

WINFIELD FAMILY MEDICINE PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL SECTIONS BELOW!

Patient's

NAME: _____
LAST NAME FIRST MIDDLE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____ SEX: Male Female

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL#: _____ WORK#: _____

E-MAIL ADDRESS _____ MARITAL STATUS: Married Single Divorced Widow Other

EMPLOYER/SCHOOL: _____ ADDRESS: _____

COMPLETE ONLY IF PATIENT IS UNDER AGE OF 18

PERSON RESPONSIBLE FOR BILL

RELATIONSHIP TO PATIENT: Self Spouse Parent

NAME: _____
LAST NAME FIRST MIDDLE

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYER _____

HOME PHONE #: _____ CELL#: _____ WORK#: _____

PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST

PATIENT INSURANCE INFORMATION

RELATIONSHIP TO PATIENT: Self Spouse Parent

NAME OF INSURED _____
LAST NAME FIRST NAME MIDDLE

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

HOME PHONE #: _____ CELL#: _____ WORK#: _____

SECONDARY INSURANCE

RELATIONSHIP TO PATIENT: Self Spouse Parent

NAME OF INSURED _____
LAST NAME FIRST NAME MIDDLE

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

HOME PHONE #: _____ CELL#: _____ WORK#: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP _____
LAST FIRST

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ CELL#: _____ WORK#: _____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?

YES NO IF YES, PLEASE NOTIFY RECEPTIONIST

CONSENT

- I authorize the office to leave messages on my voice mail regarding health information, ie. Test results, appointments, and schedules for tests.
- I authorize the office to leave messages on my voice mail regarding any billing, payment or insurance information regarding my account.
- The following family members may receive health information regarding the patient.

Names: _____

Relationship to patient: _____

- The following family members/friends may pick-up prescriptions for the patient.

Names: _____

Relationship to patient: _____

- I give consent for the following people to bring my child/patient in for treatment.

Names: _____

Relationship to patient: _____

Parent/Guardian/Personal Representative

Date

By signing below I authorize the following:

CONSENT FOR TREATMENT: I Hereby authorize and consent to examinations and treatment which, in the Judgment of my physician, may be considered necessary or advisable for the diagnosis or treatment of my case.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize Winfield Family Medicine To release any information regarding my condition & treatment required by my insurance company, Medicare, Or other third party payer for determination of benefits payable for related services.

ASSIGNMENT OF BENEFITS: I hereby authorize information and payment of any benefits made to me, to be forward directly to Winfield Family Medicine.

FINANICIAL: Payments of co-pays, deductibles, or non-covered services are due **BEFORE** office visit.

Signature of responsible party/Parent/Guardian

Date

PATIENT NAME: _____ **DATE OF BIRTH** _____

Information listed below is used to capture data for a core government objective. The data collected is used to determine demographic disposition for certain types of diseases. You have the right to decline answering these questions.

RACE: Declined

- American Indian or Alaska Native
- Asian
- Black or African American
- White
- Other Race

Ethnic Group: Declined

- Hispanic or Latino
- Not Hispanic or Latino

Language: English

- Spanish

Primary Source of contact: Home Phone

- Cell Phone
- Work Phone
- Texting
- E-mail

If you would like to receive appointment reminders, billing statements VIA e-mail please list your e-mail address

_____ @ _____

We follow all HIPAA and HITECH guidelines in regards to securing patient information.

WINFIELD FAMILY MEDICINE PAYMENT POLICY

*Thank you for choosing us as your primary care provider.
We are committed to providing you with quality and affordable healthcare.
In doing so, we believe that it is important that you understand our financial policy.
Please feel free to ask questions.*

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required unless verification of coverage is provided. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Self-Pay Patients.** If you do not have insurance you will be considered a self-pay patient. You will be responsible for the office visit and/or procedure at time of visit. We do not bill for the service already provided.
4. **Non-Covered services.** Please be aware that some services/procedures you receive could be considered not medically necessary by Medicare and other commercial insurances. If we know the procedure to be a non-covered service under your policy, we may ask for payment in full at the time of service. Regardless, you will be responsible for any services not covered by your insurance.
5. **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 correct insurance information you will be responsible for visit at the time of service. You may be responsible for the balance of a claim if correct insurance information is not given at time of visit.
6. **Claims Submission.** We will submit your claims and assist you in any way we legally 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 before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance may be transferred to patient responsibility.
8. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice and a collection fee will be added to your balance. The collection fee will range from 25% of your balance or \$25.00 whichever is greater. If this is to occur, you will be notified by regular and/or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
9. **Bankruptcy.** Should you file bankruptcy on your medical bills, please be aware that you may be dismissed from the practice and/or fall under the self-pay protocol. (See above #3 and #7)
10. **NSF Check.** Returned checks will be charge a \$25 fee. The amount of the returned check and the fee must be paid in cash or with a credit card.
11. **Missed appointments.** Our policy is 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 schedule appointment. Appointments arriving more than 15 minutes late will be considered a missed appointment and needs to be rescheduled.
12. **Physician Ownership.** Both physicians have ownership interests in Pinnacle Hospital. Your signature below confirms that you are aware of said interest and understand that there is no obligation to go to the above facilities. You retain all rights to be referred to any facility of your choice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to abide by the above payment policy.

Signature of patient or responsible party

Date

WINFIELD FAMILY MEDICINE, LLC.
Attachment 19

WINFIELD FAMILY MEDICINE, LLC.
Acknowledgement of Receipt of Notice of Privacy Practices

IMPORTANT NOTICE TO OUR PATIENTS

As required by HIPAA, all Patients who receive health care services from WINFIELD FAMILY MEDICINE, LLC. must:

- Receive or at least be offered the attached "Notice of Privacy Practices" Form; and
- Sign the "Acknowledgement" Form below and return it to our front desk for our records.

Please note that the attached Notice is not a consent form that must be read in full and signed before treatment can be provided; rather, the Notice provides our Patients with a summary description of (1) how our office will use and disclose medical and billing information for legitimate business purposes, and (2) how our Patients can exercise their rights with regard to this medical information. These notices are similar to the ones that the general public received from their banks and other financial institutions last year.

Please Sign the Acknowledgement Form below and return it to our front desk for our records.

Thank you,

WINFIELD FAMILY MEDICINE, LLC. Physicians and Staff

ACKNOWLEDGMENT FORM

I hereby acknowledge that I have received (or was at least offered) a current copy of WINFIELD FAMILY MEDICINE, LLC.'s Privacy Notice.

Patient or Personal Representative* Signature

Date

(*) If signed by Personal Representative, please state your relationship to Patient:

I have tried, in good faith, to obtain a signature from the patient for receipt of the Privacy Notice. However, the patient has refused to sign for the following reason:

Staff signature

Date