



PATIENT REGISTRATION

Demographics

Name (First, MI, Last): _____ Preferred Name: _____

Date of Birth: ____ / ____ / _____

Social Security #: ____ - ____ - _____

Driver's License #: _____

Sex Assigned at Birth (circle one): M F Gender Identity: _____

Marital Status (circle one): Single Married Divorced Widowed Other (specify): _____

Contact Information

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

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

May we leave a detailed message on your voicemail (circle one): Yes No

With whom may we speak regarding your health information?

Name: _____ Relationship: _____ Phone #: (____) ____ - _____

Name: _____ Relationship: _____ Phone #: (____) ____ - _____

For Minors Only, please indicate with whom child lives: _____

Occupation

Employer Name: _____

Employer Address: _____

Job Title: _____

Insurance Information

Primary Insurance Company _____ Secondary Insurance Company _____

Policy/ID# _____ Policy/ID# _____

Group # _____ Group # _____

Policyholder's name _____ Policyholder's name _____

Policyholder's SS# _____ Policyholder's SS# _____

Policyholder's DOB _____ Policyholder's DOB _____

Employer name _____ Employer name _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care. To avoid any questions or problems, we need your assistance and understanding of our financial policy.

1. All co-pays are due at the time of service. There is a \$5.00 fee for any co-pay not paid on the date the services are provided. Even if you have a secondary insurance that picks up your co-pay, you are responsible for paying the co-pay. We will abide by the contract we have with your primary insurance company.
2. There is a \$50.00 fee for any appointment that is not cancelled 24 hours before your scheduled appointment time. Two "NO SHOW" appointments will be grounds for dismissal from the practice. A \$50.00 "NO SHOW" fee will be applied for any missed appointment.
3. Insurance is a contract between you and your insurance company. We will file your insurance claims as a courtesy to you. You agree to pay any portion of the charges not covered by insurance. We will file your insurance claims on time. If no payment is made, the balance is your responsibility. We emphasize that as a medical provider, our relationship is with YOU and NOT your insurance company. We cannot be responsible for any loss of benefits. It is YOUR responsibility to know your policy.
4. Not all services are covered benefits in all insurance contracts. Some insurance companies select certain services they will not cover and regardless of our participation with a plan, payment for any non-covered services will be the patient's responsibility.
5. In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for any charges or co-pays. It is the authorizing parent's responsibility to collect from the other parent if necessary.
6. There is a \$40.00 fee for any returned check. Payment will need to be made by cash, credit card, or cashier's check within 14 days for the amount due, and the returned check fee.
7. Accounts over 60 days old are subject to a billing fee.
8. Accounts over 90 days old are subject to a \$5.00 delinquent fee. Balances will need to be paid in full at this time to avoid dismissal from the practice and the account being sent over to collections.
9. Accounts over 120 days old or accounts for whatever reason are dismissed from the practice are subject to a \$15.00 dismissal fee.
10. Accounts that are sent to collections are subject to the collection agency's fees that are charged to Medical and Surgical Associates, which is usually 30% of the balance sent to collections. The balance includes any interest added, delinquent and dismissal fees,
11. There is a \$10.00 fee for any records transferred to another physician. The fee increased to \$25.00 if you have an unpaid balance at the time of transfer or if you have been dismissed from the practice. Once your records have been transferred, no further appointments will be made with our office. This aforementioned clause is applicable if you have been dismissed from our practice.
12. There may be a \$20.00 fee for any medication prior authorization your insurance requires.
13. There may be a charge for forms filled out by a physician.

Signature of Patient or Guardian: _____ Date: _____

If guardian, please print name and relationship to patient: _____



AUTHORIZATIONS

- (1) We participate in one or more Health Information Exchanges. Your Healthcare providers can use this network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers may allow access to your Health Information through the Health Information Exchange for treatment, payment, or other healthcare operations. This is a voluntary agreement. You may opt out at any time by notifying Medical and Surgical Associates Staff or the office Administrator.

Signature of Patient or Guardian: _____ Date: _____
If guardian, please print name and relationship to patient: _____

- (2) I hereby authorize Medical and Surgical Associates, Inc. and/or any of its representatives to disclose medical or other information obtained in the course of my diagnosis and treatment to any government and/or third party (insurance) payer, or any other entity required by law. I permit a copy of this authorization to be used in place of the original, and request payment of any insurance benefits to Medical and Surgical Associates, Inc. or myself. I further authorize the disclosure of my diagnosis and treatment records, including the charges for the same to any billing service, attorney, or debt collection agency selected by Medical and Surgical Associates, Inc. Said disclosure shall be solely for the collection of charges incurred for treatment provided by Medical and Surgical Associates, Inc. to me and/or my spouse and children. I will notify you of any changes made in my health status or insurance information.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware I may be responsible for all charges that are incurred.

Signature of Patient or Guardian: _____ Date: _____
If guardian, please print name and relationship to patient: _____

- (3) This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your healthcare information.

I hereby give my consent to Medical and Surgical Associates, Inc. to use and disclose my protected health information for the purpose of treatment, payment and operations of my healthcare at this practice.

Consent for treatment: I, with my signature, authorize (this practice), and any employee working under the direction of the physician, to provide medical care for me, or this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not be limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other healthcare professionals for care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care.

Consent related to the Privacy Notice: I have had a chance to review the Privacy Practice Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take effect until the practice receives it.

Signature of Patient or Guardian: _____ Date: _____
If guardian, please print name and relationship to patient: _____

IF REVOKING THE ABOVE CONSENT, PLEASE SIGN/DATE BELOW:

Signature of Patient or Guardian: _____ Date: _____
If guardian, please print name and relationship to patient: _____

Practice Privacy Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

I.

- This is a formal notification, as required by the government concerning the privacy policy of this practice. This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as "PHI" or protected health information. This new policy requires that you, the patient, identify at the time of registration with us specific information about release of information. You can change this information at any time with either written notification or verbal notification, followed up in writing. Changes can only impact the care or information from that point in time forward.

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying [the Health Information Management Services/Medical Records Department [] OR [the office administrator].

11. Your protected health information (PHI) is a part of your medical care, and can be used or disclosed as follows:

- For your treatment in this practice and other locations under the immediate care for care needs. This may include any referral for services; diagnostic tests or treatment related to your medical care needs.
- For obtaining payment for treatment with your identified health care program. This would include any documentation related to this care, including history forms, progress notes or operative notes. This would include eligibility verification, prior authorization and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders and health related benefit services only with your consent identified on the registration form • Disclosure to your family and friends concerning any related health care information with your on the registration form which can be modified at any time orally, followed by written consent.
- Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician requires information for care on your behalf.

Certain disclosures can be made without our consent and they are as follows:

- Disclosure required by the government or law enforcement agencies. An example would be victims of abuse • Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking. Specific governmental functions
- Information used for health care oversight, such as a site review by an insurance program,

III. Yours rights for your health information include: The right to request limits on the uses and disclosure at registration or any time during your care. The right to choose how we send this information to you, including an alternate address.

The right to see and obtain copies of your PHI, but there may be copy and postage fees. The right to get a listing of which we have made disclosures to about your PHI. The right to correct your file through an amendment process if appropriate.

IV. This practice reserves the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

V. If you have a concern or complaint about how your protected health information is being used, from this time forward you should first contact our Practice Administrator at our Business office to resolve your concerns or you may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA. Palmetto.

Office of Civil Rights - Regional Manager	Palmetto GBA
Department of Health & Human Services	Part B Operations — HIPAA Compliance Concerns
233 N. Michigan Avenue, Suite 240	PO Box 18957
Chicago, Illinois 60601	Columbus, Ohio 43218

Patient signature on receipt of Privacy Notice: _____