

COMMUNICATIONS

Who should we contact in case of an emergency? _____

Phone () _____

I hereby authorize Dr Emery-Culberson to release any information regarding my illness and treatment to the following person(s)

_____ phone () _____

Please thank _____ for referring me.

Primary Care Doctor _____

Primary Care Clinic Name & Date of last visit _____

PRIMARY INSURANCE COVERAGE

Primary Insurance Carrier _____

Policy Holder's Name _____

Policy Holder's SS# ____/____/____ Date of Birth ____/____/____

Relationship to Patient _____

SECONDARY INSURANCE COVERAGE

Secondary Insurance Carrier _____

Policy Holder's Name _____

Policy Holder's SS# ____/____/____ Date of Birth ____/____/____

Relationship to Patient _____

Be sure to give staff a copy of your picture ID and ALL your insurance coverage cards.

Bring and give staff a complete list of ALL medications prescription and non-prescription.

THANK YOU

X _____ Date _____

PATIENT FINANCIAL POLICY

In order to eliminate confusion and misunderstandings between our patients and practice, Dr. Emery-Culberson has adopted the following policies. Please discuss any questions regarding these policies with our billing manager. For your convenience we accept Visa, MasterCard, and Discover credit cards.

Our office contracts with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment or deductible at the time of service.

In the event that your health plan determines a service to be “not covered”, you will be responsible for the complete charge.

We will bill your health plan for services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Payment is expected on the day services are rendered. A \$25 fee will be charged for each returned check. All co pays, deductibles, and co-insurances are due at the time of service.

For all services rendered to minor patients, payment is due from the parent or guardian with custody.

The responsible party is billed for appointments broken or cancelled with less than 24 hours notice.

I have read and understand the financial policy of the practice, and I agree to be bound by the terms. The information in this paragraph may not be altered or amended by patients. I understand and agree that the practice may amend such terms as the need arises.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any information necessary to insurance carriers or medical professionals regarding my illness and treatments; (2) allow a photocopy of my signature or foot generated during examination if needed for claims processing or treatments.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I understand and agree that I was provided a copy of the Notice of Privacy practices and that I have read (or had the opportunity to read) this notice which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance carrier(s) including Medicare, private insurance and any other health/medical plan, to issue payment to Dr. Emery-Culberson for medial services rendered to myself and /or my dependents in accordance with documented insurance benefits.

I understand that if I fail to provide all necessary information to file my insurance claim, I will be required to pay all charges in full for all services rendered on my behalf.

A photocopy of this assignment is to be considered as valid as the original.

CONSENT TO TREAT

I have requested medical services from Dr. Carla Emery-Culberson on behalf of myself and /or my dependants.

Patient /Responsible Party Signature

Date_____