****

**ACCOUNT INFORMATION: Please Print Legibly**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Circle: M / F Patient DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient SS#(Optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Secondary Phone** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse*(Parent)* Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Spouse*(Parent)* Phone #**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POLICY HOLDER: *If self may leave blank*.**

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**RELATION SHIP**: \_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_City:\_\_\_\_\_\_\_\_\_\_\_\_ST:\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_**

**PHONE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICY HOLDER SS#(Optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIALLY RESPONSIBLE PARTY:**

IF THERE IS SOMEONE OTHER THAN THE PATIENT (I.E. MINOR) WHO IS RESPONSIBLE FOR PAYMENT OF THE ACCOUNT, POLICY HOLDER PLEASE PROVIDE:

**Guardian Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Guardian SS#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB**:­­­­­­­­ ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian's Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact:**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

If Any Labs Are Sent Out For Testing, I Understand I Will Have A Separate Bill From The Laboratory.

Quest Diagnostics. Completes Outside Lab Services, Providing Results, Services Are Billed To Insurance Then Patient.

**HIPAA:** I AUTHORIZE ALL AND ANY OF MY CLAIMS BE RELEASED AND SUBMITTED TO MY INSURANCE COMPANY FOR PAYMENT.

I authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (family member) to have access to my records/call for any questions.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPAA Patient Consent Form**

**(Health Insurance Portability and Accountability Act)**

**Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Right section describing your rights under the law. You have the right to review this notice before signing a consent. The terms of our notice may change.**

**You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.**

**By signing this form, you consent to our use and disclosure of protected health information about you for; treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

**The Patient understands that:**

* **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
* **The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.**
* **The practice reserves the right to change the Notice of Privacy Practices.**
* **The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.**
* **The patient may revoke this consent in writing at any time and all future disclosures will then cease.**
* **The Practice may condition receipt of treatment upon the execution of this Consent.**
* **The Practice utilizes a number of contracted services in the conduct of business. These contractors may have access to Patient health information but must agree to abide by the confidentiality rules of HIPAA.**

**I,*(Sign)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(date)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**THIS IS NOT A RELEASE OF RECORDS.**

Spencer Convenient Healthcare Financial Policy

Patient (Printed)­­­­­\_\_­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian (Printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for choosing Spencer Convenient Healthcare as your health care provider. Please carefully read and initial under each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered which allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payments for services is as simple and straightforward as possible.

1. I understand that if I do not have my insurance card, referral, and/or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments. Spencer Convenient Healthcare will collect all co-payments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Spencer Convenient Healthcare.

Initials: \_\_\_\_\_\_\_\_\_\_\_

1. I understand that that I am personally responsible for the payment of my own and/or my dependent’s medical care. I further understand that the payments for which I may be personally responsible include but are not limited to co-payment(s), deductible(s), and/or any outstanding balances that are not covered by my health insurance policy.

Initials: \_\_\_\_\_\_\_\_\_\_\_

1. I understand that a **$25 service fee will be added for any Nonsufficient Funds or declined transactions**, that and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier’s check, money order or cash).

Initials: \_\_\_\_\_\_\_\_\_

1. A $25 fee will be assessed for all no-show appointments and $50 for all missed procedures not canceled at least 30 minutes before my scheduled appointment time.

Initials: \_\_\_\_\_\_\_\_\_\_

1. Spencer Convenient Healthcare will allow 30 days from the date of filing for my insurance company to process or pay a claim. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Spencer Convenient Healthcare if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

Initials: \_\_\_\_\_\_\_\_\_\_

1. I understand that a 1.5% interest charged will be applied each month to account balances over 30 days.

Initials: \_\_\_\_\_\_\_\_\_\_

1. I understand if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and the account will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Initials: \_\_\_\_\_\_\_\_\_\_

1. I will be charged $0.20 per page for copies of my medical records or records that we print and send elsewhere. We are happy to send records for you to your provider of choice but a release of records release is required by law. We reserve the right to take to complete this request as our schedule allows and within 5 days.

Initials: \_\_\_\_\_\_\_\_\_\_\_

1. I understand there is a $10 charge for filling out any forms outside of regular appointment time. For example, additional physical forms, employer or insurance company forms, FMLA, and work release/restrictions. This amount is due from you before we complete the form. We reserve the right to complete this as our schedule allows and within 5 days if forms are not presented at appointment.

Initials: \_\_\_\_\_\_\_\_\_\_\_\_

1. It is our policy to require every patient, parent, and/or legal guardian to provide us with a credit card (debit/HSA) authorization or voided check for any remaining balances for services rendered and determined to be the responsibility of the patient, parent, and/or legal guardian. We are PCI compliant and your information is kept in your secured medical record. Following your office visit you will receive an explanation of benefits (EOB) from your insurance company, your insurance also notifies this office of your benefit and what amount is considered the patient responsibility. When we have this information, you will be emailed your statement and given 24 hours to respond if you have another payment source you prefer to use. If we do NOT hear from you, the amount due will be paid from the payment source we have on file. This payment source will be considered valid for one calendar year or until expiration of the card.

Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and agree to all of the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to provider’s office.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Spencer Convenient Healthcare. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*A Credit Card (Debit/HSA) or Voided Check is Required\***

□ Please email me my statement prior to using this payment method.

**Print** email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Billing ZIP** code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: Please watch for your EOB from your insurance company. You will receive an email statement after insurance has processed.**

**\*For your protection we can also swipe your card into our secure payment portal\***

