

Family Medicine of Greenfield Office Policies and Procedures

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this office policy. Please read it, ask us any questions you may have, and sign and initial where indicated. A copy will be provided to you upon request.

1. **Consent to Treat.** I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health, and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial _____

2. **Financial Agreement.** I understand that all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs. Collection fees will equal 50% of the amount turned over for collection. Reasonable attorney fees incurred to effect collection of this account or future outstanding accounts will be the responsibility of the patient.

Initial _____

3. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Initial _____

4. **Release of Medical Info and Authorization to Pay Ins. Benefits.** I authorize my physician to release information from my medical record to my insurance carrier (s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

Initial _____

5. **Co-payments and Deductibles.** 100% of all co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients could be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Initial _____

6. **Non-covered Services.** Please be aware that some - and perhaps all - of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit. Should lab or other testing outside the office be required, those entities will bill your insurance carrier. Once again, be aware that some - and perhaps all - of these services may be non-covered or not considered reasonable or necessary by Medicare or other insurers.

Initial _____

7. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Initial _____

8. **Claims Submission.** We will submit your claims and assist you in anyway we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Initial _____

9. **Medicare Certification.** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

Initial _____

10. **Medigap Authorization (Medicare Patients Only).**

Name of Beneficiary (Patient) _____ Medigap Policy
Number _____

I am giving Community Physicians of Indiana, Inc. permission to ask for Medigap payments for my medical care. I understand that _____ (name of Medigap Insurer) needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to _____ (Name of Insurer.) I request that payment authorized by Medigap benefits be made either to me or on my behalf to Community Physicians of Indiana, Inc. for any services furnished to me by that physician/supplier. I authorize any holder of medical information to release to _____ (Name of Medigap Insurer) any information needed to determine benefits payable for related services.

Signed _____ Date _____

11. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Initial _____

12. **Non-Payment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Initial _____

13. **Missed Appointments.** Unless cancelled at least 24 hours in advance, our policy is to charge \$25 for missed appointments. If you do not cancel 24 hours in advance or no-show your scheduled appointment 3 times in a 12 month period you will be dismissed from our care.

Initial _____

14. **Returned Checks.** For any check that is returned, due to non-sufficient funds, you will be charged a \$25 returned check fee.

Initial _____

15. **Telephone Release.** I give consent and authorization for the Medical, or Billing Staff of my Physician's Office to leave protected Health Care Information about me or for me on my answering machine or voice mail via the telephone number I have listed below. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

Phone Number _____

Initial _____

Who may we leave test results with if unable to contact patient or parent?

Name _____

Initial _____

Advanced Directive

- Do you have a living will? Yes__ No__
- Have you appointed a Healthcare Representative? Yes__ No__
- Have you given anyone your Power of Attorney? Yes__ No__
- Resuscitate? Yes__ No__

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. If you have any questions about our office policies and/or procedures please ask our office staff they will be happy to answer any questions you may have.

I have read and understand the office policies and agree to abide by its guidelines. I acknowledge that I have received the Notice of Privacy Practices*.

Signature of patient or responsible party

Date

* If patient did not sign, give reason and initial _____