PATIENTS FIRST
Get in. Get out. Get better.

Privacy Procedures, Authorization to Treat, and Acknowledgment

These authorizations, acknowledgements, and waivers cover all services rendered for today's services and for all future dates of service.

Authorization to Treat

In signing this document you agree to give authorization to receive treatment by our medical staff and release **Patients First (PFT),** its Owners, Physicians, Physician Assistants, and Nurse Practitioners, and/or any clinical staff member from any liability claims that may result from any treatment, medications, and/or procedures that have been provided to you.

You may be seen by a Nurse Practitioner or Physician Assistant contracted with our facility to conduct services for **PFT** patients. These medical personnel are highly qualified to meet the medical needs of our patients; however, some of them are not **PFT** employees, and are contracted on an as-needed basis by **PFT**. If you do not wish to be treated by a Nurse Practitioner or Physician Assistant, please inform the front desk personnel.

Financial Policy

Payment is due prior to services being rendered

All account balances, co-pays, deductibles, and self-pay charges are due at the time of service. This includes both patients with and without insurance.

Accounts with a balance must be paid prior to being seen. For delinquent/bad debt accounts, we reserve the right to turn the account over for collection to a collection agency. Once your account is transferred to a collection agency, all further correspondence must be with them. Having your account in collections could interfere with us providing you medical care in our office.

As a courtesy, we will submit your claims and assist you in any way we reasonably 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.

In the event that your insurance fails to pay for services rendered at **PFT** (e.g., deductible not met, out-of-network charges, denial of claim, cancelation of coverage, etc.), in signing this, you agree to be responsible for any remaining balance, with the exception of an adjusted contractual agreement, within sixty (60) days of service.

In addition, you agree to a late payment penalty of 10% of the balance and 1.5% interest per month until the balance due has been paid in full.

Payment can be made by: Cash, Check, or most Major Credit/Debit Cards.

All returned checks, stop payments, and credit card "charge-backs" will incur a fee of $30.00.

All products sold in our office are non-returnable.

For our patients **without insurance**, payment for the office visit is expected prior to being seen. There are costs associated with any additional services provided to you and payment for these services must be paid in full at the time the services are rendered.

For our patients **with insurance**, this includes **Co-pays**, **Co-Insurance**, and **Deductibles**. Please understand that this is only an ***estimate*** which is subject to final approval by **your** insurance company and may change the amount due to our office.

Providing quality Health Care to you and your family is our highest priority. That is why, when it comes to talking about finances, our goal is to provide you with clear information regarding our fees and your payment options.

WAIVER OF OUTSIDE LABORATORY AND RADIOLOGIST

In reading this, you understand that **PFT** may send lab specimens to an outside laboratory or send x-rays taken at **PFT** to an outside radiologist to over-read. In addition, you give permission to bill your insurance company for these services. You may incur additional charges as a result of these procedures. **PFT** is not responsible for these additional charges.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In signing this document, you acknowledge your understanding that Privacy Practices are posted for your information and that a copy can be provided to you upon request.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

Please initial and check mark where appropriate:

_____ I have been advised of and provided access to **Patients First's** *Notice of Privacy Practices.*
(please initial)

_____ I hereby _____ **do /** _____**do not** authorize **Patients First** to release
(please initial) any of my Personal Health Information via general mail, including materials of a potentially sensitive nature, such as laboratory or radiology reports, HIV or STD testing results, or mental health treatment records to the address provided.

_____ I hereby _____ **do /** _____**do not** authorize **Patients First** to contact
(*please initial)* me by phone to discuss the same such Personal Health Information at the phone numbers provided.

I _____ **do /** _____**do not** authorize the disclosure of the same such Personal Health Information to certain designated individuals other than myself as listed below:

Name: _____Relationship: _____Phone:_____

Name: _____ Relationship: _____ Phone:_____

If I am unavailable, **Patients First** may leave a detailed message at the provided phone numbers.

_____ Yes _____ No

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REGISTRATION FORM

Reason for Visit: _____ Work Related: _____ Auto Related: _____

Patient Name: LAST: _____ FIRST: _____MI:_____

Soc. Sec. #: _____-_____-_____ DOB: _____/_____/_____ Gender: M _____ F _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Address: _____ Apt #: ____ City: _____ State: _____ Zip:_____

Home Phone #: _____Cell Phone #: _____ Work Phone #: _____

Email Address: _____ Would you like to receive informational emails: _____Yes ____No

What is your preferred method of communication? _____Email _____ Home Phone _____ Cell Phone _____ Other

What is your marital status? _____ Child _____ Divorced _____ Married _____ Separated _____ Single _____Widowed

Employer Name: _____Employer Phone: _____

Employment Status: _____ F/T _____ P/T _____Unemp _____Retired _____Self Empl _____ Student

Who is your primary care physician? _____ Phone: _____

How did you hear about us? _____

Pharmacy Information: Name:_____ Phone:_____

Address: _____ City: _____ State: _____ Zip:_____

Emergency Contact: LAST: _____ FIRST: _____MI:_____

Relationship _____ Primary Phone #: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip:_____

Please give your insurance cards to the receptionist.

Primary Insurance Company: _____**Co-Pays**: Urgent care: $_____ Primary care: $_____

Member #: _____ Group #: _____

Subscriber Name: _____ Subs. SS#: _____-_____-_____ Subs. DOB: _____/_____/_____

Patient relationship to subscriber: self _____ spouse _____ child _____ other _____

Secondary Insurance Company: _____

Member #: _____ Group #: _____

Subscriber Name: _____ Subs. SS#: _____-_____-_____ Subs. DOB: _____/_____/_____

Patient relationship to subscriber: self _____ spouse _____ child _____ other _____

The above information is true to the best of my knowledge: I hereby authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize **Patients First** to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions.

_____ _____ _____/_____/_____

Patient/Responsible Party Signature Relationship Date