FAMILY PRACTICE CENTER
PATIENT *UPDATE* FORM, YEAR 2023
(Please print)

Patient Name:____

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

PATIENT INFORMATION

Patient's last name: First: Middle:	Date of birth: / /	Age:	Sex: □ M □ F □ Nonbinary □ FtM □ MtF
Preferred Pronouns: □ she/her □ she/they □ they/them □ he/him □ he/they	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 (*one business day*) 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*

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Telemedicine Visit Information

- Please log in 10 minutes prior to your scheduled appointment time to troubleshoot any issues by clicking this link: https://doxy.me/precall-test
- If you experience any issues, try restarting your computer/device or visit: http://help.doxy.me
- If you would like to pay for this appointment as a self-pay option and not go thru your insurance, we can do that. Please contact our front office staff for pricing at 404.256.1727.
- Our administrative fee does apply to Telemedicine visits just as it would for a standard in-office visit.
- You must give us 1 business days' notice for cancellation, or you will be charged a $35 late cancellation/No Show Fee and any fees that have been pre-paid will not be refunded.
- If you are receiving a schedule 2 drug, we will do our best to e-prescribe this to your pharmacy. If that is unsuccessful, we will put a physical prescription in the mail to you.

Telemed Informed Consent

1. I understand that my healthcare provider may wish for me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit since I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider to operate the video equipment. The abovementioned people will all maintain the confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my (1) medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting healthcare provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from my practitioner.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language that I understand.

By signing this form, I certify:

- ☐ That I have read or had this form read and/or had this form explained to me.
- ☐ That I fully understand its contents including the risks and benefits of the process.
- ☐ That I have been given ample opportunity to ask questions and any questions have been answered to my satisfaction.

______________________________ ______________________________
Signature of patient or legal guardian *Date*

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Attention Patients-Please Review New Billing & Insurance Changes to MyChart

In the spirit of respect and transparency, we are informing all our patients about this new billing policy, and we want to be sure that we communicate the expectation clearly, so we have provided very specific details and some examples below.

At Family Practice Center, we strive to provide easy access to our outstanding providers in a timely fashion. To help accomplish this, we offer telemedicine appointments, and we leave space on our schedules to accommodate same day visits and walk-ins. We also have a great team of live, on-site operators working hard every day to facilitate appointments and communications. The use of email communication and appointment scheduling via MyChart is another example of how we empower our patients with efficient access to our providers.

Over the past several years, the use of MyChart messaging has escalated considerably on a national scale. Owing in large part to its convenience, and spurred on by the COVID-19 pandemic, patient messages now account for a considerable part of our daily workflow. Most of our providers field dozens of messages per day in addition to seeing and managing scheduled patients. Historically, almost all the clinical time it takes to handle these messages has been free to you and not compensated by insurance companies. However, starting January 1, 2023, you may begin to receive bills for MyChart message exchanges that require your provider's clinical time and expertise to answer. **Some insurance providers may cover this fee, but it will be your responsibility to check with yours ahead of time to know for sure.**

Similar policies have been implemented by many healthcare systems nationally including at the Cleveland Clinic, The University of California San Francisco, and Northwestern Medicine.

It's important to know that not every message you send to your provider will be billed. **It's also very important to know that your provider may not feel that managing your issue(s) by messaging is appropriate. In these cases, we can help facilitate an appointment for you.**

Examples of messages that will **not** be billed:

- Messages that result in an appointment with us within 7 days.
- Asking a question about an issue you saw your provider for in the last 7 days. This does **NOT** include asking about things that you forgot to mention during your visit or a new issue that has come up since your visit.
- Checking in as a part of your follow-up care after a procedure.
- Giving a quick update to your provider.

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Depending on your insurance policy, the cost of most of the applicable messages will be between $30-$60. You could owe closer to $100 for more complex message exchanges requiring at least 20 minutes of your providers' time. In some cases, insurance will cover the costs completely and you will owe nothing.

Examples of messages that may be billed include:

- A new issue or symptom requiring medical assessment, medical decision making or referral ***In almost all these cases, we strongly encourage (and may even require) a scheduled appointment over a MyChart message*. **You should call 911 in an emergency or be taken to a hospital.** **
- Medication management including dose adjustments, changes that you make to your pharmacy, emergency refills and short-term (30 days or less) refills when you're due for a follow up visit.
- Chronic disease check-in and management
- Flare-up or change in chronic condition

We want our patients to rely on us to be available for all their healthcare needs. MyChart is a great communication tool, and you can continue to expect responses from us **within three business days.** Even with the convenience of MyChart, without question, the best way to ensure you get the highest level of care in the timeliest manner is by scheduling an appointment either in person or via telemedicine.

We are grateful to all of you who trust us with your healthcare. We believe that this new policy will help us to continue providing the highest level of care and service that sets us apart. Please let us know if you have any questions regarding this policy. Additionally, if you are interested in checking on the specifics of this with your insurance company, the CPT codes currently in use for this are 99421, 99422 and 99423.

Acknowledgement signature: ______________________________ Date: _______________