require that you provide us with all of the information necessary to file a worker's compensation claim. You MUST provide the name, address and phone number of your employer, the name, address and phone number of the worker's compensation carrier, the exact date of injury, and verification from your employer that a valid on the job injury occurred. If you are unable to provide us with this information on your FIRST visit, you will be required to pay in full at the time of service.

BILLING OF ACCOUNT BALANCES

You will receive a statement for which payment is due upon receipt. If your statement reflects an "insurance balance" your claim is still pending payment. If your statement reflects a "patient balance", this is the portion for which you are responsible. We strongly recommend your active involvement in the management of your account. When you receive your statement, compare it with your insurance explanation of benefits to ensure that the balance is correct. If payment has not been received by your insurance company, contact them. In this way, we can work together to ensure insurance companies honor their part of the agreement.

PAYMENT PLANS

We understand that from time to time unexpected circumstances may arise which make paying for medical care difficult. With this understanding, we provide payment plans to assist you in the management of your account. You may contact a patient account representative at 806-358-9400, extension 244 or 271 to arrange for this service.

NON-PAYMENT OF ACCOUNTS

Accounts for which we are unable to collect the balance due will be referred to an outside collection agency. We also reserve the right to report this activity to a national credit-reporting agency. This action will be taken as a last resort but once we have to go to this extreme FMC will be unable to see you or your family member until balance is paid in full.

.....
ACCEPTANCE OF FINANCIAL POLICY

The undersigned hereby certifies that he/she has read, understood and agrees to the financial policy of Family Medicine Center of Pampa, PLLC.

Signature of Patient or legal Guardian

Date

ASSIGNMENT OF BENEFITS

The undersigned hereby requests that payment from authorized insurance carrier or state benefits program be made directly to the Family Medicine Center, PLLC physician who rendered services on their behalf for the period of: LIFETIME. The undersigned also releases the disclosure of medical information for use in obtaining reimbursement by an authorized insurance carrier.

Signature of Patient or legal Guardian

Family Medicine Center of Pampa, P.L.L.C.

Notice of Privacy Practices

This notice describes how Medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At our facility privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you when necessary to provide treatment, verify eligibility and obtain authorization about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principals.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name, address, and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Also, in order to remind you of appointments or changes in appointments we may leave a message with someone in your household or answering machine either at home or place of employment. From time to time, we may send information via USMail regarding appointments, follow-up, or other health information.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please contact the office manager at this clinic. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How-and why-information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within our organization.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

Family Medicine Center of Pampa, P.L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of this practice's Notice of Privacy Practices. This Notice describes how this practice may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

(Signature of Patient, or Personal Representative)

(Date)

(Relationship to Patient)