Today's Date: _____

FORCARE
MEDICAL CENTER

Patient Information

Name_____ Date of Birth_____/_____/_____ Gender ☐M ☐F

Address_____ City_____ State_____ Zip_____

Social Security Number _____-_____-_____ E-mail _____ Marital Status _____

Best phone number (____)_____-_____ ◯ Home ◯ Mobile ◯ Work Alternate phone number (____)_____-_____ ◯ Home ◯ Mobile ◯ Work

Student ☐Yes ☐No Employment status ☐Employed ☐Retired ☐Other_____

Advance Directive ☐Yes ☐No If yes, please advise: _____

Pharmacy _____ Phone number _____

Address/Side Streets _____

Employer:_____ ☐Full Time ☐Part Time

Primary Language: ☐English ☐Spanish ☐Other: _____

Ethnicity: ☐Hispanic ☐non-Hispanic ☐Prefer Not to Disclose

Race: ☐White ☐Black/African-American ☐Asian ☐American Indian or Native Alaskan ☐Native Hawaiian/Pacific Islander ☐Hispanic ☐Prefer Not to Disclose

Primary Care Physician_____ Referring Physician_____

Insurance Info (If your Insurance is Family Coverage, Complete This for the Primary Insured)

Name_____ Date of Birth____/____/_____ Relationship to Patient _____

Primary Insurance: _____ Secondary Insurance: _____

Emergency Contact

Name_____ Relationship _____

Best phone number (____)_____-_____ ◯ Home ◯ Mobile ◯ Work Alternate phone number (____)_____-_____ ◯ Home ◯ Mobile ◯ Work

Patient Name: _____

Insurance Authorization and Assignment Consent to Treat

I hereby authorize ForCare Medical Group to furnish information concerning this illness/accident to insurance carriers and/or audit/compliance agencies. I also hereby request and consent to treatment and services reasonable and proper by today's standards provided by a physician or provider of ForCare Medical Group and any employee acting under my physicians' orders. **Pathology services –** I authorize ForCare Medical Group to send my tissue or other specimens to the Laboratory for microscopic slide processing and interpretation, and understand I may be responsible for any additional cost not covered by my insurance. **Medical Photography** – I understand photographs may be taken and added to my medical record. I understand if I request release of my medical records these photographs may be included. I understand that these photographs may be used for the following purposes: education, training, medical or scientific publication, in which case my identity will be protected.

Acknowledgement of Notice of Privacy Practices and Authorization to Release Information

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment, and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", MAY WE USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol treatment/abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, mobile voice mail, text mail, email or with a household family member. *I understand I may be charged for calls, texts or automated dialing systems by wireless carrier.*

◯ Please check here if you **DO NOT** want us to leave messages on your answering maching or with a household member.

◯ Please check here if you **DO NOT** want us to leave a message on your mobile voie mail, text mail or email.

◯ **Please check here if you authorize us to send your healthcare information by email. Please understand that email is an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to send us an email authorizing transmission of your healthcare information to you by unsecured email.**

Provide email address that we would send/receive information: _____

If you choose, please list below the person(s) with whom we may share your healthcare or payment information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- You may request a copy of, and you have the right to read our *"Notice of Patient Provacy Practices"* prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.
- I understand the Financial Policy and have the right to receive a copy of the Financial Policy, if requested.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

_____ _____ _____

Signature | Print name of person signing if other than patient | Date

Patient Name (please print):_____

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP_____

FORCARE
MEDICAL CENTER

FINANCIAL POLICY

The doctors and staff at ForCare Medical Group would like to welcome you to our Practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

- It is your responsibility to inform our office of any address or telephone number changes.
- Your account is to be kept current – accordingly, all self-pay or insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard, Discover, or American Express.
- If you do not have your payment(s) your appointment may be rescheduled.
- You may be asked to schedule another appointment for issues other than the reason for your original appointment.
- A returned check will result in a $30 service charge and all future payments being required in the form of cash or credit card.
- You will only be sent a statement if your balance exceeds $5 and you will only receive a refund if the credit amount is over $10. Refunds will be issued within 4-6 weeks from the date requested, if there are not pending insurance claims.
- There is a $30 charge for the completion of paperwork. (Example: disability, FMLA, etc.)
- You may receive a statement from two different laboratories. Lab specimens are processed by the ForCare laboratory and commercial laboratories. You may receive a billing statement after your Insurer has processed your insurance claim just as you would if your specimen was sent to any laboratory. These charges are separate from your Medical visit charges and may be subject to deductibles and/or co-insurance based on your insurance coverage benefits.
- Any unpaid balances older than 30 days may be subject to a 1.5% interest per month.
- If your account is turned over to a collection agency, you will be responsible for any costs incurred in collection of said balance, which may include collection agency fees up to 25% of your outstanding balance, court costs and attorney fees.
- If unable to keep your appointment, please notify us in advance so that we may offer that time to another patient. A pattern of repetitive “no shows” or late cancellations may regretfully result in an assessment of a cancellation/no show fee.

If you have health insurance coverage:

We will submit your claims, however **we must emphasize that as medical providers, our relationship is with you, <u>not</u> your insurance company.** Although we attempt to verify your benefits with your insurance policy, please be advised this is only an estimate of your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

- It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be re-verified prior to your appointment.
- If you insurance policy requires a referral from your primary care physician, it is your responsibility to have that referral faxed to our office prior to your appointment.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
- You are responsible for any non-covered charges not payable by your insurance policy.
- Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to contact us. <u>We are here to help you.</u>

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____
Patient Name (please print)	Patient Signature	Date
_____	_____	_____
Responsible Party If other than patient (please print)	Responsible Party Signature	Date