Primary Care of Jamestown

Patient Registration Information

Please **PRINT** and complete **ALL** sections below and return to the front desk with Insurance Cards

PATIENT'S PERSONAL INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

MAIDEN NAME: _____ NICKNAME (GOES BY ANOTHER NAME): _____

DATE OF BIRTH: _____ / _____ / _____ SOCIAL SECURITY # : _____ - _____ - _____

ADDRESS: _____ APT # : _____ CITY: _____ ST: _____ ZIP: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

RELATIONSHIP: _____ SELF _____ SPOUSE _____ PARENT OTHER: _____

PRIMARY CARE OF JAMESTOWN, LLC HAS MY PERMISSION TO LEAVE MESSAGES AT THE ABOVE NUMBERS: ____ YES ____ NO

PATIENT SIGNATURE: _____ DATE: _____

A GUARANTOR IS THE PERSON WHO IS RESPONSIBLE FOR ANY UNPAID BALANCE, USUALLY IS PARENT OR LEGAL GUARDIAN OF A MINOR CHILD. AN INSURANCE POLICYHOLIDER IS THE PERSON WHO CARRIES COVERAGE FOR THE PATIENT, BUT MAY NOT BE RESPONSIABLE FOR UNPAID BALANCE (EX: A SPOUSE IS THE POLICYHOLDER FOR A PATIENT). PARENTS OR LEGAL GUARDIANS MAY BE BOTH GUARANTOR AND INSURANCE POLICYHOLDER FOR A MINOR CHILD. IT IS RESPONSIBILITY THAT WE HAVE CORRECT INFORMATION TO INSURE PROPER BILLING.

PLEASE MARK ONE: IS THE PERSON LISTED BELOW THE GUARANTOR OR INSURANCE POLICYHOLDER FOR PATIENT? ___ GUARANTOR ___ INSURANCE POLICYHOLDER

GUARANTOR/INSURANCE POLICYHOLDER INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

DATE OF BIRTH: _____ / _____ / _____ SOCIAL SECURITY # : _____ - _____ - _____

ADDRESS: _____ APT # : _____ CITY: _____ ST: _____ ZIP: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

RELATIONSHIP: _____ SELF _____ SPOUSE _____ PARENT OTHER: _____

EMERGENCY CONTACT ******Please list someone who does NOT live with you that can reach you******

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

PRIMARY PHONE: _____ SECONDARY PHONE: _____

RELATIONSHIP: _____

SECONDARY FACILITIES *PLEASE LIST ANY HOME HEALTH, SITTER SERVICE, OR DURABLE MEDICAL EQUIPMENT COMPANIES YOU USE*

HOME HEALTH AGENCY: _____ CITY: _____ PHONE: _____

SITTER SERVICE AGENCY: _____ CITY: _____ PHONE: _____

MEDICAL EQUIPMENT AGENCY: _____ CITY: _____ PHONE: _____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHONE: _____

CITY: _____ ST: _____ ZIP: _____

Primary Care of Jamestown

FINANCIAL AGREEMENT:

To reduce the confusion and misunderstanding between our patients and practice, we have adopted the following policies and procedures. If you have any questions regarding these policies, please discuss them with the billing manager. We are dedicated to providing the best possible care and service to you. We request complete understanding of your financial responsibilities as an essential element of your care and treatment.

- We have made prior arrangements with many insurers and health plans to accept assignments of benefits. This means we will bill your insurance carrier and will only require you to pay the co-pay, and/or co-insurance at the time of service.
- We will accept cash, credit or debit card, money order or cashier's check for your convenience.
- If you have Medicare and a secondary coverage, it is your responsibility to understand what your secondary insurance covers in relation to your Medicare deductible and/or co-insurance. Out of Pocket expenses (co-pays, deductibles, co-insurance) are due at time of your visit.
- If you have Medicare Part B only, you are responsible for your deductible and your 20% co-insurance of the allowable charges. These are due at time of your appointment.
- If you fail to notify us of an insurance change, you are responsible for any amount not paid by your insurance company.
- All health plans are not the same and do not cover the same services. In the event that your health plan determines a service to be "not covered", **you will be responsible for the complete charge.**
- Patients with no Insurance are required to pay for the visit in full at the time of the service.
- We will bill your health plan for all services provided by our provider at **Primary Care of Jamestown, LLC**. Any balance due is your responsibility and is due in full, within 10 days of a statement from our office, unless other arrangements have been made. Statements are sent out monthly. If you find you have a large balance and would like to arrange a payment plan, we may be able to help you. ***Please call our billing department at 931-200-2246 to make arrangements.***
- If payment is not received in a timely manner and collections become necessary, the signature below shall serve as authorization to release the information to collection agencies selected by the provider(s) who have provided service to me.

ACKNOWLEDGEMENTS, AUTHORIZATIONS ASSIGNMENTS, AND CONSENT TO TREAT:

- To the best of my knowledge the information on the patient registration form is complete and correct.
- I have read and understand the HIPAA/Privacy Policy for **Primary Care of Jamestown, LLC**.
- I hereby authorize the release of any medical and other information (necessary to process my claim) to my insurance carrier or the Center of Medicare and Medicaid Services and its agents.
- I understand that payment for services is my responsibility. My insurance carrier(s) will be billed for these services as a courtesy. Any uncovered charges, deductibles, co-pay, or co-insurance will be my responsibility.
- I assign and authorize payments of medical benefits to be made directly to the medical provider(s) who have treated me or rendered services and materials.
- **MEDICARE/MEDICAID AUTHORIZATION:** I request that payment of authorized Medicare or Medicaid benefits be made on my behalf to **Primary Care of Jamestown, LLC**.
- I have read and understand the financial policy of **Primary Care of Jamestown, LLC** and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.
- I consent to treatment from providers employed by **Primary Care of Jamestown, LLC**.
- I authorize **Primary Care of Jamestown LLC** to obtain/have access to my medication history as electronically provided by my pharmacy.
- I authorize my provider's office to contact me and leave appointment information at the numbers listed on the patient registration form.

Primary Care of Jamestown

CLINIC POLICIES:

- Please let the front desk know of any changes in your address, phone number, or insurance.
- Please let the nurses know of any changes in your pharmacy.
- Please bring **ALL** of your medications in the bottles to every visit. This will ensure that we have the correct medication list.
- If you are unable to come to a scheduled appointment, please call 24 hours in advance to cancel or reschedule the appointment. Appointments that are not cancelled are considered **"no shows"**. Patients with 3 or more no shows in a 6 month period will be considered non-compliant. **Primary Care of Jamestown, LLC** reserves the right to terminate its relationship with the patient for non-compliance.
- Refill should be requested during your office visit. Refill requests left on a nurse's refill line may take up to 72 hours to be processed and called in.
- Please do not wait until you are completely out of medication to call in a refill as it will take the provider until at least end of day to submit the request to your pharmacy.
- Controlled Medications **WILL NOT** be filled without an appointment. **NO EXCEPTIONS!** Please make your follow up appointment accordingly and bring in medication bottles for appointment, empty or with medication still in them.
- Any patient taking a Controlled Medication is subject to random medication counts. Our nursing staff will contact you that morning asking you to come in with your medication by End of Day for a controlled medication count. Failure to come in at an appointed time will result in controlled medications being tapered down and discontinued for non compliance.
- As a courtesy, our staff will call you 24-48 hours in advance of your appointment to remind you of the time. If you have had any test done, labs drawn, seen any specialist or other provider, or been in the hospital, please make sure to tell us before your appointment so that we can have these records ready.
- It is essential that we have a good communication system with our patients. To help with this, please contact us immediately if you have a phone number change. An inability to contact you via phone for extended periods of time will be considered non-compliance. **Primary Care of Jamestown LLC** reserves the right to terminate any patient relationship due to non-compliance.
- Test results will be called **AFTER** the provider has reviewed them. Abnormal test results will require an office visit to discuss findings and treatment options. Normal lab results will be reviewed with patients at their next scheduled appointment.
- Referrals for specialists and prior authorizations for tests and medications is time consuming depending on the insurance you have. We work on these DAILY and will contact you as soon as we have all of the information completed. Multiple calls regarding the status of your referral slow down the process. If you have any questions regarding a referral or prior authorization, please leave a message and a nurse staff member will contact you within 24-48 hours. Once again, having the correct phone numbers and voice mails is vital to the communication process.
- Messages will be returned by staff AFTER they have discussed the message with the provider. Usually this is done after clinic patients have been seen. Please understand if it takes a little longer to return your message as they are handled in which they are received.
- Completing FMLA, disability, and workman's comp forms and printing medical records is time consuming and goes beyond routine daily medical care that cannot be billed to insurance companies. Therefore, payment may be required upon the completion of these services. Please see the front desk for cost and more information. Please allow 7 working business days for these forms to be completed. They can be picked up at the front desk.

I have read and understood the financial information policy, acknowledgements, authorizations, consent to treatment and clinical policies and I agree to be bound by these terms. I also understand and agree that such terms may be amended from time to time by Primary Care of Jamestown, LLC

Patient Signature: _____ Date: _____

Minor Patient Parent or Legal Guardian Signature: _____ Date: _____

Primary Care of Jamestown

PRACTICE INFORMATION

YOUR APPOINTMENT

Your time is important to us. Your Appointment was scheduled based on the **reason you gave us** when you scheduled your appointment. If you have additional problems or need to discuss other concerns with your provider, we will have to schedule a separate appointment to address these problems/concerns. This will allow us to be considerate of other patients' appointments.

CONFIRMING YOUR APPOINTMENT

Due to the high demand for primary care appointments and frequent no-shows, we do require you to confirm your appointment prior to your scheduled appointment. As a courtesy, we work to confirm your appointment by a phone call. We know how easy it is to forget your appointment you booked months ago. Please understand that it is your responsibility to remember your appointment dates and times. Not receiving notification of your appointments from us is not sufficient reason to miss an appointment. Please call our clinic at 931-879-5864 if you have any questions or concerns or need to update your contact information.

LATE ARRIVALS

Out of respect for other patients arriving on time, if you arrive more than 20 minutes late, you may be asked to reschedule. However, arriving less than 20 minutes late **DOES NOT** guarantee that you will be seen. It is at the discretion of your health care provider whether you can be worked back into the schedule.

YOUR PRESCRIPTIONS

Prescriptions are sent electronically to your pharmacy. This often means that your prescription will not be ready for pickup until the end of the day. We strongly recommend you call your pharmacy to make sure your prescriptions are ready before going to pick them up.

Insurance companies often change their list of “preferred drugs”. We try very hard to keep current with these changes. However, you may find that your insurance company has rejected your prescription because it is not on their “preferred list”. Again, we recommend that you call your pharmacy to make sure your prescription(s) are ready before going to pick them up. If your prescription is rejected by your insurance because it is not on their “preferred list”, additional time will be required for approval of a substitute medication.

CANCELLATION/NO-SHOW POLICY

We respectfully request for a 24 hours notice if you will be unable to keep your scheduled appointment. If you have more than three (3) no-show occurrences, you may be discharged from the practice. **PROCEDURES:** If you cancel or miss a procedure appointment without providing at least 24 hours' notice, you may not be eligible to reschedule your procedure. Your new appointment will be booked based on the provider's next available time. If you miss two procedures without proper notice within a 12-month period, you may be discharged from the practice for non-compliance. We will call to confirm this appointment the business day before your appointment. If you need to update your contact information, please update this with the receptionist or call us directly at 931-879-5864.

CONSENT TO TREAT MINORS

Minors, persons under the age of 18, must be accompanied by a parent or legal guardian for all appointments.

Patient Name (please print): _____ **DOB:** _____

Patient Signature: _____ **Parent/Legal Guardian:** _____

Primary Care of Jamestown

RELEASE OF MEDICAL RECORDS

PERMISSION TO RECEIVE OR SEND RECORDS

I, _____, with a date of birth, _____, give my permission to receive/send my records to **Primary Care of Jamestown, LLC** so that he/she can better understand my condition and help me.

REQUESTING RECORDS FROM:

Name of Provider/Practice: _____

Fax Number: _____ Phone Number: _____

Address: _____

Types of Records that we are requesting:

- ☐ Any and all information/types of records you have for patient
- ☐ DoctorVisit Notes
- ☐ Emergency Room Notes
- ☐ Urgent Care Notes
- ☐ History & Physical
- ☐ Operation/Procedure Notes
- ☐ Clinic Notes
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Consultations
- ☐ Nurses Orders
- ☐ Doctors' Orders
- ☐ Discharge Summary
- ☐ Other: _____

Records within the following dates:

- ☐ All records for this patient
- ☐ Records dated between _____ and _____

Patient's Signature: _____ Date: _____

Authorized Witness Signature: _____ Date: _____

Primary Care of Jamestown

MEDICAL INFORMATION RELEASE FORM

(HIPAA Release Form)

Name: _____ Date of Birth: _____

Discuss/Release Information from my records:

- ☐ I authorize Primary Care of Jamestown, LLC to discuss/release information including diagnosis, records, exams, or claims information to:
- ☐ Spouse: _____
- ☐ Children: _____
- ☐ Other Individuals: _____
- ☐ I DO NOT authorize information to be discussed/released to anyone.

This form will remain in effect until terminated by the patient in writing.

Messages:

Please call (mark one): ____ Home ___ Work ___ Cell Number: _____

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Other: _____

The best time to reach me is ___ Morning ____ Evening between (times) _____

Patient Signature: _____ Date: _____