CLINE FAMILY MEDICINE

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PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell: _____

Marital Status: S M D W Social Security#: _____ Email: _____

Employer: _____

Employer Address: _____ City, State, Zip: _____

Race: (circle one) American Indian, Alaskan Native, Asian, African American, Native Hawaiian or other Pacific Island, White, Other

Ethnic Group: (circle one) Hispanic or Latino, Not Hispanic or Latino

INSURANCE POLICY HOLDER: **Relationship to Patient: _____**

Name:_____ Date of Birth: _____Sex M/F

Mailing Address:_____City,State,Zip_____

Home Phone:_____ Work Phone:_____ Cell:_____

Employer:_____ Address:_____

EMERGENCY CONTACTS: (MUST LIST 2 CONTACTS)

Name:_____Relationship:_____

Home#_____Work#_____Cell#_____

Name:_____Relationship:_____

Home#_____Work#_____Cell#_____

ASSIGNMENT OF BENEFITS
Consent to Treatment

I, voluntarily consent to receive medical and healthcare services provided by Cline Family Medicine that they deem necessary in my diagnosis and treatment. I understand that such services may include diagnostic procedures, examinations, and treatment. The services will be provided by Dr. Cline, or a supervised licensed mid-level employed with Cline Family Medicine.

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. **BALANCES MUST BE PAID IN FULL MONTHLY OR A $25 LATE FEE WILL APPLY. CO-PAYS ARE DUE AT TIME OF SERVICE. BALANCES MAY NOT BE CARRIED OVER MONTH TO MONTH.**

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to Cline Family Practice for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Cline Family Practice to: 1) release any information necessary to insurance carriers regarding my illness and treatments; 2) to process insurance claims generated in the course of examination or treatment; and 3) to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Cline Family Practice on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature:_____Date:_____Relationship_____

Parent or Guardian must sign if patient is under 18.

HIPAA NOTICE OF PRIVACY PRACTICES

The following people have my permission to pick up my medical records:

_____ _____

The following people have my permission to pick up my prescriptions:

_____ _____

The following people are authorized to talk with you regarding my medical information:

_____ _____

If the patient is a MINOR, the following people are authorized to bring my child for medical care:

_____ _____

******These authorizations are good until I change them in writing.****

_____ _____

SIGNATURE (Parent or Guardian must sign if patient is under 18.) DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have reviewed a copy of this office's Notice of Privacy Practices. Upon my request, I may obtain my personal copy from the business office.

_____ _____

SIGNATURE (Parent or Guardian must sign if patient is under 18. DATE

PATIENT FINANCIAL POLICY SHEET

In order to reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment (for the patient due portion of the service) is due at the time of service. For your

convenience we accept VISA and MasterCard. Payment for co-pays will be taken at the time of check-out.

Your Insurance ***(IT IS YOUR RESPONSIBILITY TO NOTIFY US OF INSURANCE CHANGES)***

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized deductible and co-payment at the time of service. It is the policy of our office to collect this deductible and co-payment when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim. However, each insurance company has its own version of "usual and customary" and the patient will be responsible for payment of this amount.

- ***In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.***

- ***EACH INSURANCE PLAN IS DIFFERENT, IT IS PATIENT RESPONSIBILITY TO KNOW WHAT THEIR PLAN COVERS AND DOES NOT COVER. IF YOU ARE UNSURE YOU WILL NEED TO CONTACT YOUR INSURANCE COMPANY.***

Minor Patients

- **For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian *WITH custody* for payment. YOU CAN NOT LIST THE NON CUSTODIAL PARENT AS THE RESPONSIBLE PARTY FOR BILLING!!!!**
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PATIENTS 18 AND OVER ON THEIR PARENTS INSURANCE: Your parent is listed as the policy holder on your insurance when the insurance is in their name. You can NOT list them as the guarantor for patient balances. **YOU ARE RESPONSIBLE FOR YOUR BALANCES DUE.**

ADDITIONAL FEES:

LATE FEES: Patient balances must be paid monthly or a $25.00 late fee may apply.

NO SHOW: If you do not notify us of appointment cancellations 24 hours in advance a $25.00 no show fee may apply.

You have the right to choose which provider you see. At the time of scheduling please be sure your appointment is scheduled with whom you want to see that day.

PRESCRIPTIONS: Please allow 48 hours notice on all refills!! Call your pharmacy and they will fax over a refill request to our office. (UNLESS it is one you have to pick up in the office.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

SIGNATURE (Parent or Guardian must sign if patient is under 18.) DATE

RELATION TO PATIENT (if patient is under 18) _____