

Fountain Hills Family Practice, P.C.

Patient Information

First name: _____ Middle Initial: _____ Last name: _____

Address: _____ DOB (date of birth): _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Voicemail okay #1: Yes or No Voicemail okay # 2: Yes or No

Marital status: _____ Sex F or M Email: _____

Alternate address (physical address if you are out of state or have a PO Box in case of emergency):

Employer (name, phone, address) _____

Guarantor (Person responsible for bill if not paid by insurance) *CANNOT BE A MINOR*

Name _____ DOB: _____ Relation to Pt. _____

Address (if different from above) _____ Phone: (____) _____ - _____

Insurance Information

Holder of insurance (subscriber): _____ DOB: _____ Relation to Pt. _____

Address (if different from above) _____ Phone#: _____

Contacts and HIPAA information

***Family members or friends whom we may discuss your healthcare with:**

Contact # 1: _____ Relation to pt: _____ Phone: ____ - ____ - _____

Contact # 2: _____ Relation to pt: _____ Phone: ____ - ____ - _____

Do not discuss my healthcare with anyone

I hereby authorize payment directly to FHFP for medical benefits and the release of any information necessary to process claims for said services and authorization to release medical records pertaining to my treatment to my insurances or other third party. I also agree to pay all charges and/or copays at the time of service. In the event of default, I promise to pay all legal fees, collection costs, and/or interests as may be required. Information on this form is accurate and I am responsible for payment of treatment. **I have received and acknowledge the HIPAA privacy policy.**

Signed: _____ Date: _____

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Patients are responsible for the cost of services rendered.

Co-pays are due at the time of service. Payment is due at the time of service for self pay patients. Extended payment plans must be made in advance.

Patients are responsible for providing their current insurance information, address, and phone number(s) at **every** visit.

We will bill insurance companies but, there still may be a substantial amount owed by the patient even after the insurance company is billed (e.g. deductibles, coinsurances). If you request a well visit, that is how it will be billed. We do not bill secondary insurance companies.

We are not responsible for knowing your benefits.

We will help direct your care to specialists and outside testing but, it is the **patient's** responsibility to make sure they have coverage at these places. **LAB & XRAY costs** are the patient's responsibility. Please check with your insurance company for your coverage regarding tests and which facilities your insurance wants you to use.

Workman's compensation patients must have all the necessary information from their employer before they can be seen.

Returned checks will be charged a \$25 fee. If your account is sent to collections, there will be an additional \$35 fee added to the balance. Prescriptions will not be renewed or visits will not be allowed until the balance is paid.

Medicare Patients: We do not participate with Medicare. Payment is due at the time of service. We will bill Medicare limiting fees for you. Medicare will bill your secondary insurance company as long as you inform them which company you contract with. There may be a 10-20% difference in what you receive in reimbursement versus the Medicare limiting fees. We do NOT bill Medicare as a secondary insurance.

There will be a fee for a copy of your medical records based on the quantity of records copied.

Consults with a physician must always be done as an office visit not over the telephone.

Our goal is to treat everyone the same regardless of their insurance situation. Please do not hesitate to ask questions regarding this policy.

I have read and understand the financial policy.

Signed: _____ **Date:** _____