I CAME HERE TODAY TO SEE DR. _____

DATE: _____ MRN: _____

**PATIENT INFORMATION** (PLEASE PRINT PATIENT'S COMPLETE LEGAL NAME) **Social Security Number:** _____

**PATIENT: Last** _____ **First** _____ **Middle** _____

**Gender:** ☐ **Male** ☐ **Female** **Date of Birth:** _____ **Primary Language:** _____

**Race:** Black/African American Asian White American Indian / Alaskan Native Native Hawaiian / Pacific Islander Other Decline

**Ethnicity:** Hispanic / Latino Non-Hispanic / Non-Latino Unknown

**Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widowed**

**Street Address:** _____ **APT/UNIT#:** _____

**City:** _____ **State** _____ **ZIP:** _____

**Primary Phone # (INCLUDE AREA CODE)** (___) _____ **Secondary phone # :**(___) _____

**NORTHERN ADDRESS:**

**Street Address:** _____

**City/State/Zip:** _____ **Phone # :**(___) _____

## Additional Information:

**Email Address:** _____ **Would you like access to NCH Patient Portal? Y / N**

**Referring Physician:** _____ **Local Primary Care Physician:** _____

**Pharmacy:** _____ **Phone # and/or Location:** _____

**PATIENT/GUARANTOR EMPLOYER:**

**Name of Employer:** _____

**Employer Street Address:** _____

**Employer City/State/Zip:** _____ **Phone # :**(___) _____

**Employment Status** ☐ **FT** ☐ **PT** ☐ **Retired** ☐ **Self** ☐ **Unemployed**

**EMERGENCY CONTACT INFORMATION:**

**Name:** _____ **Relationship:** _____ **Phone:** (___) _____

**INSURANCE INFORMATION (COMPLETE IF THE POLICYHOLDER IS NOT THE PATIENT ON ANY POLICY)**

**Subscriber's Name:** _____ **Subscriber's Date of Birth:** _____

**Relationship of patient to subscriber:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other:** _____

**Subscriber's Social Security Number:** _____ **Gender:** ☐ **Male** ☐ **Female**

**Address of Subscriber (if different from patient):** _____

**City/State/Zip:** _____ **Phone # :**(___) _____

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**I hereby acknowledge and/or agree to the following:**

**1)** I hereby authorize this provider to treat me or my child and attest that the personal and financial information given above is true and that no information has been falsified.
**2)** I hereby authorize NCHMD, INC to contact me using my email address if I supply it on this form
**3)** A parent or guardian responsible for payment of the bill is accompanying the child at the time of service unless a separate permission form has been signed. NCHMD, INC cannot be bound by any divorce or other family relationship contracts.
**4)** I hereby authorize insurance benefits, including Medicare benefits, to be paid directly to the physician providing services and recognize it is my responsibility to pay for all non-covered services. I also authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid (CMS) and its agents, any other third party liability or insurance carrier, any information needed to determine these benefits or the benefits payable for related services.
**5)** I authorize NCHMD, INC to apply any funds received under this assignment which exceed the amount necessary to pay my charges to any unpaid NCHMD, INC bills of myself or an immediate family member.
**6)** I have reviewed and understand all the information on the back of this document, including HIPAA Notice of Privacy Practices Statement, as indicated with my signature and date below.
**7)** That the pathologists and radiologists who may provide services to me are NOT agents or employees of the NCH Physician Group but are independent practitioners; that the NCH Physician Group delegates to the pathologists and radiologists the providing of physician professional services to me, which operates to discharge the NCH Physician Group from any contractual obligations to provide said services to me; that the NCH Physician Group is not legally or vicariously responsible for the conduct or actions of the pathologists or radiologists that may provide services to me.
**8)** That the undersigned does hereby release the NCH Physician Group, its agents, employees, officers and directors, from liability for all acts of the aforesaid physicians, negligent or otherwise.

**Signature** _____ **Date** _____

**WELCOME TO THE NCH PHYSICIAN GROUP!**
**THANK YOU FOR CHOOSING US AS YOUR HEALTHCARE PROVIDER**

We believe it is important for our patients to fully understand our Financial Policy and acknowledge that they have read our Notice of Privacy Practices. Please review the Financial Policy below and the separate Notice of Privacy Practices document carefully. To avoid any misunderstanding regarding either policy, it is necessary for you to read both and sign on the first page of this document, before treatment is rendered. Please ask us any questions you may have regarding either document and take a copy of both policies home for future reference if necessary.

## OUR FINANCIAL POLICY

This policy covers office visits, lab or radiology testing and therapy services performed at NCHMD, INC (d/b/a NCH Physician Group) facilities. By signing on the first page of this document, I am agreeing to the terms of this Financial Policy.

**Medicare Patients:** We are participating physicians with Medicare. This means that you will be responsible for the 20% of the approved Medicare fee for covered services, the current yearly deductible and full payment of any non-covered services. Non-covered services include, but are not limited to, most annual physical exams, most labs and diagnostic tests performed for screening purposes.

**Payment is due at time of service:** Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate (please see insurance below). You will be charged a $35 service fee for any returned checks, no exceptions.

**Insurance:** Patients will be asked to present their insurance card to the receptionist for copying upon check-in at the office each time they are seen for medical services. Please make it a point to bring your insurance card with you each time you visit our office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those patients covered by insurance plans with which we **ARE** participating providers, all co-payments, deductibles and non-covered services are due at the time of service. We will file a claim to the insurance company on your behalf. In the event that you are covered by (or your coverage changes to) a plan with which we **ARE NOT** participating providers, we may require payment in full at the time of service. Any charges that are not paid by your insurance are your responsibility. Your insurance policy is a contract between **YOU** and your insurance company**. Any pre-certification of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.**

**Surcharge for Missed Appointments**: Patients may be subject to a surcharge for missed appointments if cancellation is not received at least 24 hour before the time of the appointment. Check with your provider regarding their policy. More than three missed appointments without the required notice may result in termination from the practice.

**Lab Specimens:** Lab specimens may be sent to NCH Lab, LabCorp or Quest and you may receive additional statements from one of these labs. These charges are based on the type of specimen(s), further studies needed to complete the test, and the type of insurance coverage you may have. Your signature on page one acknowledges that you understand this.

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES STATEMENT

I have been given the opportunity to review NCH Physician Group Notice of Privacy Practices (a separate document) prior to signing this acknowledgement. NCH Physician Group reserves the right to revise its Notice of Privacy Practices at any time.

By signing on the first page of this document, I hereby acknowledge that I have been notified of the following:

- The NCH Physician Group utilizes an electronic medical record system and this allows access to your prescription history, drug benefit coverage and enables new prescriptions to be electronically routed to the pharmacy of your choice.

- The NCH Physician Group participates in a Health Information Exchange ('HIE') which is an organization that allows health care providers in different places to access information about you so that each provider has a complete picture of your health. HIEs can also avoid the need for you to undergo duplicate tests, because health care providers will have access to results of tests conducted elsewhere. The information that may be provided to an HIE includes both medical and demographic information about you. Your health information will be made accessible to health care providers who participate in the HIE unless you "opt out" by notifying the registration clerk now or by notifying us by email at:optouthie@nchmd.org, or by calling (239) 624-2236.

- NCH Physician Group may use and disclose my protected health information to carry out treatment, payment and healthcare operations. The NCH Physician Group Notice of Privacy Practices provides a complete description of such uses and disclosures. Uses and disclosures not listed in the Notice of Privacy Practices will require my prior written authorization. NCH Physician Group is authorized to use my personal information to secure payment for services rendered and will comply with all reasonable measure to follow the FTC guidelines regarding identify theft. I understand that I can require that medical information not be disclosed to a health plan if I pay for those services out of pocket. I may make restrictions to the use and disclosure of my protected health information or revoke a previous request for restriction at any time except to the extent that the practice has already made disclosures in reliance upon my prior authorization to do so. Both Requests for Restriction and Revocations must be in writing. By signing on the first page of this document I am acknowledging that I have received the NCH Physician Group Notice of Privacy Practices and understand my rights to modify how my information is used and disclosed. If the NCH Physician Group determines that my restrictions make it impossible for them to carry out my treatment, payment and healthcare operations, they may refuse to accept me as a patient.

Revised 7/2016