Patient Information and Insurance

Associated School

First

Middle

Last

Social Security Number:

Date of Birth: *

Cell Phone: *

EMAIL ADDRESS: *

Primary Language: English / Spanish / Other:

Age: *

Sex: *

ADDRESS:

Street

City

State / Province

Postal / Zip Code

Race: Black / White / Hispanic / Other:

Please list any medication allergies

Primary Insurance:

Policy #

Subscriber / Policy Holder Name:

Secondary Insurance:

Subscriber/ Policy Holder Name:

Subscriber DOB:

Subscriber / Policy Holder SS#:

Parent's/Guardian's Information

Name

Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Employer

Work Number/Extension

Person to Notify in Case of Emergency (other than parent/guardian)

Relation to patient:

Contact Name

Home Phone

Cell Phone

PHARMACY NAME:

PHONE NUMBER:

Check the conditions that apply to you or to any members of your immediate relatives:

- [ ] Asthma
- [ ] Cancer
- [ ] Cardiac Disease
- [ ] Diabetes
- [ ] Hypertension
- [ ] Psychiatric disorder
- [ ] Epilepsy
- [ ]

Check the symptoms that you're currently experiencing:

- [ ] Chest pain
- [ ] Respiratory
- [ ] Cardiac disease
- [ ] Cardiovascular
- [ ] Hematological
- [ ] Lymphatic
- [ ] Neurological
- [ ] Psychiatric
- [ ] Gastrointestinal
- [ ] Genitourinary
- [ ] Weight gain
- [ ] Weight loss
- [ ] Musculoskeletal
- [ ]

Please list any medication you are currently taking:

Financial Policy
Thank you for choosing ESE Telehealth providers. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Insurance: Your responsibility of payment depends upon your particular plan. You are responsible for co-payments, co-insurance, and deductibles at the time services are rendered. Your claim will process according to your plan. Verification of your insurance benefits are not a guarantee of payment.

Medicare Patients: Please make certain that you fully understand your benefits and your financial responsibility if your benefits are not covered. Medicare requires a deductible. Supplement coverage may not cover that deductible. If you do not have supplemental coverage, you will be expected to meet pay until it is met. Your co-insurance responsibility will be 20%, due at time services are rendered.

Medicare Supplements: We will only bill your supplement insurance once. If payment is not received in 45 days, any pending balance will be transferred to patient responsibility.

Medicaid Patients: Please be sure to provide the correct Medicaid information to process claims. If you are covered under a CMO such as WellCare or Peachstate, you will need to provide the member id listed on that card. CMO's will have a different member id than Medicaid. Claims denied for invalid subscriber id will be

Out of Network: If you have insurance coverage under a plan in which we do not have contract, you will be treated as self-pay (cash-pay) patient and may request documentation to assist you in filing your claim.

Uninsured Patients: If you do not have insurance and would like to be treated as a self-pay patient, you will be charged $65.00 for new patient visits and $45.00 for established patient visits. Additional charges may occur according to services rendered such as Strep or Flu testing. Payments are due at time services are rendered.

Co-pay and Co-insurance: Co-pay, Co-insurance, and/or any balance are expected prior to services rendered.

Deductibles: Some insurance plans require patients to pay a pre-determined dollar amount prior to services rendered.

Charges for Medical Records and/or Forms: You may print your medical records at any time from patient portal. Requests for records in house will have a charge of $2.00 per visit note.

Payment Responsibility: The patient or legal representative is responsible for all charges of services rendered. This includes any "non-covered" services. We are happy to help assist you in an attempt to "overturn" an adverse determination. However, we will not falsify and/or change a diagnosis, symptom, or medical documentation. If you are unsure whether a service is covered by your plan, it is your responsibility to call your insurance company to inquire what benefits are allowed.

Prescriptions: Refill and/or new prescriptions that are not requested during the appointment may require an additional visit. This will be determined by the provider at time of request. Approved prescriptions may take up to 24-48 hours. We encourage you to call your pharmacy during those hours as repeated requests may cause delay in processing.

At the conclusion of your visit with us, you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

Payments may be made on the patient portal located at www.mwcofga.com

PATIENT FINANCIAL RESPONSIBILITY

By signing below, I am attesting that I have read, understand, and agree to the provisions provided in this form.

I am responsibility for payment of services rendered.

It is my responsibility to provide updated insurance information prior to being seen and will be accountable for any charges incurred if correct insurance is not supplied.

I am responsible for co-pay, co-insurance, deductibles, and/or any services not covered by my insurance.

$25 charge for returned checks
$2.00 charge per visit for medical records
Any costs associated with collections, legal fees, and/or interest should my account become delinquent.

I agree to the Financial Policy *

☐ Agree

Privacy Policy
This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review carefully.

This Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or oral, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse and disclose your health information.

As required by HIPAA, we have prepared this statement of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities, as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to our insurance carrier for payment.

Health care operations include business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction if we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of December 12, 2006, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reservice the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a review Notice of Policy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provision of this notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information about HIPAA or to file a complaint, by asking to speak to our Privacy Officer or for written inquires, note “Attention Privacy Officer.”

The U.S. Department of Health & Human Services
Office of Civil Rights 200 Independence Avenue
SW Washington, DC 20201
PH (202) 619-0257 or toll free: 1-877-696-6775

Acknowledgement of Receipt of Notice of Privacy Practices

Respect for our patients' privacy is of utmost importance to us. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices. Our medical staff and affiliated health care providers value your privacy as much as your well-being.

Our Notice will be posted on our website and in any other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing the patient portal or our website at www.mwcofga.com , or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me, may be used and disclosed, and how I may obtain access to and control this information.

Finally, by signing below, I consent to the use and/or disclosure of my health information as described in this Notice, including treatment, to seek and receive payment for services given me, and for the business operations of the practice and its staff.

If you have any questions about this Notice or would like further information, please contact the Privacy Officer at 877-755-2212

For Office Use Only: If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement and consent.

I agree to the Privacy Policy

☐ Agree

By signing below you agree to conditions above.