Family Practice Group

A Rogue Valley Physicians, PC clinic

Please fill in the following information completely (Please Print)

PATIENT INFORMATION: **TODAY'S DATE** _____

NAME _____ HOME PHONE: _____
LAST FIRST MIDDLE

IF MINOR CHILD, PARENT(S) NAME _____ EMAIL: _____

ADDRESS _____
STREET, PO BOX CITY STATE ZIP

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY # _____-_____-_____ MARITAL STATUS _____ SEX _____

RACE: _____ LANGUAGE _____ HISPANIC OR LATINO [ ] YES [ ] NO SMOKER [ ] YES [ ] NO

EMPLOYER _____ WORK PHONE _____ OCCUPATION _____

HAVE YOU RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME: [ ] YES [ ] NO

IF YES, UNDER WHAT NAME? _____

RESPONSIBLE PARTY: If same as Patient, check box [ ]

NAME _____ HOME PHONE: _____
LAST FIRST MIDDLE

RELATIONSHIP TO ABOVE PERSON: [ ] SPOUSE [ ] PARENT [ ] CUSTODIAL PARENT [ ] RELATIVE (please check one)

ADDRESS _____
STREET, PO BOX CITY STATE ZIP

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY # _____-_____-_____ MARITAL STATUS _____ SEX _____

EMPLOYER _____ WORK PHONE _____ OCCUPATION _____

PREFERRED METHOD OF CONTACT: _____

SPOUSE INFORMATION: If same as Responsible Party, check box [ ]

NAME _____ HOME PHONE: _____
LAST FIRST MIDDLE

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY # _____-_____-_____

EMPLOYER _____ WORK PHONE _____ OCCUPATION _____

INSURANCE INFORMATION (please check those which apply)

PLEASE PRESENT CURRENT INSURANCE IDENTIFICATION CARD(S) TO RECEPTIONIST. PROOF OF INSURANCE IS REQUIRED.

I HAVE: [ ] MEDICARE [ ] MEDICAID [ ] HEALTH INSURANCE [ ] NO INSURANCE

MEDICARE ID# _____ MEDICAID CARD ID#: _____

(If Medicare, complete back of form)

PRIMARY COVERAGE:

HEALTH INSURANCE: _____ Policy # _____ Group # _____

POLICY HOLDER'S NAME _____ DOB _____/_____/_____ SEX _____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

SECONDARY COVERAGE:

HEALTH INSURANCE: _____ Policy # _____ Group # _____

POLICY HOLDER'S NAME _____ DOB _____/_____/_____ SEX _____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

MEDICAL TREATMENT RESULTING FROM AN ACCIDENT (Please Complete Accident Report)

I AM RECEIVING MEDICAL TREATMENT AS A RESULT OF AN ACCIDENT: [ ] YES [ ] NO

IF YES, WHAT TYPE OF ACCIDENT? [ ] MOTOR VEHICLE [ ] WORK ACCIDENT [ ] OTHER _____

INFORMATION FOR PHYSICIAN:

EMERGENCY CONTACT: _____ PHONE: _____ RELATIONSHIP: _____

HOW DID YOU HEAR OF OUR CLINIC? _____ _____

IF SELF-REFERRED, HOW DID YOU CHOOSE US: [ ] WEBSITE [ ] PHONE DIRECTORY [ ] OTHER _____

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MEDICARE SECONDARY PAYOR FORM

1. Is the patient eligible for Medicare Benefits?.....…… _____

   Part A (Hospital) benefits.....…… _____

   Part B (Medical) hospital.....…… _____

2. Is the patient employed?.....…….. _____

   If yes, approximately how many employees?.....….....……. _____

   If no, date of retirement.....……...… _____

3. Is the patient's spouse employed? ……..…… _____

   If yes, approximately how many employees?.....……. _____

   If no, date of retirement.....….....……... _____

4. Is the patient or spouse covered by:

   Group Health Insurance?.....….....….....…. _____

   Medicare HMO?.....…….. _____

5. Does the patient have a VA service connected disability?..…… _____

6. Is the patient eligible for Black Lung Benefits?.....……. _____

7. Has the patient had dialysis and been on Medicare more than18 months?.... _____

SIGNATURE OF PATIENT:_____

How to code:

Code group health insurance primary if patient is over age 65 and either patient or spouse is employed, there are 20 or more employees, and the patient is covered by the group health plan.

Code health insurance primary if the patient is under age 65 and either patient or spouse are employed, there are 100 or more employees, and the patient is covered by the group health plan.

Code VA primary only if the patient is receiving treatment related to his/her VA service connected disability.

Any patient being treated as the result of a motor vehicle accident, industrial accident, or injury resulting from a third party liability must have that insurance coded as primary over Medicare.

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FAMILY HISTORY QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Please list all close, "**Blood**" relatives with a history of any of the following conditions:

DISEASE	FAMILY MEMBER
HEART DISEASE	_____
HIGH BLOOD PRESSURE	_____
HIGH CHOLESTEROL	_____
DIABETES	_____
ASTHMA	_____
EPILEPSY	_____
KIDNEY DISEASE	_____
OSTEOPOROSIS	_____
CANCER:	
BREAST	_____
OVARIAN	_____
UTERINE	_____
COLON	_____
PROSTATE	_____
LUNG	_____
OTHER CANCER	_____
OTHER DISEASE	_____

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CONDITION OF TREATMENT

PLEASE PRINT

Name: _____ Birth date: _____

1. **INSURANCE COVERAGE:** Many companies do not cover preventative services, i.e., annual physicals or other screening tests your physician may order. It is my responsibility to contact my insurance company to verify the covered benefits on my plan. Failure to do so may result in a reduction or rejection of payment by the insurance company.

2. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize my insurance company to pay Family Practice Group directly. I understand that I am responsible for charges not covered by my insurance company including late penalty charges. I agree that a photocopy of this authorization is as effective and valid as the original.

3. **CONFIDENTIALITY:** Confidential information expressly identifies the medical nature of the services rendered to a patient, and includes all information and records obtained in the course of treatment. It includes information from history and physical examination, diagnoses, treatment rendered, laboratory and radiology results, progress notes and miscellaneous medical reports.

4. **MEDICARE AUTHORIZATION; PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named above to release such information to the Social Security Administration or its intermediaries or carriers, effective the date below.

5. **AUTHORIZATION FOR DISCLOSURE OF INFORMATION FOR PURPOSE OF SERVICE REIMBURSEMENT:** I hereby authorize Family Practice Group to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient's medical charges. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release Family Practice Group from all legal responsibility or liability that may arise from disclosure for these records. I understand that I may revoke this authorization at any time in writing, except to the extent that Family Practice Group has already taken action on my claim.

6. **FINANCIAL AGREEMENT:** I understand that in consideration of the services rendered, I am obligated to pay Family Practice Group in accordance with its regular rates, terms, or contractual agreements. I understand that I am responsible for any services "not covered" by insurance and that the obligation to pay for medical services may not be deferred for any reason. If the account is referred to any agency for collection, I agree to pay all collection expenses.

I HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND HAVE RECEIVED A COPY. I ACCEPT THE RESPONSIBILITY OF ITS TERMS.

_____ _____

Patient / Responsible Party Date

Family Practice Group

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POLICY ON PATIENT ACCOUNTS

PLEASE PRINT

Name: _____ Birth date: _____

Family Practice Group, a Rogue Valley Physicians, PC clinic, is a private institution, which operates for the benefit of the people who seek the services of our medical staff. We provide quality care, at what we believe to be fair and reasonable fees. Since we do not receive financial assistance from any outside source, we must recover the cost of providing services from our patients.

It is Family Practice Group's policy that the responsibility for paying for care will be placed on those who receive it. Therefore, all accounts will be administered under the following guidelines:

- **Payment is expected at the time of service. Established and New Patients without evidence of insurance coverage are required to pay in full unless prior arrangements have been made with our Patient Account Department.**
- **If you are unable to pay at the time of the appointment, your appointment will be rescheduled.**
- Cash or checks will be accepted. There will be a $25.00 fee for NSF checks. For your convenience, we do accept debit/credit VISA and MasterCard.
- As a courtesy, we bill your insurance for you if you provide us with the appropriate billing information. Your insurance will make payment directly to Family Practice Group and you will be responsible for any deductible, co-payments, or other patient balances. **Your insurance is a contract between you and your insurance carrier**, if they do not pay Family Practice Group within a 90-day period, **we will look to you for payment**. You will be refunded any overpayment you may make; in the event the insurance pays.
- Any balance remaining after your health plan pays or denies as non-covered under your plan, will be your responsibility. Payment is due upon receipt of a statement from our office.
- All bills are due and payable upon receipt of your monthly statement. If you have special financial needs, please discuss this with our Patient Accounts Department in order to establish an extension of credit terms. Interest accrues on charges not paid after 90-days of the first billing, at a rate of 1% per month (12% per year) until paid in full.
- Family Practice Group is a participating provider with Medicare. Medicare will actually pay 80% of what they allow, minus your annual deductible if it has not been met. You will be responsible for the deductible and 20% through either supplemental insurance or patient payment.
- Family Practice Group physician services provided while you are in the hospital will be billed to you or your insurance carrier. Any additional bills you receive are for services provided by the hospital, or from other providers or services you received during your hospital stay. These statements are not connected with Family Practice Group and any questions regarding these services must be referred to the responsible provider.
- It may be necessary to send laboratory, radiology or pathology specimens to an outside facility. If this is necessary, you will receive a separate bill for these services.
- In the case there is suit filed by Family Practice Group or Collection Agency for recovery of unpaid balance, you will be responsible for any incurred costs and/or Attorney fees associated with this action.

I HAVE READ AND UNDERSTAND THIS POLICY ON PATIENT ACCOUNTS. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND HAVE RECEIVED A COPY.

_____ _____

Patient / Responsible Party Date

FAMILY PRACTICE GROUP, PC

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature _____ Date_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.