Hillside Family Medicine

Patient Information

Name:____ SSN: ____________________
Last First MI

Martial Status: _____Married _____Single _____Other Spouse Name: ______________________

Birthdate:____________ Sex: M / F Employer: ______________________ Occupation: ______________

Mailing Address: ____________________________ City:________________ State________Zip________

If under 18 years of age please list Parent(s) or Guardian(s) *(if not the biological parent, proof of guardianship or adoption required)*

Name:____________________________________ Relation: ________________ DOB: ____________

Name:____________________________________ Relation: ________________ DOB: ____________

Emergency Contact:

Name: ______________________________ Relation: ________________ Phone Number: ______________

Insurance Coverage

Primary Insurance :_________________________ **Secondary Insurance** :_________________________

Subscriber Name (If Different): ____________________ Subscriber Name (If Different): ____________________

Subscriber Employer: _________________________ Subscriber Employer: _________________________

Birthdate:____________ Birthdate:____________

CONFIDENTIAL COMMUNICATION

I wish to be contacted in the following manner (**check all that apply**).

Home Telephone:_________________________
- ☐ Leave message with detailed information
- ☐ Leave message with call back number only
- ☐ Leave detailed message with a family member

Cellular Telephone:_________________________
- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Work Telephone:_________________________
- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Email Address: _________________________

Individuals allowed to accept detailed messages:

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If you would like someone other than yourself to have complete access to your medical records please request a "PHI" form.

How did you find us??? Phone Book ☐ Newspaper ☐ Online ☐ Sign ☐

Whom May We Thank for Referring You to Our Practice? Name:_________________________________

Please Initial the following and sign at the bottom:

_____ **All patients:** 18 years and older are required to present a valid picture identification. A copy of that picture identification will be entered into the patient's electronic medical record. This is required for continuation of services. If under the age of 18 the parent or legal guardian is required to present valid picture identification to be entered into the patient's electronic medical record. Hillside Family Medicine reserves the right to refuse service to anyone. We are not contracted with Champus/Tricare, Medicare, Medicaid, or Denali Kid Care and are not able to see patients covered by these insurances.

_____ **Financial Policy (full policy copied on the back):** As a courtesy to our patients, Hillside Family Medicine will bill most U.S. health plans. Deductible, co-pay and/or coinsurance will be collected in full at the time of service. The amount of payment due at the time of visit depends on your insurance plan. We will also collect on any balance due on your account. Signing below indicates that you have read and understand our full Financial policy copied on the back of this form.

_____ **Noncovered Services:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. Since your agreement with your insurance carrier is a private one, we do not routinely research whether a service is covered. It is the patient's responsibility to find out if a service is covered prior to service.

_____ **Personal Injury Cases:** This office does not bill for auto accidents or other liability or lawsuit related cases for various reasons. You are responsible at the time of service. We do not accept liens.

_____ **Demographic & Insurance Updates:** All patients are required to update medical history and demographic information on a yearly basis. A copy of the medical insurance card is required on a yearly basis as well in order to ensure proper billing information.

Missed Appointments: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. If you miss three appointments in a 12 month period, you may be dismissed from the practice. You will be charged an $85 fee for a missed appointment.

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Patient Signature or Signature of Legal Guardian if patient is under the age of 18 Date

Thank you for choosing Hillside Family Medicine.
Our aim is to provide you with high-quality medical care provided by a team of compassionate, committed, and friendly medical professionals.

Being "cared for" is the result of a mutually agreeable, voluntary service. It can be terminated at any time by either party.

In order to effectively bill and collect on charges incurred, we require all patients to read and sign the following financial policy. Thank you for your cooperation.

- We accept cash, checks, and all major credit cards. Your bill will include office visits, x-rays, procedures performed, fees, lab work, and other charges related to your care.

- As a courtesy to our patients, Hillside Family Medicine will bill most U.S. health plans. Deductible, co-pay and/or coinsurance will be collected in full at the time of service. The amount of payment due at the time of visit depends on your insurance plan. We will also collect on any balance due on your account. *We are not contracted with Champus/Tricare, Medicare, Medicaid, or Denali Kid Care and are not able to see patients who are covered by these insurances.*

- Hillside Family Medicine requires payment in full if an insurance card is not provided before your appointment. Providing correct insurance information and any necessary authorization(s) are your responsibility. You are responsible to pay any charges denied by your insurance because of missing/inaccurate information.

- If you do not have insurance, payment in full is expected at the time of service. Patients who do not have insurance or choose NOT to file with their insurance and pay in full at the time of service, will receive a 20% discount. Discounts will not be given for DOT, sport, or school physicals. Additionally, due to the high cost of drugs, vaccinations, and other injectables/implants, the 20% paid-in full discount will not be applied to these services.

- Any care not paid for by your existing insurance coverage will require payment in full at the time of service or upon notice of insurance claim denial. We do not routinely research whether a service is covered, so it is up you, the patient, to contact your insurance carrier or employer to determine coverage information.

- If a request to restrict disclosure to a health plan is elected, we will need to be notified prior to the start of the appointment and payment in full is expected at the time of service.

- Vaccinations required for travel are often not covered by insurance. Due to this fact, our office requires payment in full at the time of service. Your insurance will be billed, and any amount covered by insurance will be refunded to you.

- Patients visiting Alaska are required to pay in full at the time of service. We do not bill insurance for these individuals. The necessary paperwork will be provided to the patient to file their own claim.

- If insurance does not pay within **90 days** of the service date, Hillside Family Medicine reserves the right to request payment in full for services from you and transfer the responsibility of obtaining the insurance payment to you. The agreement with your insurance carrier is a legal contract between YOU and your insurance company. Our office is not part of this legal contract. Ultimately, you are responsible for any and all charges incurred at our office.

- Balances are due within **30 days** of the first statement. If you are unable to make payment in full, payment plans are available. Payment plans consist of a term rate of no greater than 1 year. If new services are incurred, recurring payments must be adjusted to reflect new balance.

- Accounts past **60 days** are considered delinquent. Accounts past **90 days** are subject to review as well as the account being sent to our collection agency, Cornerstone Credit Services, and dismissal from our practice.

- There is a $25 charge for all returned checks. After the first returned check, we will only accept credit/debit, cash, and money order.

- In fairness to other patients and the doctor, we require at least 24 hour notice to cancel an appointment. If you miss three (3) appointments within a 12 month period, you may be dismissed from the practice. An $85 fee will be charged for a missed appointment.