Welcome to Meridian Family Medicine

PATIENT INFORMATION

Last Name:	First Name:	MI:
Preferred Name:	Previously Used Names (Maiden):	
Mailing Address:	City:	State:	Zip:
Home Phone: □ Primary	Cell Phone: □ Primary	

Date of Birth:	Age:	Birth Sex: □ Male □ Female	Gender: □ Male □ Female □ Other:

Social Security No: *(not applicable for minors)*	Email Address:
Race: □ White □ Asian □ Black or African American □ Other:	Ethnicity : □ Non-Hispanic or Latino □ Hispanic or Latino □ Other:
Language : □ English □ Spanish □ Russian □ Other:	Marital Status: □ Minor □ Single □ Married □ Divorced □ Widowed □ Partnership □ Separated

Occupation:	Employer:	Work Phone:

PHARMACY INFORMATION

Pharmacy Name:	Cross-Streets:	City:

EMERGENCY CONTACT

Name:	Relationship to Patient:
Home Phone:	Cell Phone:

FINANCIAL RESPONSIBILITY / PRIMARY INSURANCE HOLDER INFORMATION

Last Name:	First Name:		MI:
Mailing Address *(if different from above)*:	City:	State:	Zip:

Date of Birth:	Birth Sex: □ Male □ Female	Social Security No:

Phone:	Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnership □ Separated
Email Address:	Relationship to Patient:

FAMILY INFORMATION FOR MINORS

Parent/Guardian Name:	Relationship to Patient:
Parent/Guardian Name:	Relationship to Patient:
Sibling Name: DOB: □ M □ F	Sibling Name: DOB: □ M □ F
Sibling Name: DOB: □ M □ F	Sibling Name: DOB: □ M □ F

FINANCIAL INFORMATION

PRIMARY INSURANCE ☐ Self-Pay

Subscriber Name ____________________

Insurance Company ____________________

Subscriber ID # ____________________

Group # ____________________

SECONDARY INSURANCE

Subscriber Name ____________________

Insurance Company ____________________

Subscriber ID # ____________________

Group # ____________________

FINANCIAL 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. Please see below policies. If you need further information about any of these policies, please ask to speak with our Billing Specialist at Precision Billing 208-296-5880.

PAYMENT METHODS

We accept payment by cash, credit card, and/or checks. Returned checks will be assessed a $25.00 service charge.

CONTRACTED INSURANCE PLANS

Meridian Family Medicine is contracted with most insurance plans.
We do NOT accept Medicaid for ages 19+, Medicare, Tricare, and First Health Network.
We do not check pre-eligibility for services or verify contracted plans. Please call you insurance to verify your policy.

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 or coinsurance. 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.

INTEREST CHARGES FOR LATE 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.

PAYMENT RESPONSIBILITY FOR MINORS

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 described above.

GOOD FAITH ESTIMATE

Under law, health care providers may give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services. You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees. Your health care provider will provide your Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visitwww.cms.gov/nosurprises or call 208-888-1199.

ACKNOWLEDGMENT

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. 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**: ______/______/______

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.

HIPAA NOTICE OF PRIVACY POLICY

NOTICE OF PRIVACY PRACTICE

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, follow the information practices that are described in this notice, obtain your acknowledgement of receipt of this notice, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect. We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use or disclose health information about you for the purpose of treatment, payment, administrative purposes, and other reasons as permitted by law. Subject to certain requirements, we may use or disclose your health information without your authorization for reasons such as: public health issues, auditing, research studies, emergencies, and for other purposes allowed by 45 CFR 164.512 or other applicable laws and regulations. As permissible by state and federal law, we may disclose your information to individual's granted access to your healthcare information or payment for your healthcare. We will limit the disclosure to the information relevant to that individual's involvement in your healthcare or payment. Meridian Family Medicine participates in one or more Health Information Exchanges (HIE) which allows disclosure of your electronic health record via electronic transfer to other facilities and providers for your treatment purposes. Your health information and basic identifying information regarding your visits may be shared with the HIEs for the purposes of diagnosis and treatment including health information for your continuing care, as well as care you may seek at other locations. Other providers participating in these HIEs may access this information as part of your treatment. Any other uses and disclosures of your health information not described in this Notice will be made only with your written authorization.

INDIVIDUAL RIGHTS

You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are not required to agree to the requested restriction except in limited situations in abidance of state and federal laws. You may revoke your authorization by submitting a written notice. The revocation will not be effective to the extent we have already taken action in reliance on the authorization. In most cases, you have the right to access or obtain a copy of your health information that may be shared by paper mail, fax, or other methods. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others or for other reasons as permitted by state and federal law. If you request copies, we require 30 working days to fulfill your request. The first copy of your own records will be of no charge and any additional copies of your records will result in a $50.00 fee. You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete. We normally contact you by telephone, text, mail, portal, and possibly by e-mail if you have provided your e-mail address. We will accommodate reasonable requests to contact you by alternative means or at alternative locations. You may obtain an electronic copy of this notice on our website and a paper copy upon request. 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 send a written notice to our office or to the U.S. Department of Health and Human Services.

AUTHORIZATION FOR RELEASE OF INFORMATION

The following individual(s) have the right to access my medical records per my permission:

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

ACKNOWLEDGEMENT

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

Signature: ______________________________ **Date**: ______/______/______

Printed Name of Patient/Responsible Party ______________________________

****If signing for a minor, relationship to the patient*** ______________________________

MISSED APPOINTMENT POLICY

Our goal is to provide quality medical care in a timely manner. In order to achieve this, we have implemented a policy for missed appointments. This policy allows Meridian Family Medicine to better utilize available appointments for our patients in need of medical care.

CANCELLATIONS
Appointments which are canceled or rescheduled with less than 24-hour notification may be subject to a ***missed appointment fee of $50-$100.***

NO SHOWS/LATE ARRIVALS
Patients who do not show up for their appointment (including late arrivals that cannot be seen) will be considered a No-Show and may be subject to a ***missed appointment fee of $50-$100.***

DISCHARGE/TERMINATION FOR MISSED APPOINTMENTS
Three (3) or more missed appointments (as described above) can end your ability to schedule future appointments and may ***lead to dismissal from our practice.***

PATIENT RESPONSIBILITY
The missed appointment fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

NEW PATIENTS
New Patients that No-Show their initial appointment will not be able to reschedule or seen for future appointments.

ACKNOWLEDGEMENT

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

Signature: ____ **Date**: ________/_________/__________

Printed Name of Patient/Responsible Party ____