Physician HealthCare Network

The more information we know about you and your family, the better medical care we can provide you. None of this information will be released to any person except with your written consent.

LAST NAME_____FIRST NAME_____MI_____BIRTHDATE_____

SEX: M F MARITAL STATUS: MARRIED SEPARATED DIVORCED WIDOWED SINGLE

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE#_____CELL#_____ S.S. #_____

EMAIL ADDRESS_____

RACE: African American American Indian Asian White Hispanic/Latino Multi-racial Other Decline

ETHNICITY : Hispanic/Latino Non-Hispanic/Latino Decline

IF PATIENT IS A MINOR PLEASE LIST PARENTS/GUARDIAN

MOTHER'S NAME_____MOTHER'S BIRTHDATE_____MOTHER'S PHONE #_____

FATHER'S NAME_____FATHER'S BIRTHDATE_____FATHER'S PHONE #_____

LEGAL GUARDIAN_____LEGAL GUARDIAN BIRTHDATE_____

LEGAL GUARDIAN PHONE #_____

EMERGENCY CONTACT_____PHONE #_____
(Please list someone not already listed above)

PLEASE LIST INSURANCE INFORMATION

PRIMARY INSURANCE

SUBSCRIBER NAME_____ _____SUBSCRIBER BIRTHDATE_____

SUBSCRIBER RELATIONSHIP TO PATIENT_____SUBSCRIBER S.S.#_____

INSURANCE_____SUBSCRIBER ID #_____

EMPLOYER_____OCCUPATION_____WORK PHONE #_____

SECONDARY INSURANCE

SUBSCRIBER NAME_____ _____SUBSCRIBER BIRTHDATE_____

SUBSCRIBER RELATIONSHIP TO PATIENT_____ SUBSCRIBER S.S.#_____

INSURANCE_____SUBSCRIBER ID #_____

EMPLOYER_____OCCUPATION_____WORK PHONE #_____

Physician HealthCare Network

E-prescribing Consent/Acknowledgment

I hereby authorize my physician to prescribe and refill medications through a computerized e-prescribing system. I understand that my physician may be sending my prescriptions electronically, and I have been informed on the E-prescribing process.
I also give permission for Physician HealthCare Network, PC to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Patient Name_____

Signature_____Date_____

Preferred Pharmacy_____

Race/Ethnicity Questionnaire

Dear Patient or Guardian of patient:
As of today, we will be reporting statistics on race, ethnicity, and language for our patient population. PATIENT NAME and ANY OTHER PATIENT IDENTIFIERS OR SPECIFICS WILL NOT BE REPORTED. We appreciate your participation in helping us collect this information.

PatientName_____Date_____

ETHNICITY	RACE	LANGUAGE
Hispanic or Latino Non-Hispanic or Latino Unavailable Declined	American Indian Asian African American White Declined Unavailable Multiracial Other	English Other Indian (including Hindi & Tamil) Spanish Russian

I give Physician HealthCare Network authorization to release information regarding my health to the following people: (i.e. spouse, siblings, parents, etc.)
Please note that anyone not listed on this form, including immediate family members and/or relatives, **will not** have access to any information in your medical file.

Name_____Relation_____

Name_____Relation_____

Name_____ Relation_____

Name_____Relation_____

Name_____Relation_____

Patient Signature_____Date_____

If our office cannot reach you personally, may we leave protected health information,
(i.e. test results, appointment dates, returned messages, etc.) by the following methods?:

With a family member: Yes_____No_____

Home Answering machine: Yes_____No_____

Cellular Phone voicemail: Yes_____No_____

By mail to home address: Yes_____No_____

By email: Yes_____No_____

Patient Signature_____Date_____

Patient-Provider Partnership Agreement

The health and wellness of our patients is a top concern of Physician Healthcare Network, PC. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if we, Physician HealthCare Network and you, the patient, work together. This concept is called the ***Patient Centered Medical Home.***

*Patient's Responsibilities:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms, and other important information about your health
- Tell your provider about any changes in your health and well-being
- Follow your provider's instructions, including taking your medication(s) as directed
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visit in advance whenever possible
- Call your provider first with all problems, unless it is a medical emergency
- Leave every visit with a clear understanding of your provider's expectations, treatment goals, and future plans
- For coordination of care purposes you authorize your provider to exchange your medical information(written or electronic), when appropriate, with other providers involved in your care (i.e. admissions, discharges and transferred to/from hospital based care settings, specialist referrals or any other healthcare encounters outside of your provider's office.)

*Provider's Responsibilities:

- Explain diseases, treatments, and results in an easy-to-understand way
- Listen to your feelings and questions; help you make the best decisions about your care
- Keep treatments, discussions, and records private
- Provide 24 hours access to medical care and same day appointments, whenever possible
- To care for you to the best of my abilities based on my understanding of current medical methods available
- Give my patients clear directions about medications and other treatments
- Send my patients (along with appropriate medical information) to trusted experts, when needed
- End every visit with clear instructions about expectations, treatment goals, and future plans

_____	_____	_____
Patient/Guardian Signature	Provider's Signature	Today's date

Patient Financial Policy

Thank you for selecting Physician HealthCare Network for your healthcare services. The physicians and staff within the Network are committed to providing the best and most compassionate healthcare possible to all of our patients.

The following is a statement of our Patient Financial Policy. Please take a moment to review and sign prior to any treatment.

Insurance:

- Our Network physicians accept assignment of insurance benefits from many of the major insurance companies. Be sure to check with the physician's office prior to treatment on which companies they participate with.
- Adult Patients: The ultimate financial responsibility for any services provided by a physician and/or medical provider within the Network is the patient's, regardless of who is listed as the holder of the medical insurance.
- Please remember that your medical insurance policy is a contract between you and your insurance company, and we cannot be a party to that contract.
- All correspondence from your insurance company should be retained and reviewed for payment information of covered services, including "Explanation of Benefits" (EOB).
- **Note: After 60 days, any unpaid insurance claims will be transferred to the patient's financial responsibility for payment and/or follow-up with their insurance carrier.**
- For those plans that have Master Medical coverage, the patient may be required to pay in full for the services rendered before a medical claim will be submitted as a courtesy to the patient.

Co-Payments:

- If you are covered by a medical insurance that the physician participates with, all co-pays and/or deductibles must be paid at the time of service.

Payment:

- As a convenience to our patients, we accept cash, checks and most major credit and/or debit cards.
- A $40 service fee will be charged for all checks that are returned for insufficient funds.
- In the case of a financial hardship, if you are unable to meet your financial obligation, payment arrangements can be made. Contact our Billing Department to discuss payment options, **before your account becomes past due.**
- Non-fulfillment of financial obligations may result in discharge from the Network.
- Payment arrangements are available in certain circumstances.

Self-Pay:

- For patients who are not covered by medical insurance, or have a medical insurance that the physician does not participate with, we reserve the right to require full payment at the time of the service.

Minor Patients:

- All minors (anyone under the age of 18) **should** be accompanied by a parent and/or legal guardian at every visit.

- Financial responsibility for services rendered to minor patients is the sole responsibility of each parent and/or legal guardian, unless a Court Order is presented stating otherwise. Bills will be sent to the custodial parent or the address where the child resides.

Proof of Insurance:

- All patients must periodically complete our patient information form prior to seeing the doctor. **We must obtain a copy of your driver's license and your current insurance card in order to confirm proof of insurance and file your claim.**
- It is the patient's responsibility to inform the physician's staff of any changes in their health insurance coverage prior to treatment.

Referrals:

- For those plans that require prior authorizations and/or written referrals for coverage, the patient is responsible to obtain and present this information prior to treatment. Please be advised that we reserve the right to refuse treatment for non-emergent conditions, unless prior authorization has been obtained.

Missed Appointments:

- We reserve the right to charge a fee of $25.00 for each missed appointment. Maintaining scheduled appointments allow us to continue to provide the best possible medical care for our patients.

Workers Compensation Injury:

- If you are being treated for a work related injury/illness, we must have an accident injury authorization form from your employer with directions as to how to bill for this service. If you do not already have this form, please allow for extra time so that we can obtain this information from your employer.

Motor Vehicle Accidents:

- In order for us to bill your auto insurance, we require an accident injury report, carrier information as well as a claim number. If this information is not provided at the time of appointment, we cannot bill your auto insurance and you will be responsible for any charges incurred during your visit.

My signature below affirms that I have read, understand and have agreed to the terms and conditions of the Patient Financial Policy of Physician HealthCare Network, P.C. Additionally, I understand that I am financially responsible and agree to pay for any health insurance deductibles, co-insurance amounts (co-pays), and amounts not covered or paid by insurance. If my account is delinquent, I agree to pay all expenses incurred by this office to collect the account. This includes, but is not limited to, items such as collection agency fees, court costs, and attorney fees.

X (Patient Name): _____

X _____ Date: _____

(Signature of Patient or Responsible Party)

_____

(Please Print Name of Person Signing Above)

Physician HealthCare Network

AUTHORIZATION TO RELEASE INFORMATION

Physician HealthCare Network may disclose all or part of this patient's record to any insurance company, association or the Federal or State Government as may be necessary for the completion of all Physician HealthCare Network claims.

I understand that the information to be released may include information pertaining to mental or psychiatric related conditions and/or drug or alcohol abuse. A copy shall be as valid as the original.

ASSIGNMENTS OF BENEFITS

I hereby authorize payment to **Physician HealthCare Network** benefits specified and otherwise payable to me for any services rendered by the clinic subsequent to this date and for such other charges as may be made by said clinic. I hereby agree to pay the same and also agree that in the event that payment by a third party for any individual visit exceeds that necessary to cover charges incurred during that visit, any coverage may be applied to outstanding charges owed the clinic for other services rendered to myself, my spouse, or legal dependents of myself or spouse at the time.

I certify that the information given by me in applying for payment under Title XVII of the social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related medical claim. I request that payment of Authorized Benefits be made on or in my behalf to **Physician HealthCare Network**.

I, the undersigned, certify that I have read the foregoing, and am the patient, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

PATIENT NAME_____DATE_____

SIGNATURE_____

WITNESS_____

Physician HealthCare Network

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA PATIENT CONFIDENTIALITY LAW)

The undersigned Patient or legally authorized representative ("Agent" = "Parent, Guardian, Foster Parent") of the Patient acknowledges that he or she personally received a copy of the Physician HealthCare Network's Privacy Practices on the date indicated below.
*You can find the Notice of Privacy Practices on the Patient Portal.

Signature: _____ Date: _____

Patient:
_____

Information about Agent (attach appropriate documentation):

Agent:
_____

Title:
_____

The Patient or legally authorized representative ("Agent") named above received a copy of the Physician HealthCare Network's Notice of Practices but refused to sign.

Physician: _____ Date: _____