PREMIER PRIMARY CARE
Better Care. Better Health.

Demographics Verification Form

DEMOGRAPHIC INFORMATION			
Patient Name:			
Mailing Address:	City:	State:	Zip Code:
Home Phone:			
Cell Phone:			
Work Phone:			
Date of Birth:	Sex:	Marital Status:	
Social Security Number:			
Employer Name:			
Employer Address:			
Primary Care Provider:			
Email:			
Select One: White ____ Black ____ Hispanic ____ Other: _____		Language spoken:	
OK to Leave Message: ☐ **Home** ☐ **Cell**		☐ **Brief** ☐ **Extended**	
EMERGENCY CONTACT INFORMATION			
Emergency Contact Name:			
Phone Number:			
Relationship to Patient:		☐**HIPAA**	
GUARANTOR/RESPONSIBLE PARTY			
Name:			
Guarantor Address:			
Guarantor Date of Birth:			
PRIMARY INSURANCE INFORMATION			
Insurance:			
Insured's Name:	Insured's Date of Birth:		
Subscriber Number:			
Subscriber Address:			
Group Number:			
Insured's Rel to Pt:			
SECONDARY INSURANCE INFORMATION			
Insurance:			
Insured's Name:	Insured's Date of Birth:		
Subscriber Number:			
Subscriber Address:			
Group Number:			
Insured's Rel To Pt:			
PHARMACY INFORMATION			
Pharmacy Name/Location:			
Pharmacy Number:			
Alternate Pharmacy Name/Location/Phone:			

I attest that the above information is correct and have read and understand the policies of Premier Primary Care, and accept my responsibility as stated in those policies. I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge. I hereby allow the clinical staff of Premier Primary Care to view my medication history from external sources.

_____ **Date** _____

Patient Print

_____

Patient Signature

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FINANCIAL POLICY

We, the staff of **Premier Primary Care** thank you for choosing us as your primary care provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with a high level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship, and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact the office and speak with the billing manager. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the **time of service** unless a payment arrangement has been approved in advance by our billing dept in writing.

We make payment as convenient as possible by accepting cash, debit card, credit card or check. A $35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to set up an automatic debit payment plan for your convenience knowing that the security of your information is important to us.

If financial agreements or medical necessities are not kept in good faith, you will be notified by regular or certified mail that you have 30 days to find alternative medical care.

If your account is placed with an outside collection agency, you will be charged the full amount of collection fees, attorney fees and allowable court costs. Please note that placement with an outside agency may cause us to terminate your care with our office.

Initials_____

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Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you try to receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier. This is a contractual agreement between you and your insurance carrier. Your insurance company will determine what amount, if any, you owe to Premier Primary Care. Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. If there is a balance due on your account, we will mail a detailed statement which is due upon receipt. **Do not assume that any statement you receive will be paid by your insurance company**.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of- network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Initials_____

Miscellaneous Forms, Additional Information and Authorizations

We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for school, sports, or extracurricular activities, there will be an administrative fee, not to exceed $30.00, for the additional information.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance, a missed appointment fee may apply. These fees are typically $25.00 for regular office visits and $50.00 for physicals. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information, and we follow applicable Federal and State regulations to provide patients with these rights, including as set forth in the Health Insurance Portability and Accountability Act (HIPAA). As permitted by HIPAA, our medical record fees are a reasonable cost-based fee for copies, including the copying, supplies, labor, and postage of the files, and or summaries. We realize that temporary financial problems may affect timely payment of your account. If this should occur, please let us know and contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Treatment

Patients are entitled to be directly involved in their treatment plans. Testing, referrals, medications, and any other treatment ordered during your visit will be listed on the patient's visit summary provided at the end of the visit. We may provide a paper copy and may post an electronic copy to your Patient Portal. Our providers treat patients based on medical necessity and not on insurance coverage. It is the patient's responsibility to know your benefits and coverage. We will obtain any prior authorizations required by your insurance carrier; however, this does not guarantee payment and does not define patient responsibility amounts.

Initials_____

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I have read and understand the above financial policy. I agree to assign insurance benefits to Premier Primary Care whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections **if** such action becomes necessary.

Printed Name of
Patient:_____

Signature of Patient or Authorized Representative: _____
(If under 18 yrs old, must be parent or guardian)

Relationship to
Patient:_____

Date: _____

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Notice of HIPAA Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment, including from third-party payers.
- Conduct healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices,* including for information held prior to the effective change. I understand that I may request in writing that you restrict how my health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are generally not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions. I also understand I have the option to pay for a health care service personally and not have such claim submitted to a health plan. To choose this option, I and/or the Patient must notify your Business Office and must pay the bill for that health care service in full.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

To address any special needs you may have and to confirm your wishes, please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Circle one YES NO

If YES, please list names below for our record.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason:

Staff Initials: Date: