SALECREEK FAMILY PRACTICE

# PATIENT INFORMATION SHEET

## PATIENT INFORMATION

☐ Male ☐ Female

**PATIENT NAME:** ______________________________________________
Last First Middle

**MAILING ADDRESS:** ______________________________________________

**CITY**: ____________________ **STATE:** __________ **ZIP CODE:** ______________

**HOME PHONE:** ____________________ **CELL PHONE:** ____________________

**E-MAIL:** ______________________________________________

**SOCIAL SECURITY NO:** ____________________ **DATE OF BIRTH:** ______________

**DRIVER LICENSE NO:** __________________ **EXPIRATION:** __________ **STATE:** _____

**EMPLOYED:** ☐ Full Time ☐ Part Time **STUDENT:** ☐ Full Time ☐ Part Time

**EMPLOYER:** ________________________ **PHONE:** ____________________

**** EMERGENCY CONTACT ****

**NAME:** ________________________ **PHONE:** ____________________

☐ I would like to receive information concerning a Living Will

☐ I would not like to receive information concerning a Living Will.

## GUARDIAN/SPOUSE INFORMATION

**NAME:** ________________________ ☐ **Parent/Guardian** ☐ **Spouse**

**HOME PHONE:** ____________________ **CELL PHONE:** ____________________

**EMPLOYER:** ____________________ **WORK PHONE:** ____________________

# RESPONSIBLE PARTY INFORMATION

**(If the person that is the carrier of the insurance card is the same as the patient, you do not have to fill this section out. Please read the Payment Policy below, sign and date it.)**

**INSURED NAME:** ______________________________________________
Last First Middle

**RELATIONSHIP TO PATIENT:** ______________________________________

**MAILING ADDRESS:** ____________________________________________

**CITY**: ______________________ **STATE:** __________ **ZIP CODE:** ______________

**HOME PHONE:** ____________________ **CELL PHONE:** ____________________

**SOCIAL SECURITY NO:** ____________________ **DATE OF BIRTH:** ______________

**EMPLOYER:** _________________________ **PHONE:** ____________________

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights regarding my protected health information. I understand the information below can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers
3. Conduct normal healthcare operations such as quality assessment and physician certification.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at one of the above to obtain a copy of the Notice of Privacy Practices.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions , but if you do agree then you are bound to abide by such restrictions.

**PATIENT NAME:** ______________________________________________

Last First Middle

**RELATIONSHIP TO PATIENT (if other than patient):** ______________________

**SIGNATURE:** ______________________________________________

**DATE:** _______________

If you would like tests results given to someone other than yourself if you are unavailable, please list that person below and their relationship to you. If no one is listed, you will be the only one able to receive the test results and no results will be left on answering machine or voicemail.

**NAME:**______________________ **RELATIONSHIP:**_______________

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

_____________ ________ ______________________________

Date Initials Reason

# PAYMENT INFORMATION

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 been advised to develop this payment 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. **FEES**. Our fees are based on research and comparison with other medical practices in our area. While we make every effort to ensure our rates are reasonable and competitive, it is important to note that payment amounts are set by Medicare and the private insurers.

2. **INSURANCE.** Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. We participate in most insurance plans, including Medicare. Please note, however, that we do not take Medicaid patients and are not accepting any new Medicare patients. If you are an existing patient when you become Medicare eligible, you will remain a patient of the practice and we will continue to process your insurance claims.

3. **PROOF OF INSURANCE.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim. If you are not insured by a plan we do business with, payment in full is required at each visit.

4. **CO-PAYMENTS AND DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service -- without exception. 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-payment at each visit.**

5. **NON-COVERED SERVICES.** Please be aware that some of the services you receive may be considered unnecessary by Medicare or other insurers. We will do our best to inform you of these "non-covered" procedures prior to performing the service. You must pay for these "non-covered" services in full at the time of visit.

6. **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.

7. **COVERAGE CHANGES.** If your insurance changes, please notify us so we can make the appropriate changes to help you receive your maximum benefits.

8. **PAYMENT PLANS.** If your account is past due and you are not able to pay the balance in full, you will be required to set up a payment plan. If you choose not to set up a payment plan, you will not be able to schedule any appointments until your balance is paid in full. Payment plans will not exceed 3 months without the approval of Dr. Black. As long as your payments are made per your payment plan, you can continue to schedule appointments. Should you miss a payment, the payment agreement is void and the balance in full is due before you can schedule as appointment with either of our providers.

We understand there may be circumstances that affect your ability to make a payment on time. If you are unable to make a scheduled payment, please call the Billing Office at (423) 521-7492 to modify your payment schedule.

9. **COLLECTION AGENCY.** Please be aware that if your balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharges from this practice. If you are discharged, 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 providers will only be able to treat you on an emergency basis. Once your balance is paid, should you elect to continue with our practice, you will be required to pay for all services on the day they are performed. Payment must be either in cash or with a credit/debit card.

10. **RETURNED CHECKS.** If your check is returned by your bank, we will assess a $30 returned check fee. You will not be able to schedule an appointment until you pay your balance in full plus the $30 check fee. If you have a check returned, all future payments must be in cash or by credit/debit card.

11. **MISSED APPOINTMENTS.** We reserve the right to charge for missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Thank you for taking the time to read and understanding our payment policy. Please contact our Billing and Insurance Department with any questions or concerns you may have.

**I have read and understand the payment policy and agree to abide by its guidelines:**

______________________________________ ________________
**Signature of patient or responsible party** **Date**