Christian Family Medicine & Pediatrics

PATIENT UPDATE FORM *Please Print Clearly*

Patient Information

Legal Name_____ Date of Birth_____ SSN _____ Marital Status_____

(Circle One) Sex: M F *(Circle One)* Race: African American Asian Caucasian Other *(Circle One)* Ethnicity: Hispanic Not Hispanic

Home Phone_____ Cell Phone_____ Work Phone_____

Mailing Address_____ City/ State/ Zip _____

Email address:_____

Patient Employer_____Phone:_____

Local Pharmacy of Choice_____ City_____ Phone:_____

Emergency Contact: _____Contact #_____Relationship:_____

Parent/ Guardian Information (Person who is legally responsible for above person)

Guardian Relationship: *(Circle One)* Self Spouse Mother Father Grandmother Grandfather Aunt Uncle Other

Guardian Name_____ Guardian Date of Birth_____ _____

Guardian S. S. # _____Marital Status_____ (Circle One) Sex: M F

Address_____

City/State/Zip_____ Guardian Contact # _____

Guardian Employer_____ Employer Phone Number_____

Primary Insurance

Name of Ins. Co_____ Policy # _____ Group/ Plan # _____

Policy Holder: Name_____ DOB _____ SSN : _____

Contact # _____ Relationship _____

Secondary Insurance

Name of Ins. Co_____ Policy # _____ Group/ Plan # _____

Policy Holder: Name_____ DOB _____ SSN : _____

Contact # _____ Relationship _____

NOTIFICATION OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Christian Family Medicine, Inc. has given me notification of their Privacy Practice for protected health information. I authorize Christian Family Medicine Inc. to speak to the following person(s) regarding my visits, care, and/or account:

_____ _____

Name *Relation* *Name* *Relatio*

In the above section please list ALL persons that you wish to have access to your personal health information. Under no circumstance will this information be released except by court order to anyone who is not listed above without a signed release.

Please indicate your permission for our communication with you regarding your personal health information. **Check all that apply**

- □ Telephone call to your home or cell
- □ Telephone call to your place of employment
- □ Leave a message at your home with someone
- □ Answering machine
- □ Mail
- □ Fax

_____ _____

Signature of patient or guardian *Date*

Patient Responsibilities Notification

We will submit all charges to all insurance (primary, secondary, etc.) as a courtesy to you. However, we do require payment at the time of service for all co-payments, deductibles, and co-insurance. We cannot bill your insurance unless you bring all current insurance information with you. It is your responsibility to provide us with complete and accurate information at EACH office visit. Failure to do so will result in the patient incurring complete and total financial responsibility for all charges. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some services provided may be "non-covered" under the terms of your contract and, therefore, not paid by insurance. You are responsible for the payment of your deductible and co-pay if there is no secondary insurance. Copies of your information will be made for our files.

It is the patient's responsibility to inform us of any special requirements or specific facilities associated with your benefit plan. If we inadvertently order services, such as lab work, diagnostic tests, etc. that are not covered or ordered at an out of network facility, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

All patients are expected to provide their insurance card at the time of check in at each visit. All patients are responsible for making sure they know what benefits are included under their insurance plan and ensure they are following all regulations/ rules defined in their plan.

A deposit will be required for all patients that do not have insurance coverage prior to seeing the provider. Payment in full is expected at the time of service unless billing arrangements have been made by our billing staff PRIOR to the visit.

Adult Patients: Adult patients are responsible for full payment of their accounts.

Minor Patients: Patients under the age of 18 years will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment. The adult, parent or guardian accompanying a minor will be responsible for full payment of the account.

There is a $50.00 form fee for any forms presented to the office for completion not presented during a regular visit. Examples include: Disability, Adoption forms, Insurance claim forms, etc.

Payment in full or payment arrangements can be made on any outstanding balance. No payment activity within 120 days from the date of service will result in the account being turned over to an outside collection agency. The patient will be responsible for all collection fees, cost, interest, and/or attorney fees and will be applied to the outstanding balance.

Any account that has been turned over to a collection agency **MUST** be paid fully before any treatment is rendered. Failure to meet your financial responsibilities may result in discharge from the practice.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the primary care provider. I understand if there are any changes in my insurance coverage, I will notify my primary care provider immediately. I hereby give consent for treatment of myself or my child to the primary care provider at Christian Family Medicine.

I request payment of authorized Insurance/Medicare benefits be paid to Christian Family Medicine, Inc. on my behalf. I authorize any holder of medical information about me to release to the Healthcare Financing Administration, any information needed to determine these benefits. I understand my signature authorizes the physician to furnish information to insurance carrier concerning my illness necessary to pay my medical claims and I hereby irrevocably assign payments to Christian Family Medicine, Inc. I understand I am financially responsible for all charges, whether or not covered by insurance. I also understand my medical records may not be released if I am not financially in good standing with Christian Family Medicine, Inc. A copy of this authorization shall be considered as valid as the original.

_____

Signature of Patient or Responsible Party (state relationship)

_____

Date