

Family Medical Center of Carthage

1632 Missouri Ave, Carthage, MO 64836

Patient Info (please print)

Today's Date _____

Name (first, middle, last) _____ SSN# _____

DOB _____ Sex (circle one): M F Marital status (circle one): S M D W

Address _____ City _____ Zip code _____

Phone: home _____ cell _____ work _____ ext _____

Email (to send appt reminders) _____

Employer _____ Address _____

Emergency contact _____ Phone _____ Relationship _____

Person Responsible for Bill (if minor: parent or guardian)

Name _____ DOB _____ SSN# _____

Relationship to patient _____ Address _____

Employer name _____ Employer phone _____

Spouse Information

Name _____ DOB _____ SSN# _____

Address (if other than above) _____ Phone _____

Employer _____ Employer phone _____

Employer address _____

Insurance Information

Primary _____ Subscriber _____ DOB _____ SSN# _____

Secondary _____ Subscriber _____ DOB _____ SSN# _____

Third _____ Subscriber _____ DOB _____ SSN# _____

Please remember that insurance is a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. The ultimate responsibility for payment lies with you. I hereby assign all medical benefits to include major medical benefits to which I am entitled, including private insurance and other health plans to Family Medical Center of Carthage.

Consent for Health Care: I voluntarily consent to such medical treatment, including but not limited to laboratory, Xray, diagnostic or medical treatment which may be ordered by the Physician or Nurse Practitioner for medical treatment, which they deem necessary and advisable. The agreement and assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is considered as valid as the original. I, the undersigned, authorize Family medical Center and its providers to release any information acquired in the course of my exam or treatment to my insurance company(s) or another provider to which I am referred for the purpose of business operations, payment for healthcare services rendered and continual treatment or coordination of care. I acknowledge that I had the opportunity to read and/or receive a copy of this system's Notice of Privacy Practices. A complete copy of the Notice is available upon request.

Patient or guardian signature _____ Date _____

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy we require you read and sign prior to any treatment.

All patients must complete our patient information form **before** seeing the doctor or nurse practitioner.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA AND DISCOVER.

Regarding Insurance:

As a courtesy to you we can file your insurance for you. However, at the time of your visit we do expect payment in full. Please remember your insurance policy is a contract between you and your insurance company. We are not party to that contract unless it is a managed care policy that we have carefully negotiated prior to your visit to this office. In the event that we do not accept assignment of benefits, the balance is your responsibility whether insurance pays or not. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance.

We cannot bill your insurance unless you have provided us with the necessary information. At your initial visit, we do require a copy of all your insurance cards and a copy of your driver's license.

After 60 days, if your insurance has not paid on your claim, this bill will be turned over to your responsibility and we will expect your payment in full. Upon prior approval, we can bill this balance to your credit card. You will need to provide us with this information.

Regarding insurance plans where we are a participating provider: all co-pays, co-insurance and/or deductibles are to be paid at the time of service. In the event that your insurance coverage changes to a plan where we are not participating providers, please refer to the preceding paragraphs.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients:

Adult patients are responsible for full payment at time of service.

Minor Patients:

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/Mastercard, or payment by cash or check at the time of service has been verified.

Collections:

It is the policy of our office to turn unpaid balances over to a collection agency unless extenuating circumstances are involved, communicated, documented and approved by our office.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy and I understand and agree to this Policy.

X _____
Signature of Responsible Party

Date _____