Pocahontas Medical Clinic

PATIENT INFORMATION

Name:	Date of Birth:
Address One:	Social Security #:
Address Two:	Sex: Marital Status:
City:	Employer:
State: Zip:	Spouse:
Home Phone#:	Spouse Contact Ph#:
Work Phone#:	Emergency Contact:
Cell Phone#:	Contact Ph #:
Race:	Contact Cell #:
Ethnicity:	2nd Emergency Contact:
Language:	2nd Contact Ph#:
PCP:	2nd Contact Cell#:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
Address Two:	
City:	
State: Zip:	Employer:
Home Phone#:	Employer City:
Work Phone#:	Employer State: Zip:
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

Pocahontas Medical Clinic

Financial Policy

Our goal is to provide and maintain a good physician/patient relationship. In order to maintain this high level of care, we feel it is important to communicate our office policy below: *Please read, sign and date. If you have any questions please do not hesitate to ask a member of our staff.*

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. **Co-payments, deductibles and co-insurances are due at the time of service.**
2) Self-pay patients are expected to pay for services in FULL at the time of the visit- a minimal payment is due prior to physician office visit; new patients $100.00 and established patients $50.00. Labs, x-ray, ancillary, etc will be an additional charge.
3) Outstanding balances must be paid prior to scheduled visit or payment arrangement must be set with the Billing Department.
4) A payment must be made on any outstanding collection account balance at time of appointment.
5) A monthly payment is expected on any outstanding balance. If no payment is made within 90days, further action may be taken with our collection agency.
6) We accept cash, checks, Visa, and MasterCard credit and debit.
7) A $20.00 fee will be charged for any checks returned for insufficient funds.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____ **DOB**_____

Responsible Party Member's Name _____ **Relationship**_____

Responsible Party Member's Signature _____ **Date** _____

On completion, we will provide you with a copy for your records.

Effective September 2013

POCAHONTAS MEDICAL CLINIC, P.A.

Receipt of Notice of Privacy Practices
Written Acknowledgment Form

I, _____, have received a copy of the above named practice's Notice of Privacy Practices.

X_____ _____

Signature of Patient/Guardian Date

Patient Consent

I voluntarily consent to treatment for myself, my child, or dependent, from the healthcare providers at the Pocahontas Medical Clinic, including treatment by the physicians and nurse practitioners under the supervision of the physician.

X_____ _____

Signature of Patient/Guardian Date

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Pocahontas Medical Clinic, when he accepts assignment. I am financially responsible or any services not paid for by insurance.

Authorization To Release Medical Information: I hereby authorize my Provider, Pocahontas Medical Clinic, to release any information necessary for my course of treatment.

X_____ _____

Signed (patient or parent if minor) Date