FAMILY PRACTICE CENTER – UPDATE INFORMATION SHEET – 2012

PLEASE HELP US TO ENSURE THAT YOUR ADDRESS AND PHONE NUMBER IS ACCURATE. PLEASE PROVIDE THE RECEPTIONIST WITH YOUR INFORMATION.

NAME: ____

ADDRESS:____

____

HOME PHONE:____________________CELL_________________SSN________________________

WORK PHONE:______________________________BIRTHDATE:_____________________________

E-MAIL ADDRESS:____

NEAREST RELATIVE NOT LIVING WITH YOU (EMERGENCY CONTACT)

____
Name Relationship
HOME PHONE:______________________ WORK PHONE____________________________________
CELL PHONE:_______________________
ADDRESS:____

____
****

RELEASE: I hereby authorize the release to my insurance company or appropriate medical personnel any Information required to process my insurance claim(s) regarding services and treatments provided.

Signature____Date:_________________________
Patient Responsible Party

ASSIGNMENT: I hereby authorize the payment of medical benefits for services rendered directly to Family Practice Center. I further agree that should the amount paid to my insurance company be insufficient to cover the entire amount of the charges, I will be responsible for any remaining balance.

Signature ____ Date:__________________
Patient Responsible Party

CANCELLATION POLICY: I understand that if I do not cancel scheduled appointments within 24 hours prior to the appointment time, that I will be charged a $35.00 fee for the appointment not kept and $75.00 for a physical exam appointment not kept.

Signature:____Date:___________________
Patient Responsible Party

NON-PAYMENT POLICY: I understand that if I do not pay my co-pay, co-insurance, deductible or private pay at the time of service, I will be charged a $35.00 billing fee in addition.

Signature:____ Date:____________________
Patient Responsible Party

FAMILY PRACTICE CENTER, PC
ADMINISTRATIVE SERVICES AVAILABLE

Chargeable items you will pay for on an "as requested" basis include, but is not limited to:

Completion of all patient requested forms, to include, but not limited to letters or any information requiring a physician's signature, which includes other miscellaneous or administrative forms required by third parties other than you insurance company. EACH FORM WILL COST YOU $60.00.

Examples of forms patient request us to complete on their behalf:

1. Prior authorization for approval of prescription medications when needed.
2. Foreign Travel Forms
3. Adoption Forms
4. Camp Forms
5. School Forms
6. Family Medical Leave Act (FMLA), disability forms, life insurance forms.
7. Sports physical forms
8. Other miscellaneous administrative forms required by third parties other than your insurance company.
9. Prescription pre-certifications.

● Patients who request computer generated reports (extra claims, statements, payment histories, etc) may be charged $20.00 per each request. Out Patients tend to request these computer reports for flex benefit plans and/or yearly tax needs.

●Other administrative services that are not a covered service/benefit under your certificate of insurance. Fee to be determined at time of request.

●Patient requests for copying of medical records: $35.00 per request. All Medical Records must be in writing and received in our office one business week prior to the date that records are needed. Records over 10 pages will be mailed, not faxed.

REMEMBER, if you choose not to pay the ASF fee today, you will be charged for the administrative services when you request them. Each form you request us to complete will require us to collect $60.00 per form. **You will not be given a chance to pay the ASF at the time you request a form to be filled out.**

We are committed to providing you the best possible care. With you, our patient, we look forward to a lasting and healthy relationship. Thank you for your understanding and cooperation.

FAMILY PRACTICE CENTER, INC.
FINANCIAL POLICY and
ADMINISTRATIVE SERVICES FEE

Patient Name:____
(Please print)

We are committed to meeting your healthcare needs. Our goal is to keep your insurance and financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask you adhere to the following guidelines and choose a plan that meets your needs.:

1. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.
2. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
3. All copayments are due at the time of service. A $35 service fee will be charged for failure to pay the copayment at the time of service.
4. You are ultimately responsible for payment for services you receive from our office. Any check payment dishonored by your bank will result in a $35 returned check charge being added to your account.
5. If you miss your appointment, you may be charged a NO-SHOW fee of $35 for each appointment missed. You will be charged a $75 NO-SHOW fee for missing a complete physical
6. **Our office collects an Administrative Service Fee of (a) $5 on each visit or (b) an annual, optional fee of $60.00. These administrative fees are intended to cover the cost of certain administrative services we may provide that are not covered by your insurance. You are not required to pay the Administrative Service Fee; however, if you choose not to pay the optional fee, you will be charged for all administrative services, as needed. A list of our administrative services with associated fees is attached to this Financial Policy.**

   □ I accept the financial policy that includes payment of the Administrative Services fee. ……………………………………______$5.00 per visit
   ……………………………………………………______$60.00 annually

   □ I accept the financial policy, but choose NOT to pay the Administrative Service Fee (ASF). I understand the services listed on the next page are included in the ASF. I understand that, if I elect not to pay the ASF, I will pay for the services as I need them.

Patient Signature _____________________________ Date _________________

TO: All HMO and POS Policy Holders

RE: Guidelines for obtaining a written referral

Effective: January 1, 2009

Our office will no longer accept referral requests on the day of or after an appointment. You must contact your Primary Care Provider (PCP) before scheduling an appointment with a specialist.

All HMO Plans and select POS plans require written referrals. Your PCP is the only entity authorized to provide you with this document.

If you fail to contact us prior to making your appointment, you may be responsible for any and all expenses charged by the specialist to your insurance company. You can contact your insurance company for a listing of specialists in your network that require a written a referral. If you have not been seen within six months of your last office visit, you will need to schedule an appointment to obtain your referral.

Please wait until you have received your referral, by mail, before scheduling your appointment. Referral requests will be completed within 72 hours of receipt.

Thank you for your cooperation.

Respectfully,

Referral Coordinator

I have read the above statement regarding written referrals, with comprehension, and agree to adhere to these guidelines.

____ ____________________
Signature Date