Fountain Hills Family Practice, P.C.

Patient Information

First Name: ________________________ Middle Initial: _____________ Last Name: ______________________________________

DOB (date of birth):_______________________ Marital Status: _________________________Sex: __________________________

Address: ____City: ___________________________State:_____ Zip: _________

Alternate address (physical address if you are out of state or have a PO Box in case of emergency):

____ City: ___________________________State:_____ Zip: _________

Primary Phone: (_____) - _____ - _________ Alternate Phone: (_____) - _____ - _________ **Voicemail: Y or N**

Email: ____

Primary Language: _________________________________ Race/Ethnicity: ____

Guarantor (this is the person responsible for payment after or if not paid by insurance) *CANNOT BE A MINOR*

Name____ DOB: ________________ Relation to Pt. ____________________________

Address (if different from above):___________________________________ Phone: (_______) __________-_______________

Employer (name, phone, address): ____

Primary Insurance Information

Policy Holder: ____ DOB: _______________ Relation to Pt: __________________

Address (if different from above): ____ ID#_______________________________

Secondary Insurance Information

Policy Holder: ____ DOB: _______________ Relation to Pt: ___________________

Address (if different from above): ____ ID#_______________________________

Contacts and HIPAA information

***Family members (including parents if patient is a minor) or friends whom we may discuss your healthcare with:**

Contact # 1:______________________________________ Relation to Pt: __________________ Phone: (____)-_____- __________

Contact # 2:______________________________________ Relation to Pt: __________________ Phone: (____)-_____-___________

☐ **Do not discuss my healthcare with anyone**

Preferred Pharmacy (name, phone, address):____

I hereby authorize payment directly to FHFP for medical benefits and the release of any information necessary to process claims for said services and authorization to release medical records pertaining to my treatment to my insurances or other third party. I also agree to pay all charges and/or copays at the time of service. In the event of default, I promise to pay all legal fees, collection costs, and/or interests as may be required. Information on this form is accurate and I am responsible for payment of treatment. **I have received and acknowledge the HIPAA privacy policy.**

Signed: ____ **Date:** _______________________________

Patients are responsible for the cost of services rendered.

Co-pays are due at the time of service. Payment is due at the time of service for self pay patients. Extended payment plans must be made in advance.

Patients are responsible for providing their current insurance information, address, and phone number(s) at **every** visit.

We will bill insurance companies but, there still may be a substantial amount owed by the patient even after the insurance company is billed (e.g. deductibles, coinsurances). If you request a well visit, that is how it will be billed. **We are not responsible for knowing your benefits, we can give you procedure codes if you want to check your insurance benefits**.

We will help direct your care to specialists and outside testing but, it is the **patient's** responsibility to make sure they have coverage at these places. **LAB & XRAY costs** are the patient's responsibility. Please check with your insurance company for your coverage regarding tests and which facilities your insurance wants you to use.

Workman's compensation patients must have all the necessary information from their employer before they can be seen.

Returned checks will be charged a $25 fee. Prescriptions will not be renewed or visits will not be allowed until the balance is paid.

There will be a fee for a copy of your medical records based on the quantity of records copied.

Consults with a physician must always be done as an office visit not over the telephone.

Our goal is to treat everyone the same regardless of their insurance situation. Please do not hesitate to ask questions regarding this policy.

I have read and understand the financial policy.

Signed: ____________________________________ **DATE:** _____________________