FAMILY PRACTICE CENTER
PATIENT *UPDATE* FORM, YEAR 2022
(Please print)

Patient Name:____

Today's Date: / /	Appointment Date: / /

PATIENT INFORMATION

Patient's last name: First: Middle:	Date of birth: / /	Age:	Sex: □ M □ F

Name you preferred to be called:	Social Security no:	Marital Status: □ Single □ Mar □ Div □ Sep □ Wid □ Partn

Race: □ White □ Black □ Amer. Indian □ Asian □ Hawaiian □ Other	Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Decline to answer

Home ph no:	Cell ph no:	Preferred contact method: □ Home ph □ Cell ph □ Email

Street address:	City:	State:	ZIP Code:

Email address:

Employer:	Employer/Work phone no:	Occupation (if student please specify):

Spouse/Partner Name:	Spouse/Partner Sex: □ M □ F □ Other: ______________

FINANCIAL INFORMATION

If you are under 18, person responsible for bill:	Birthdate: / /	Address (if different):	Home phone no: ( )

Is this person a patient here? □ Yes □ No

Employer:	Employer/Work phone no:	Occupation (if student please specify):

INSURANCE INFORMATION

(*Please give your insurance card(s) and identification card/driver's license to the receptionist*)

Primary Insurance Company:

Subscribers name:	Subscribers S.S.no:	Birthdate: / /	Policy no:	Group no:

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other ________________________

Name of secondary insurance:	Subscriber's name/Date of birth:	Policy no:	Group no:

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other ________________________

IN CASE OF EMERGENCY

Name of local friend or relative to contact in an emergency:	Relationship to patient:	Home phone no: ( )	Cell phone no: ( )

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Appointment reminders:

I wish to be reminded of upcoming appointments via:

▫ HOME PHONE (call)	▫ CELL PHONE (call)	▫ EMAIL	▫ TEXT

Authorization to release medical information:

In the event you must be contacted by phone with regards to appointments, test results, referrals, or any other reason, please indicate how you wish to be contacted.

Phone Number: ______________________________ Is it ok to leave a message? ☐ Yes ☐ No

Do you want Family Practice Center, and all employees thereof, to be able to determine financial matters or medical care with any family members or emergency contacts? This permission will be valid indefinitely and must be revoked in writing. If so, please specify who and which information, below.

You may discuss my financial matters or medical care with the following:

INFORMATION OK TO DISCUSS	NAME	RELATIONSHIP	PHONE NUMBER
▫ FINANCIAL ▫ MEDICAL			
▫ FINANCIAL ▫ MEDICAL			

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

With your consent, Family Practice Center, P.C. may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this contract. We reserve the right to revise our Notice of Privacy Practices at any time.

With your consent, Family Practice Center, P.C. may call, email or send mail to your home or office and leave a message about any items that assist the practice in carrying our TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent.

If you decline to sign this consent, we may decline to provide treatment for you.

____ ______________________________
Signature of patient or legal guardian *Date*

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We are committed to meeting your healthcare needs. Our goal is to keep your insurance and financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask you to adhere to the following guidelines and choose a plan that meets your needs:

1. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. **Initial** ________
2. It is your responsibility to confirm with your insurance company that our physicians participate in your insurance plan. **Initial** ________
3. You are ultimately responsible for payment of services you receive from our office at the time of service. Any nonpayment in full, including non-payment of co-pays/coinsurance/deductibles and returned checks will result in a **$35 billing fee** in addition to the balance owed. **Initial** ________
4. Cancelling an appointment less than 24 hours in advance or no-showing an appointment **(including arriving later than 15 minutes past your scheduled appt time)** will result in the following charges: $35 for a regular office visit, $75 for an annual physical and $100 for an ECHO, Ultrasound or Flexible Sigmoidoscopy. *3 late cancellations or no-shows in one year may result in your dismissal from our practice.* **Initial** ________
5. The vast majority of prescription refill requests will require an office visit. After-hours calls/emergency prescription refills are subject to a **$55 fee**. **Initial** ________

- Our office collects an **Administrative Service Fee (ASF) of $8 on each visit or $65.00 annually** to cover the cost of certain **administrative services we may provide that are not covered by your insurance**. Examples of these services are forms and letters such as the following:
  a. **Long/short-disability/FMLA/Biometric form(s)**
  b. **Medication/Procedural Prior Authorizations**
  c. School/Sports Physical/Camp form(s)
  d. **Insurance related pre-certifications**
  e. Life Insurance form(s)
  f. Parking/Handicap permit(s)
  g. **Other misc forms/drafted letters**
  h. Medical record reproduction
- **You are not required to pay the Administrative Service Fee**; however, if you choose not to pay the optional fee, **you will be charged for all administrative services, as needed**. You will not be given a chance to pay the ASF at the time you request any administrative service above. Additionally, if you have any Administrative items pending, you may not change your designation. ***Please select 1 of the 3 options below:***

  □ I elect to pay the $8.00 per visit ASF **Initial** ________

  □ I elect to pay the $65.00 annual ASF **Initial** ________

  □ I choose **not to pay the ASF**. I understand that with this decision, **I will pay for services as I need them** at a minimum rate of **$120 per form/drafted letter** and **$75 per prior authorization** per **medication/procedure**. **Initial** ________

____ ____

Patient's Printed Name *Signature of patient or legal guardian*

____ ____________________________

Relationship to patient, if other than self *Date*