UNION MULTI-SPECIALTY PRACTICES | PRIMARY & SPECIALTY CARE PHYSICIANS

Authorizations & Policies

Provider Name:_____ Date:_____

Patient Name:_____ Date of Birth:_____

For Minors: Guardian #1_____ Relationship:_____ DOB:_____
Email Address:_____

Guardian #2_____ Relationship:_____ DOB:_____
Email Address:_____

HIPAA Notice: Please list the names and relationships of any persons able to obtain medical information or documents for the above named patient. Any person not listed below will be declined your medical information and information will not be released to anyone except yourself:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Emergency Notification: Please list the name, relationship, contact phone number and date of birth of whom we should contact in the event of an emergency.

Name:_____ Relationship:_____
Phone Number:_____ Date of Birth:_____

Billing Information: Please check mark one of the following and complete the required information.

☐ Bill my insurance company. Please provide card(s) to the receptionist along with a photo ID and copay.

Policy Holder's Name:_____ Relationship:_____ DOB:_____
Guarantor Name:_____ Relationship:_____ DOB:_____

☐ I am uninsured and agree to pay for rendered services (minimum of $25.00) and will be balance billed for the remaining or will pay in full and receive a discounted rate.

Medical Records Release: If you are interested in transferring your previous physician's medical records to our practice, please see the receptionist for a release of information form. Once reviewed and signed we will request your medical records to be sent directly to our office.

Notice of Privacy Practice: Notice of Privacy Practices is posted in our waiting room and available in writing upon request. I understand that I have a right to review the Notice of Privacy Practices prior to signing this document. I understand that my demographic information including address, phone number, and email address may be shared for quality improvement purposes (Patient Satisfaction Surveys). I understand that I may be contacted for quality improvement surveys using any of the above means of contact.

Authorizations: I authorize release of any medical information to process insurance claims. I authorize payment of Medical benefits to myself or named provider for professional services rendered. I acknowledge that I am responsible for all services provided under applicable law. I authorize release of any medical records to or from previous physicians, specialists, hospitals or pharmacies for continuation of my health care. I authorize the above named provider to render medical care and/or treatment to the above named patient.

Patient/Guardian Name (please print):_____

Patient/Guardian Signature:_____Date:_____

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Authorizations & Policies

- Co-payments: If you have a copay with your insurance this amount is due at the time of visit.
- Referrals: If your insurance carrier requires a referral, it is your responsibility to obtain this and monitor to ensure it is renewed if necessary. If you are unsure if you need a referral, please check your insurance card and contact your insurance carrier to confirm. Your primary care physician is who you will need to contact to generate a referral.
- Account Balances: A minimum payment is requested if you have a balance on your account.
- Late Arrivals: If you are more than 15 minutes late for your scheduled appointment, you may be asked to reschedule.
- Medication Refills: Please allow 3 business days prior notice for a medication refill request.
- Lab or Procedure Results: You will be notified by letter and/or office staff of your lab results. If you have not received results within 2 weeks, please contact the office.
- Appointment Cancellations: In an effort to minimize patient wait times for new appointments we kindly ask that you give our office at least 24 hours advance notice if you are unable to keep your appointment.
- No Show Fees: Failure to attend a scheduled appointments and not notifying the office will result in a $25.00 no show fee. If you fail to attend 3 consecutive scheduled appointments or 4 non-consecutive scheduled appointments without notification, you may be discharged from our practice.
- Medical Records Requests Fees: Any requests for medical records from the patient/guardian, an attorney, an employer or other provider's office must be accompanied by a signed authorization from the patient/guardian. Fees will be determined based upon the request. Please allow 5 business days for receipt of medical records.
- Forms/Paperwork Fees: Any forms or paperwork that will need to be completed by the provider such as disability, FMLA, Worker's Compensation, etc. will be charged a fee of $25.00 or more based upon the extensiveness of the paperwork. Please allow 5 business days for completion of paperwork.
- Discharge from our Practice: Please note the following could result in discharge from our Practice;
    - Failure to attend 3 consecutive scheduled appointment or 4 non-consecutive appointments without notification.
    - Infringing on the rights of others
    - Failure to conduct yourself in an appropriate manner
    - Failure to act in accordance with medical advise
    - Failure to comply with Medication Management Contracts
    - Failure to comply with office policies

By signing below I am acknowledging that I understand the policies of the Practice and am aware of what is required of me as a patient.

Patient/Guardian Name:_____

Patient/Guardian Signature:_____ Date:_____