PATIENT DEMOGRAPHICS

***Preferred Provider (circle): Skinner – Nabors – Carpenter -Richardson- McLarty – Payne – Cook – Miller – Vickrey-Vanderburg**

*Last Name:_____ *First:_____ Middle:_____

Preferred/Nickname:_____ Maiden:_____ Prefix:_____ Suffix:_____ Credentials:_____

*DOB:_____ *Sex:_____ *SSN:_____ Race:_____ Marital Status:_____ Driver's Lic#:_____

Address:_____ City/State/Zip: _____

Phone-Home:_____ Work:_____ Cell:_____

Email:_____ Preferred Communication:_____

* Pharmacy:_____ _____ Pharmacy Phone Number: _____

EMPLOYER INFORMATION

Employer:_____

Address:_____ City/State/Zip:_____

Employer Phone:_____ Occupation:_____

Status: Full-Time * Part-Time * Full-Time Student * Part-Time Student * Retired * Unemployed *Unknown * Other_____

GUARANTOR INFORMATION – To be completed for minor patients

Guarantor Name:_____ DOB:_____

Relationship to patient:_____ Phone:_____ SSN:_____

Address:_____ City/State/Zip:_____

INSURANCE INFORMATION

Primary Insurance:_____ Policy Holder Employer:_____

Policy Holder Name:_____DOB:_____

SSN:_____ Relationship to Patient:_____

Policy Holder Address:_____ City/State/Zip:_____

Secondary Insurance:_____ Policy Holder Employer:_____

Policy Holder Name:_____DOB:_____

SSN:_____ Relationship to Patient:_____

Policy Holder Address:_____ City/State/Zip:_____

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the clinic/physician. I understand that I am financially responsible for any charges not covered or reimbursed by my insurance. I also authorize Family Medical Clinic of North Mississippi, Inc. or insurance company to release any information required to process my claims. I accept full responsibility for any reasonable attorney's fees, court costs and legal fees associated with the collection of this account if there is a default in payment. I understand that Family Medical Clinic of North Mississippi, Inc. utilizes family billing; therefore the charges associated with any visit may be viewed by other immediate family members. I have been offered a copy of Family Medical Clinic of North Mississippi's Notice of Privacy Practices.

_____ _____

Patient/Guardian Signature Date

Expanded Payment/Collections Policy

Patients with no insurance –

- Any past due amount must be paid in full before a patient can see a provider.
- Account aging shall start at the date of service.
- 30% Discount will only be issued to patients with no past due balance and who are paying in full at the time of service. Discount only applied to today's services.
- Accounts with >90 days aging will be considered in default and will be subject to collections and possible legal action.

Patients with insurance –

- Any past due amount must be collected before a patient can see a provider. Accounts are considered past due when a balance is greater than 30 days old.

- Upon approval by billing staff, we may allow a patient to carry over part of their balance, not to exceed 75% of the balance. This will be determined by your payment history and the age of the balance.

- Patients may be asked to pay an estimate of any co-insurance/deductible as determined by their benefit allowable, at the time of service.

- Patient's insurance will be billed as of the date of service. After 45 days, all open insurance claims will be billed to the patient. Any claim with >90 days aging and no payment made towards the balance, will be considered in default and will be subject to collections and possible legal action.

- If patient's claim is denied by their insurance company, it is the patient's responsibility to contact the insurance company. Most of the time, the insurance company is requesting information about accident details, other coverage information or student/dependent status that only the patient can provide. Claims denied by the patient's insurance company will be considered for collections after 90 days, so it is very important that the patient contacts them immediately after receiving a statement.

Payment is due at the time of service. In certain cases payment arrangements may be approved by our billing staff, allowing patients to pay off their balance over a 120 day period. Once this arrangement is in place, you will be required to pay a minimum of 25% of your account balance every 30 days. Missed or late payments will void this arrangement and Family Medical Clinic will proceed with collection efforts. Patients who provide an incorrect address and/or invalid telephone number may be referred to collections without notice.

Motor Vehicle Accident Policy

We do not file claims to Auto Insurance Policies. As a courtesy to our established patients with a good payment history and no outstanding balance, we will provide you with a copy of your fee ticket and/or a claim form to file a claim. Payment will be due within 30 days of the date of service. New patients will be required to pay the full amount due at the time of service and a fee ticket and/or claim form will be provided to you so that you may file a claim.

Patient Name:_____ Date:_____

Patient/Guardian Signature:_____

MEDICAL RELEASE/CONSENT FORM

PLEASE COMPLETE **EACH** SECTION

Patient Name: _____ DOB: _____

1. I hereby authorize the release of my protected health information, including account status, test results, scheduled appointments and information regarding my treatment to the person(s) I have listed below. Any person who is not listed will not be able to obtain protected health information. It is not necessary to list other treating physicians or insurance companies.

Name: _____ Phone: _____ Rel: _____

Name: _____ Phone: _____ Rel: _____

Name: _____ Phone: _____ Rel: _____

2. Phone Number(s), Fax(s), E-Mail(s) – ALTERNATE WAYS WE MAY CONTACT YOU:

____ OK to leave voice message: Phone#:_____
____ OK to leave voice message: Cell#:_____
____ OK to send fax: Fax#:_____
____ OK to send E-mail: E-Mail:_____

3. Emergency Contact(s) - AT LEAST ONE IS REQUIRED:

Name: _____ Phone: _____ Rel: _____

Name: _____ Phone: _____ Rel: _____

Name: _____ Phone: _____ Rel: _____

4. Special Instructions: PLEASE LIST ANY REQUESTS YOU HAVE REGARDING YOUR MEDICAL RECORDS

_____

_____

Signature of the release REVOKES any previously signed release on file. We reserve the right, in accordance with our Notice of Privacy Practices, to release information if we feel there is a serious threat to the health of safety of a patient.

_____ _____
Patient/Guardian Signature Date

I (or my legal guardian/parent) authorize Family Medical Clinic of North Mississippi, Inc. to provide medical care reasonable for today's standards.

_____ _____
Patient/Guardian Signature Date