Welcome to Meridian Family Medicine

**All fields with asterisks are required

Patient Information

Patient Name _____ I prefer to be called _____
Last Name First Name MI

Address _____

City _____ State _____ Zip _____

Primary Phone # (_____) _____ - _____ Cell Phone # (_____) _____ - _____

*Email Address _____ @ _____

Date of Birth _____ / _____ / _____ *SOCIAL SECURITY #:_____ / _____ / _____ (not applicable for minors)

***RACE**: White Hispanic African American Native Hawaiian Asian Other

***Sex** □ Male □ Female *AGE: _____ ***LANGUAGE**: English Russian Spanish Indian Other

□ Single □ Married □ Divorced □ Minor □ Widowed □ In a Partnership □ Separated

Employer/School _____

Employer/School Phone (_____) _____ - _____ Occupation _____

Primary Pharmacy: _____Location:_____

Patient #2: _____DOB: _____

Parent and/or Guardian / Primary Insurance Holder Information

Name _____
Last Name First Name MI

Address _____

City _____ State _____ Zip _____

Primary Phone # (_____) _____ - _____ Cell Phone # (_____) _____ - _____

*Social Security Number _____ - _____ - _____ (For insurance purposes only)

*Email Address _____ @ _____

Date of Birth _____ / _____ / _____ Age _____ Sex □ Male □ Female

□ Single □ Married □ Divorced □ Minor □ Widowed □ In a Partnership □ Separated

Work/School Phone (_____) _____ - _____

Relationship to the Patient _____

*To whom do we thank for your referral?

Emergency Contact

Name _____ Relationship to Patient _____

Phone #1 (_____) _____ - _____ Phone #2 (_____) _____ - _____

If you would like this party member to have authorization to obtain medical information on patient's behalf or bring them to appointments in your absence, please include them on the HIPAA form

_____ _____ / _____ / _____
Signature Today's Date

Financial Information

Primary Insurance

Subscriber Name _____

Insurance Company _____

Subscriber ID # _____

Group # _____

I certify that I, and/or my dependent(s), have Insurance coverage with the aforementioned Insurance Company and assign directly to Meridian Family Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Meridian Family Medicine 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 or the benefits payable for related services. This consent will end when my current treatment plan is completed or one when I end my relationship with Meridian Family Medicine.

_____
Signature

_____
Date

Secondary Insurance

Subscriber Name _____

Insurance Company _____

Subscriber ID # _____

Group # _____

I certify that I, and/or my dependent(s), have Insurance coverage with the aforementioned Insurance Company and assign directly to Meridian Family Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

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_____
Signature

_____
Date

Payment Policy

We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Payment is expected at the time of service. As a courtesy to you, we will bill your insurance. Please remember the insurance company's contract is with you. You are responsible for making sure your visit is covered by your insurance plan. For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Billing Specialist at 208-287-9420

How may I pay?
We accept payment by cash, imprinted check, Visa, or MasterCard. Returned checks will be assessed a $25.00 service charge.

Which Plans Do You Contract With?
Blue Cross, Blue Shield, Aetna, United Healthcare and the Primary Health Network. We accept many other insurance plans; please check with the receptionist if you have any questions.

Will I Be Charged For Missed Appointments?
A 24 hours cancellation call is required. Otherwise, a $50.00 missed appointment fee may be assessed.

What Is My Financial Responsibility For Services?
Your financial responsibility depends on a variety of factors, explained below. Please remember you may be responsible for a co-pay as well as a deductible. Remember, all insurance plans require some financial obligation from you. We will make every attempt to keep you current on your obligation, both with statements and on arrival in the office. As a courtesy to you, we will bill your insurance carrier. If no payment is received within 60 days, we will look to you for full payment.

Will Interest Be Charged If I Fail To Make Timely Payments?
We reserve the right to charge interest in the amount of 2% per month as allowed by state law beginning 60 days from the date of service.

What If My Child Needs To See The Physician?
A parent or legal guardian must accompany patients who are minors on the patients' first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous pages.

Do you accept Medicare?
We are no longer able to accept any new Medicare patients. Patients nearing age 65 who are preparing to transfer to Medicare coverage should plan ahead (at least 6 months in advance) regarding transfer of care to a Medicare Provider.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.
I authorize my insurance benefits be paid directly to Meridian Family Medicine.
I authorize Meridian Family Medicine to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

_____ _____
Signature Date

HIPAA 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

Uses and Disclosures of Health Information

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive. Subject to certain requirements we may use, or disclose this health information about you without your authorization for several reasons. Reasons may include public health issues, auditing, research studies and emergencies. We also provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing and identifiable health information about you. Such information may be shared by paper mail, fax, or other methods. Please be aware that we may change our policies at any time. You will be notified of any changes, and may request these changes in writing.

Individual Rights

In most cases, you have the right to look at, or get a copy of your health information that we use to make decisions concerning you. If you request copies, we require five working days after your request before this may be processed. Your first copy of your own records will be of no charge, any additional copies of your records will result in a $50.00 photocopy fee. If you are concerned that we have violated your privacy right, or you disagree with a decision we made about access to your records, you may contact us. You may also send a written complain to the U.S. Department of Health and Human Services.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Authorization for Release of Information

We are unable to release information about you unless we have your signed consent. If desired, please list the names of the individuals you would like us to release information to on your behalf:

_____

_____

Acknowledgement of receipt of HIPAA privacy practices:

Please sign and print your name and date this document to acknowledge this form.

*Printed name of patient/responsible party _____

*Signature of patient/responsible party _____

*If signing for a minor, what is your relationship to the patient? _____

*Date _____