Patient Information Form for McMillan Medical Center

Date: ____________

How did you hear of our practice? ____

Patients Name (Last, First, Initial): ____

Address: ______________________ **City:** ______________ **State:**______ **Zip:**__________

Home Number: ____________________**Work Number:** ________________________

Cell Number: ____________________**e-mail address(optional):**____________________

Patient Status: [ ] 1-Married [ ] 2-Single [ ] 4-Other [ ] 5- Widowed [ ] 6-Separated [ ] 7- Divorced

Date of Birth: __________ **Sex:** ______**Social Security Number:**____________________

Previous Physician(s): ______________________**Location**______________________

Has another family member been seen by this office? [ ] YES [ ] NO If **YES**, name of family member____________

*****GUARANTOR INFORMATION/SECONDARY ADDRESS:**

Name: ________________________________Phone #________________

Address: ________________________________SS#________________

Empl Status: [ ] 1-Empl FT [ ] 2-Empl PT [ ] 3-Retired [ ] 4- Not Empl [ ] 5- Studnt FT [ ] 6- Studnt PT

Employer's Name: ________________________Phone #____________________

Address: ____

Emergency Contact: _____ ________________________ **Phone Number**________________

***** INSURANCE INFORMATION:**

Primary Insurance:______________________Phone#____________________

Address_________________________ **Employer**: ______________________

Policy Holders Name:____________________Sex:____ **Date of Birth**:______________

Policy Number:________________ Group Number:__________ SS#____________

Policyholder's relationship to patient______________Effective Date: ________

Secondary Insurance: __________________________Phone#________________

Address: ________________________ **Employer**: ______________________

Policy Holders Name: ____________________Sex:____ **Date of Birth**:______________

Policy Number: ________________Group Number: __________ SS#____________

Policyholder's relationship to patient______________Effective Date: ______________

FINANCIAL POLICY

Any questions about our billing policy should be directed to our billing staff and they will be happy to assist you. We are dedicated to providing you the best possible care and service and we regard your complete understanding of your financial responsibilities as an essential element of your treatment and care. Unless prior arrangements are made, **Payment is due at the time of service** (this includes copays, co-insurances, deductibles and deposits.)

Demographic Information

You are responsible for keeping us informed of any changes to your contact information, marital status and insurance coverage.

Assignment & Release

I authorize the release of any necessary information, including protected health information, to my insurance company or their agents in order to secure payment. The information released is solely to facilitate billing and reimbursement and to meet the requirements set forth by your insurance carrier for services rendered. I authorize the use of the signature on this page on all insurance submissions and also authorize Physicians Clinic to send claims electronically to my insurance carrier under the guidelines of HIPAA. A copy of this authorization may be used in the place of the original. I understand that I am financially responsible for any balance due as my insurance plan is a contract between myself and the insurance carrier. The signature below authorizes treatment for myself and/or my minor child as advised by the medical staff.

Your Insurance:

We are contracted with many, but not all insurance plans. Variations due exist within each carrier so we can never guarantee coverage. Knowing your insurance benefits is your responsibility. Please contact your carrier with any questions that you may have regarding your contract or coverage. We will bill your insurance as a courtesy to you. If your medical plan determines that a service is *"not covered,"* you will be responsible for the entire charge. We do require that a deposit be paid at the time of service. We are required by law to collect co-pays at the time of service. Failure on our part to collect co-pays can be considered fraudulent. Therefore, we ask for your understanding and compliance on this matter.

All balances must be paid, in full, within 90 days of treatment. Our billing staff will be happy to assist you with payment arrangements to meet this requirement on current accounts. Checks returned for insufficient funds will be assessed a $20 fee. We run most checks electronically.

HMO Plans, Healthy Connections through Medicaid.

We do not contract with any managed care plans, HMO plans, Idaho Medicaid Health Home or Healthy Connections through Medicaid. If you are seen by one of our providers, you must obtain a referral from your PCP before you are seen as a patient. If your provider's office is closed or denies a referral, you may be asked to pay a deposit at the time of service. If a referral is not available at the time of treatment, you will be considered as "Self-Pay" and a deposit will be required prior to evaluation and treatment.

Minor Patients

The adult accompanying the patient and/or the parent will be billed for all services. We do not have the capability to bill separate residences for divorce situations. You will need to specify which parent is legally responsible for the medical costs for the child or children. In the absence of a legal agreement/document, the parent that accompanies the patient will be listed as the responsible party. We will work with all divorce situations, however we do not need to be involved in an uncomfortable financial situation with you and your ex-spouse. Our focus is the medical care of the patient.

Missed Appointments

In order to provide the best service and availability to our patients, we ask that you notify us 24 hours in advance if you know that you will be unable to keep your scheduled appointment. We reserve the right to charge for missed appointments. Repeat missed appointments may result in your dismissal from our clinic.

Signature:____ Date:_________________

Medicare Authorization

I request that payment of Authorized Medicare benefits be made either to me, or on my behalf to Physicians Clinic for any services furnished to me by their providers. I authorize Physicians Clinic to release any information to the appropriate Medicare authority and it's agents, required to determine these benefits or the benefits payable for related services.

I have read, understand and agree to comply with this policy.

MEDICARE REQUIRED Signature:__________________________________Date:_________________

Signature of authorized agent if pt is unable to sign: ________________________ Relationship:_____________

Acknowledgement of Notice of Privacy Practices (HIPAA)

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and /or disclose your health information. This information is posted at the receptionist area and a copy is available to you at the front desk upon request.

Signature:____ Date:________________

For staff use only please circle:

- Patient refuses to sign / unable to communicate / other circumstance:____________________________