



Patient Information *this is patient information not guarantor or parent information*

Patient's full name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell/Pager: _____

Employer's Name: _____ Your occupation: _____

Employer's Address: _____ City/St: _____ Zip: _____

Sex : Male Female Age: _____ Marital Status(current) Single Married Widowed Divorced Separated

Your Social Security No: _____ - _____ - _____ Email: _____

Emergency Contact Name: _____ Phone No: _____ Relationship to patient: _____

Guarantor/Policy Holder *this information is required in order for us to file insurance for you. You may skip if same as above.*

Name of Policy Holder: _____ Social Security No: _____ - _____ - _____

Guarantor's Address: _____
Street City St Zip

Guarantor's Date of Birth: _____ Guarantors's Phone No: _____ Wk: _____

Guarantor/Policy Holder's Employer's Name: _____ Occupation: _____

Guarantor/Policy Holder;s Employer's Address: _____

Primary Insurance Information *Complete this information only if you do not have your insurance card on day of visit*

Name of Insurance Co: _____

Insurance Address: _____

Insurance Phone No: _____ Policy No: _____ Group No: _____

We must have your insurance card to copy for our records. We would also like a copy of your ID/drivers license for identification purposes. You may be responsible for full payment today if unable to provide the insurance card.

Secondary Insurance Information(Only for Medicare Primary Patients) *Complete this information only if you do not have your insurance card on day of visit*

Name of Insurance Co: _____

Insurance Address: _____

Insurance Phone No: _____ Policy No: _____ Group No: _____

Release of Information

Your permission is required to release your medical information(lab results,appointment information,etc.) TO ANOTHER PERSON

If you are 18 yrs of age or older, we must have your written permission to release any medical information to ANY person other than yourself. Please read and sign below if you would like to give consent for us to speak to someone else(spouse,significant other,family member etc.)concerning you. I, authorize CPPFM to discuss anything pertaining to my medical care to any of the following persons; (please check the box and WRITE THEIR NAME in the blank space)

SPOUSE OTHER _____ (relation to you) _____

This information may be disclosed by mail, or by oral communication. I understand that my records are protected and cannot be disclosed without this written consent. I also understand that I may revoke this consent by written communication except to the extent that action has already been taken in reliance on it(i.e information already disclosed) My signature means that I have read this form and/or have had it read to me and explained in the language I can understand . This authorization shall remain valid until revoked my me in writing.

Patient Signature(or Parent of minor/Legal Guardian):X _____ Date _____

Assignment of Benefits

I Certify that I, and/or my dependent(s), have insurance coverage with (name of insurance) _____ and assign directly to Dr. _____ all insurance benefits, if any, Otherwise payable to me for services rendered. I understand that in the event my insurance terminates, I have no insurance coverage or services are not covered by my insurance, I am financially responsible for all services rendered. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits and the benefits payable for related services.

Patient Signature (or Parent of minor/Legal Guardian):X _____ Date _____



Our Financial Policy

Thank You for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you. As you may know, our office and physicians continue to struggle trying to get insurance companies to pay us in a timely manner. Most insurance companies unfairly delay payment to your doctor despite you paying increased premiums year after year and they are inexplicably slowly reducing reimbursement payments to your doctors which are non-negotiable. In order to stay in business, we find ourselves having to make some hard decisions. While not a comprehensive list, our financial policy outlines the most common possible charges. As a result, this is our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

PATIENT PAYMENTS _____ (please initial)

Payment is due at the time of service. This includes co pays and deductibles. You may use cash, check, credit card, or debit card to pay your account. Patients without insurance that pay in full will receive a prompt pay discount.

INSURANCE PAYMENTS _____ (please initial)

Your insurance policy is a contract between you and your insurance company. We have a separate contract with your insurance company. Your insurance company dictates the applicable copays and deductibles that you are required to pay providers and the fees providers can collect. ***Be assured our office works diligently to obtain payment from your insurance company. However, if we file your insurance, and the claim has not been paid for any reason within 60 days, we require that you pay the balance using one of the approved payment methods without exception.*** In the event that your insurance pays us after that time, you will be reimbursed.

INSURANCE COVERAGE _____ (please initial)

We make no claim to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by *you or your* insurance is correct. It is your responsibility alone to know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. In addition, be aware that some and perhaps all of the services provided may be non-covered services by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered. **We are not in network with BCBS HMO or Medicaid.** Finally, in the event you provide incorrect insurance information that delays payment, you may be asked to pay full billed charges and seek reimbursement from your insurance provider directly.

THIRD PARTY PAYORS _____ (please initial)

Our office does not bill third party payors such as PIP (Personal Injury Protection) for a motor vehicle accident, or attorneys.

RETURNED CHECKS _____ (please initial)

Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a \$35.00 handling fee. If a second check is presented that is returned from the bank, we request that future visits be paid with cash, credit or debit card.

COLLECTION SERVICES _____ (please initial)

In the event that external collection services become necessary to obtain payment, you will become responsible for all such collection agency fees and attorney fees, as well as court costs. Once you receive a notice from a collection agency, you can not pay directly to our office.

MEDICAL RECORDS/FORM FEES _____ (please initial)

We will provide copies of your records within 15 days of receipt of a signed records release and the \$25.00 charge for copies. There are also nominal fees for forms such as insurance forms, school forms, FMLA, disability, etc. These forms will be completed within 5-7 business days. Fee must be paid prior to completion of any form.

We welcome the opportunity to discuss any aspect of our financial policy and we thank you for your support, and look forward to serving your health needs.

MISSED/LATE CANCELLED APPOINTMENTS _____ (please initial)

Please give us at least 24 hours notification if you cannot keep an appointment. This courtesy will allow others to be seen. We do realize that emergencies arise and therefore do not charge for the first 2 missed or late cancelled appointments. However, you will be required to pay a \$100.00 fee for subsequent missed or late cancelled appointments. We attempt to make reminder calls for well visits, but *it is ultimately your responsibility to remember appointments.*

-Patient Authorization-

I have read, understand, and agree to abide by the terms stipulated above. I request that payment of benefits be made to Cedar Park Pediatric and Family Medicine. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoked by me in writing.

Patient name (print) _____ DOB _____

Patient signature (or parent of minor/legal guardian) X _____ Date _____

*** Parent or legal guardian is responsible for payment at the time of visit.***

Name of person completing form if other than patient: _____

Relationship to Patient _____



**Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operation**

I, hereby, consent to the administration and performance of all tests and treatments by members of the medical staff and personnel at Cedar Park Pediatric and Family Medicine which in the judgment of the physicians may be considered necessary or advisable for the diagnosis or treatment for the condition for which I am presenting myself now or in the future. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me. _____ (please initial)

***for patients not accompanied by a parent or legal guardian, written permission to treat the child is required before any treatment can be given. Please ask for the appropriate form.**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care treatment. I authorize Cedar Park Pediatric and Family Medicine to release these records to my insurance companies, employer insurance groups, health plans, primary care physician or physicians to whom I've been referred to by CPPFM
_____ (please initial)

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance there on.

Patient signature (or parent of minor/legal guardian) X _____ Date _____

Name of person completing form if other than patient: _____

Relationship to Patient _____

I, the undersigned, do hereby confirm that I have been given access to and have reviewed a copy of Cedar Park Pediatric & Family Medicine Notice of Privacy Practices.

Patient / Guardian Signature _____

I would like a copy of this statement