Memorial MEDICAL GROUP

PATIENT INFORMATION

PERSONAL INFORMATION

Name: _____
Last Name First Name Middle Initial

Date of Birth: **Social Security Number:** **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other

Hand Dominance: ☐ Left Hand ☐ Right Hand **Date of Last Physical Exam:**_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other:_____ **Primary Language:**_____

Home Address: _____
Street City State Zip Code

Home Phone: **Work Phone:** **Cell Phone:**

Email Address:

Pharmacy: _____
Name Street City State Zip Code

REFERRAL INFORMATION

Primary Care Physician: **Referring Physician:**

Physician of Record (BWC):

What is your preferred appointment reminder method? ☐ Phone Call ☐ Text Message

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Name: _____
Last Name First Name Middle Initial

Relationship to Patient: ☐ Self (*if self, skip to Emergency Contact*) ☐ Spouse ☐ Parent ☐ Other

Home Address: _____
Street City State Zip Code

Date of Birth: **Primary Phone:** **Secondary Phone:**

Email Address: **Social Security Number:**

Primary Insurance: **Identification Number:**

EMERGENCY CONTACT INFORMATION

Name: _____
Last Name First Name Middle Initial

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other:_____ **DOB:** _____

Home Address: _____
Street City State Zip Code

Home Phone: **Work Phone:** **Cell Phone:**

Oftentimes we may need to contact you regarding your medical care or any related concerns. In an effort to protect your privacy, we have established a procedure we will follow when leaving messages:

- We will ***NOT*** leave messages with anyone except the patient or legal guardian.
- We will ***NOT*** leave any messages on your voicemail or answering machine.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

I, _____ authorize Memorial Medical Group to speak with and/or leave messages regarding my medical care with the contacts and/or the numbers listed below. I fully understand that this consent will remain valid until I notify otherwise.

Please indicate below who we are authorized to speak with regarding your care.

Contact Name	Phone Number	Relationship
1.		
2.		
3.		

Please indicate below the numbers in which we are authorized to leave messages regarding your care.

My **CELLPHONE** voicemail phone number: _____

My **HOME** answering machine phone number: _____

My **OFFICE/WORK** phone number: _____

Do you have a Legal Guardian or Power of Attorney for Healthcare? ☐ Yes ☐ No

Contact Name: **Contact Phone Number:**

Signature (Patient or Legal Representative):	**Date:**

I, _____ **DO NOT** authorize Memorial Medical Group to speak with anyone other than myself or leave messages regarding my medical care. I fully understand that this consent will remain valid until I notify otherwise.

Signature (Patient or Legal Representative):	**Date:**

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is provided to avoid any misunderstanding or disagreement concerning payment for services, tests, and supplies provided by our office(s).

INSURANCE

Our office participates with a variety of insurance plans. It is your responsibility to:

1. Bring your current insurance card to every visit and notify us of any changes regarding your insurance coverage.
2. **Be prepared to pay your co-pay, coinsurance and/or deductible at the time of service.** Payment may be made by cash, check, Discover, MasterCard, or Visa. All co-pays and deductible amounts owed are due at the time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service. If you have elected to use our practice and our physicians out of your network of coverage please check with your insurance regarding benefit levels. Your employer or provider of insurance determines your benefit coverage by contracting with a particular insurance company. If you have questions regarding your coverage, please speak with your human resources representative or use the payer web address listed on your card. It is your responsibility to understand your benefit coverage.
3. We will submit a claim to your insurance company for you through our billing company, MedComm Billing Consultants. Balances not paid per contract with your primary insurance company may be billed to your secondary insurance.
4. Understand that your insurance carrier can choose to assign benefits to Memorial Medical Group or your insurance carrier may make payment directly to you.
5. I understand and agree that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier.

PAYMENT DETAILS

We accept Cash, check, Discover, MasterCard, or Visa. We have the capability to accept payments over the phone with your debit or credit card account information. We reserve the right to process your payment electronically based on the information you provide us.

SURGICAL AND LABORATORY SERVICES

If you are having surgery at Memorial Hospital, the hospital and anesthesiology services are separate providers and will be billed separately from the office services provided to you. Laboratory services provided at our office are also provided by Memorial Hospital and will also be billed separately from the office services provided to you.

NON-COVERED SERVICES

If you are seeking a non-covered service, do not have insurance, or if you are covered by an insurance for which we are not a provider, we require that you be prepared to pay our fees at the time services are rendered. You may inquire with our staff about self-pay cash discounts for payment at the time of service.

If temporary financial problems affect timely payment on your account you may set up a payment plan.

Specific coverage issues should be directed to your insurance company's member services department (the number should be located on the back of your insurance card).

Our office(s) charges for all services that are significant and separately identifiable. Patients that are seen for physical exams and require treatment for illnesses or problems may be charged separately for each service when both are provided on the same day.

Our office(s) can only code and file a claim for a patient's visit with a diagnosis that was encountered and documented in the medical record.

Memorial MEDICAL GROUP

COLLECTIONS

All balances billed are due upon receipt of a statement. Unpaid balances greater than 90 days are subject to our collection process.

RETURNED CHECKS

There is a $20.00 fee charged for all returned checks.

SMALL BALANCE POLICY

If a credit or due balance exists on your account equal to $9.99 or less, and is more than 90 days old, the account will be automatically adjusted according to our small balance policy. If you are seen within the 90 day period, the small balance will either be credited to your account or requested at the time of service. Following the 90 day period, we will not issue any refunds or send statements for balances equal to or less than $9.99.

APPOINTMENT CANCELATIONS/NO-SHOWS

If you cancel, miss or no-show for three (3) appointments you may be dismissed from the office(s) for not complying with the plan of care you and your physician(s) have discussed.

HIGH DEDUCTIBLE HEALTH PLANS (HSA, HRA, FSA PARTICIPANTS)

Please inform us prior to your visit if you are a participant in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). You must be prepared with the plan information and pay the patient responsible portion from the HSA, HRA or FSA at the time of service.

MINOR AGED PATIENTS

Adults accompanying minor patients (parent or legal guardian) will be required to complete a Release of Liability and Permission Form. The parent or legal guardian is responsible for payment of any financial balances for that minor not covered by insurance. For unaccompanied minors, treatment will be denied unless the proper paperwork is received, and the insurance card lists the minor's name.
I have read, understand and agree with this Financial Policy.

CONTACT AUTHORIZATION

I authorize Memorial Hospital and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

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Printed Name (Patient or Legal Representative):		**Date:**
Signature (Patient or Legal Representative):		**Date:**
	Office Staff Initials:	**Date:**

Patient Name: **Date of Birth:**

NOTIFICATION TO ALL PATIENTS

The rigid regulations of the insurance industry require us to have you sign the following release:

I agree to pay for any and all medical services I receive from the provider(s) of this office(s) that my insurance company refuses to pay, for whatever reason. This office(s) will file a claim on my behalf, however, if my insurance denies payment for any reason (i.e. non-covered services, does not pay for preventive medical visits, failure to secure a referral from my primary care physician, etc.) I will pay for the visit(s) upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is for the purpose of this agreement and constitutes a refusal to pay.

I further agree and understand that this office(s) can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus to ask this office(s) to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

INSURANCE RELEASE

I hereby assign all medical benefits to which I am entitled to Memorial Medical Group in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount due as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney fees, and all court and legal fees associated with the recovery of this debt. I hereby authorize Memorial Medical Group to release all information necessary to secure the payment of said benefits. A copy of this consent shall be considered as effective and valid as the original.

CONSENT TO TREAT

I do hereby consent to such treatment by the authorized personnel of this office(s) as may be dictated by prudent medical practice of my illness, injury or condition. I authorize this office(s) to download my prescription history and eligibility benefits prior to my visit(s) for the purposes of medical decision making and eligibility verification. This consent is intended as a waiver of liability for such treatment with the exception of negligent acts.

Responsible Party Signature:	**Date:**

HIPAA RECEIPT CONFIRMATION: I have received a copy of Memorial Medical Group's *Notice of Privacy Practices*. Additional copies can be provided upon your request.

Responsible Party Signature:		**Date:**
	Office Staff Initials:	**Date:**

Memorial MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: **Date of Birth:**

AUTHORIZATION: I hereby authorize _____ to release/disclose the above named individual's health information. The applicable contents and purpose for disclosure is selected below: *(check all that apply)*

Date(s) of Service:

CONTENTS:

- ☐Entire Record
- ☐Assessment/History and Physical
- ☐Discharge Summary
- ☐Lab Tests
- ☐Radiology Reports
- ☐Behavioral/Mental Health Visits
- ☐Other:_____

PURPOSE:

- ☐Insurance/Third Party reimbursement
- ☐Continuity of care
- ☐Pending legal matter
- ☐At the request of the patient
- ☐Other:_____

I understand that the information in my medical record may include information relating to sexually transmitted disease and acquired immunodeficiency virus (HPV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization I am authorizing the release of such information unless specified otherwise.

THE INFORMATION IS TO BE RELEASED TO:

Name:

Address:

Fax Number:

Patient is aware of confidentiality risks involved and releases Memorial Medical Group of responsibility of this fax transmission.

RESTRICTIONS: According to the Federal and State regulations, if the medical information requested relates to AIDS/HIV or treatment in a federally-recognized chemical dependency unit, then the information will be accompanied with a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the requested information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

DURATION: This authorization will remain valid for 1 year from the date below. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to my authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

Signature (Patient or Legal Representative):	**Date:**

Memorial MEDICAL GROUP

HISTORY FORM

Patient Name: **Date of Birth:**

Chief Complaint (s) Reason for your visit

1.
2.
3.
4.
5.

Allergies: (please check all that apply)

☐ Aspirin	☐ Vicodin	☐ Codeine
☐ Penicilli	☐ Percocet	☐ Latex
☐ n Sulfa	☐ Topical Iodine	☐ IV Contrast

Other(s): _____

_____

Hospitalization / Surgical History

Hospitalization / Surgery	Date / Year

Social History

Type:			Amount Daily	Years
Alcohol	Yes ☐	No ☐		
Caffeine	Yes ☐	No ☐		
Illegal Drugs	Yes ☐	No ☐		
Marijuana	Yes ☐	No ☐		
Tobacco	Yes ☐	No ☐	Packs:	

Immunization History

Immunization	Date / Year
Hepatitis A	
Hepatitis B	
Human Papillomavirus (HPV)	
Influenza	
Measles, Mumps, Rubella (MMR)	
Pneumonia	
Prevnar 13	
Tetanus, Diphtheria, Pertussis (Tdap)	
Varicella	
Zoster (Shingles)	
Tetanus	

Examination / Test History

Examination / Test	Date / Year	Result (abnormal, normal, high, low)
Bone Density		
Breast Exam		
Cholesterol		
Colonoscopy		
Eye Exam		
Hearing Test		
Hemoglobin A1C		
Mammogram		
PAP / Pelvic Exam		
PSA Screening		
TB Test		

Patient Name: **Date of Birth:**

Past Medical History *(check all that apply)*	
☐ AIDS/HIV	☐ Infectious Mono
☐ Allergies	☐ Kidney Disease
	☐ Learning Disorder
☐ Anemia	☐ Measles
☐ Arthritis	☐ Migraines
☐ Asthma	☐ Mumps
☐ Back Pain	☐ Neuropathy
☐ Bladder Infection	☐ Osteoporosis
☐ Blood Clots/ DVTs/ Pulmonary Embolus	☐ Pneumonia
☐ Bronchitis	☐ Polio
☐ Cancer Type:	☐ Pulmonary/ Respiratory Disease
☐ Chicken Pox	☐ Rheumatic Fever
☐ Diabetes	☐ Scarlet Fever
☐ Diphtheria	☐ Sleep Apnea
☐ Eczema/ Hives	☐ Small Pox
☐ Epilepsy	☐ Stroke
☐ Glaucoma	☐ Thyroid Disease
☐ Heart Attack	☐ Tuberculosis
☐ Hemorrhoids	☐ Transfusions
☐ Hepatitis	☐ Ulcer
☐ Hernia	☐ Sexually Transmitted Disease
	☐ Sickle Cell Disease
☐ High Blood Pressure	☐ Whooping Cough
☐ Other:	
☐ Other:	

Family History *(check all that apply)*	**Relationship**
☐ Allergies	
☐ Alzheimer's	
☐ Anemia	
☐ Cancer (see below) Type:	
☐ Dementia	
☐ Diabetes	
☐ Epilepsy	
☐ Glaucoma	
☐ Heart Disease	
☐ Hypertension	
☐ Parkinson's	
☐ Stroke	
☐ Tuberculosis	
☐ Other:	
☐ Other:	
☐ Other	

***Women Only**	
Are you currently pregnant? ☐ Yes ☐ No	
Are you currently breastfeeding? ☐ Yes ☐ No	
Age of First period:	Pregnancies (#):
Date of Last period:	Miscarriages (#):
Birth Control:	Abortions (#):

Patient Name: **Date of Birth:**

Current Medications *(Please include over the counter medications, herbal supplements, vitamins, etc.)*		
Medication:	**Dosage:**	**Directions:**

List any Specialists you have seen and the medical condition they have diagnosed		
Specialist Name:	**Condition:**	**Date:**