FROST FAMILY MEDICINE

REGISTRATION

Patient Information (Please Sign and return to Receptionist)

Last Name		First Name	Middle Initial	Date of Birth
Address		City	State	Zip
Home Phone	Day Phone	Cell Phone	E-mail	Driver's License #
Preferred Language		Race	Soc Sec #	
Gender: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Life Partner				
Preferred Method of Contact: ❑ Mail ❑ Phone ❑ Cell Phone				

Responsible Party (Parent or legal guardian who resides with patient)

Last Name		First Name	Middle Initial	Date of Birth
Address		City	State	Zip
Home Phone	Day Phone	Cell Phone	E-mail	Driver's License #
Gender: ❑ Male ❑ Female Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Life Partner				
Relationship to patient:				

Emergency Contact (If different from responsible party)

Last Name		First Name	Middle Initial	Date of Birth
Address		City	State	Zip
Home Phone	Day Phone	Cell Phone	E-mail	
Relationship to patient:				

I/We do hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of Frost Family Medicine, Inc. which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage, excluding only authorized covered services provided under a valid prepaid HMO contract.

I furthermore agree to pay legal interest, collection expense, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Frost Family Medicine, Inc. to release information requested by insurance company and/or its representative.

_____ I fully understand this agreement and consent will continue until cancelled by me in writing.
Initial

_____ I authorize MemorialCare Medical Group, Inc. to render necessary medical or surgical
Initial treatment to the above named minor or whom I am the parent or legal guardian.

SIGNATURE: _____ DATE: _____

NAME (Please print): _____ RELATIONSHIP: _____

Pharmacy Information

Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advance Directives

❑ None ❑ Do Not Resuscitate ❑ Durable Power of Attorney ❑ Living Will ❑ HC Proxy
Date Reviewed:

Medications

❑ I do not take any medications.

List all medications you take, prescription and nonprescription, and their dosage.

Medication Name	Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Medication and Food Allergies

❑ No Known Allergies

List all known allergies (DRUGS, FOOD, ANIMALS, ETC):

1.
2.
3.
4.
5.
6.
7.
8.

Medical History

Please check if you have ever experienced any of the following conditions, and year of onset.

Condition	Year	Condition	Year
❑ None		❑ Gallbladder disease	
❑ Allergies		❑ GERD (Reflux)	
❑ Anemia		❑ Hepatitis C	
❑ Angina		❑ Hyperlipidemia	
❑ Anxiety		❑ Hypertension	
❑ Arthritis		❑ Irritable bowel disease	
❑ Asthma		❑ Liver disease	

Medical History (continued)

Condition	Year	Condition	Year
❑ Atrial fibrillation		❑ Migraine headaches	
❑ Benign prostatic hypertrophy		❑ Myocardial infarction	
❑ Blood clots		❑ Osteoarthritis	
❑ Cancer Type:		❑ Osteoporosis	
❑ Cerebrovascular accident		❑ Peptic ulcer disease	
❑ Coronary artery disease		❑ Renal disease	
❑ COPD (Emphysema)		❑ Seizure disorder	
❑ Crohn's disease		❑ Thyroid disease	
❑ Depression		❑ Other	
❑ Diabetes		❑ Other	

Surgical History

Please check if you have had any of the following procedures, and provide year procedure was done.

Surgical procedure	Year	Surgical Procedure	Year
❑ None		**Men Only**	
❑ Angioplasty		❑ Prostate Biopsy	
❑ Angioplasty w/ stent		❑ TURP (Trans-Urethral Resection of the Prostate)	
❑ Appendectomy			
❑ Arthroscopy knee		❑ Vasectomy	
❑ Back surgery		❑	
❑ CABG (heart bypass)		❑	
❑ Carpal tunnel release			
❑ Cataract extraction		**Women Only**	
❑ Cholecystectomy		❑ Augmentation mammoplasty	
❑ Colectomy		❑ Bilateral tubal ligation	
❑ Colostomy		❑ Breast biopsy	
❑ Gastric bypass		❑ Cesarean section	
❑ Hernia repair		❑ D and C	
❑ Hip replacement		❑ Hysterectomy	
❑ Knee replacement		❑ Mastectomy	
❑ LASIK		❑ Myomectomy	
❑ Liver biopsy		❑ Reduction mammoplasty	
❑ Pacemaker		❑ TAH/BSO	
❑ Small bowel resection		❑ Vaginal hysterectomy	
❑ Thyroidectomy		❑	
❑ Tonsillectomy		❑	

Health Maintenance

Please check if you have had any of the following exams and provide the date of the last exam.

Exams	Date	Exams	Date
❑ None		❑ GYN exam	
❑ Breast Exam		❑ Influenza Vaccine	
❑ Cardiac Stress Test		❑ Lipid Panel	
❑ Colonoscopy		❑ Mammogram	
❑ DEXA Scan		❑ PAP Test	
❑ Echocardiogram		❑ Physical Exam	
❑ EKG		❑ Pneumococcal Vaccine	
❑ Eye Exam		❑ Pulmonary Function Test	
❑ FOBT(stool card for hidden blood)		❑ Sigmoidoscopy	
❑ Foot Exam		❑ Tetanus Vaccine	

Family History

Please check if any family member has had any of the following conditions. ❑ Adopted							
Diagnosis	**Mother**	**Father**	**Sister**	**Brother**	**Other**	**Other**	**Other**
Alcoholism							
Allergies							
Alzheimer's disease							
Asthma							
Blood disease							
CAD (heart attack)							
Cancer/ Indicate Type:							
CVA (Stroke)							
Depression							
Developmental delay							
Diabetes							
Eczema							
Hearing deficiency							
Hyperlipidemia (high cholesterol)							
Hypertension (high blood pressure)							
Irritable bowel disease							
Learning disability							
Mental illness							
Tuberculosis							
Obesity							
Osteoarthritis							
Osteoporosis							
PVD							
Renal disease							
Other:							

Social History

For Adult Patient:

Do you have children? ❑Yes ❑No	How Many?	Female/s:	Male/s:
Tobacco Use:	❑Yes ❑No ❑Former, Year Quit:_____ Type: ❑Chewing ❑Pipe ❑Cigar ❑Cigarette ❑Smokeless, Brand:_____ Frequency: ❑ Daily ❑ Some days ❑ Not sure		
Alcohol Use:	❑ Never ❑Yes ❑No ❑ Former/Year Quit:_____ Type: ❑ Beer ❑ Liquor ❑ Wine ❑ Other:_____ Frequency: ❑ Daily ❑ Some days ❑ Not sure		
Exercise/Activity	Level: ❑ Moderate ❑ Sedentary ❑ Vigorous Frequency: ❑ Daily ❑ Some days ❑ Not sure	**Sleep Pattern:** Changes: ❑ Yes ❑ No	
Caffeine Use:	❑ Never ❑ Yes ❑ No ❑ Former/Year Quit: Type: ❑ Chocolate ❑ Coffee ❑ Soda ❑ Tablets ❑ Tea ❑ Other:_____ Frequency: ❑ Daily ❑ Some days ❑ Not sure		

For Pediatric Patient:

Patient Resides With:	Primary:	❑ Mother	❑ Father	❑ Both Parents	❑ Other:
	Secondary:	❑ Mother	❑ Father	❑ Other	
Parents Occupation: Mother:				Father:	

Parents Relationship: ❑ Married ❑ Divorced ❑ Separated	Childcare:					
	Mother	Father	Sibling	Grandparent	Nanny	Daycare
Tobacco Exposure: ❑ Yes ❑ No Smokers at Home: ❑ Yes ❑ No	Current Smoker: ❑ Daily ❑ Some days ❑ Not sure ❑ Former/Year Quit:					

Family History

Frost Family Medicine

Controlled Substances Policy

Abuse of Controlled Substances is a constant problem in the practice of medicine. At Frost Family Medicine (hereby FFM), we take our responsibility to prescribe these types of medications very seriously. To do otherwise would risk our own licensure, our reputation, and the patient's wellbeing.

These include, but are not limited to, opioid medications, such as Oxycontin, Percocet and Lortab, as well as benzodiazapenes, such as Xanax, Ativan, or Valium.

We will not prescribe Controlled Substances on a first visit. We will prescribe them when, in our clinical judgement, they are necessary.

Patients that require large doses of these medications, or patients that are on them chronically, will need to need to be established with a Pain Specialist. If you are not, we will gladly provide you a referal.

We have the ability to access your prescription history from anywhere in the state of South Carolina. Any patient that is found to be "doctor shopping", receiving narcotics from multiple sources, or violating our sacred professional trust, will be immediately released from our practice.

Thank you for your understanding.

Read and acknowledged,

_____ _____

Name of Patient Date

_____

Signature of Patient

Frost Family Medicine

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Who Will Follow This Notice

Frost Family Medicine (hereby FFM), its providers, staff, ancillary services, and volunteers while in the pursuit of providing your care.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive while in our care. We need this record to provide you with quality care and to comply with certain regulatory requirements. This Notice will tell you about the ways in which we may use and disclose medical information about you. This Notice also describes your rights, and certain obligations we have regarding the use and disclosure of your medical information. We are required by law to:

- Keep medical information that identifies you private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

How We May Use And Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to healthcare providers who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different healthcare professionals within FFM also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you outside FFM that treated you to people who may be involved in your medical care after you leave a FFM facility.

Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to, and payment may be collected from, you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at a FFM so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your insurance will cover the treatment.

Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without knowing the identities of the specific patients. We may disclose your medical information to another health care professional that you have seen so they may improve their quality or costs of care.

Health Information Exchange (HIE). FFM may make your individual medical information available to a local, regional and/or national Health Information Exchange ("HIE") including, but not limited to, the National Health Information Network ("NHIN"). An HIE is a state and/or federal government sponsored initiative that provides a mechanism for healthcare providers in our community to share information electronically, all with a common goal of improving the quality of care for our patients while protecting the privacy and security of your medical information. This type of access provides your physician with the most current information about your care and treatment.

FFM will only transmit your medical information to an HIE for the purposes of treatment, payment, or healthcare operations, or as required by law. Individual health information that currently by law requires an additional signed authorization for release WILL NOT be transmitted to an HIE without your consent, or as otherwise mandated by law or regulatory requirement.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at FFM.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care; Disaster Relief Efforts. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends about your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave our site. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at FFM.

Business Associates. There are some services provided for our organization through contracts with an outside organization, also known as a business associate. Examples include billing services to submit your claim to the insurance company for payment, transcription services to transcribe dictated reports from the health professionals caring for you in the hospital and copy services for making copies of your health record. When these services are performed by a business associate, we may disclose your information to our business associates so they can perform the job we have asked them to do.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

Averting a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Marketing and Sales. Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

Special Situations

Organ and Tissue Donation. We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military.

Workers' Compensation. We may release medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report the abuse or neglect of children, elders and dependent adults;
- to notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

Law Enforcement. If permitted by applicable law, we may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the hospital; and
- in emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Protective Services for the President, National Security and Intelligence Activities. We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official, if the release is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Multidisciplinary Personnel Teams. We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

Note on Other Restrictions. Please be aware that certain federal or state laws may have more strict requirements on how we use and disclose your medical information. If there are stricter requirements, even for the purposes listed above, we will not disclose your medical information without your written permission, or as otherwise permitted or required by such laws. For example, we will not disclose your HIV test results without obtaining your written permission, except as permitted by state law. We may also be restricted by law to obtain your written permission to use and disclose your information related to treatment for certain conditions such as mental illness, or alcohol or drug abuse.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy the information that we have about you that may be used to make decisions about you and your care, including your medical and billing records. We may deny your request to inspect and copy in certain very limited circumstances. To inspect and copy your information that may be used to make decisions about you, you must submit your request in writing to the Medical Records Department at FFM. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by FFM. To request an amendment, your request must be made in writing and submitted to the medical records department of FFM. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for FFM;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

You also may have the right to ask us to add an addendum to your records, which can be up to 250 words for each item you believe to be incorrect or incomplete. Please submit your request for an addendum to the medical records department of FFM.

Right to an Accounting of Disclosures. You have the right to request an "Accounting of Disclosures." This is a list of the disclosures we made of medical information about you other than disclosures for certain purposes, such as for treatment, payment and health care operations purposes, as those functions are described above, or any disclosures that have been specifically authorized by you. To request this list or accounting of disclosures, you must submit your request in writing to the Medical Records Department of FFM. Your request must state a time period, which may not be longer than three (3) years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

In addition, we will notify you as required by law following a breach of your unsecured protected health information.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations purposes. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you. If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the medical records department of FFM. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the medical records department at FFM. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Authorize or Refuse to Authorize Other Uses and Disclosures of Medical Information. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us your authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice at our website (www.frostfamilymedicine.com).

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on our website (www.frostfamilymedicine.com).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us and with the Secretary of the United States Department of Health and Human Services. All complaints must be submitted in writing. We will take no action against you and you will not be penalized for filing a complaint.

FFM Chief Compliance/Privacy Officer Contact Information:

Chief Compliance Officer/Privacy Officer
Frost Family Medicine
PO Box 1577
Bluffton SC 29910

FROST FAMILY MEDICINE

ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Your name and signature on this form indicates that you have received a copy of Frost Family Medicine's ***Notice of Privacy Practices*** on the date and time indicated below.

If you have any questions regarding the information contained in the ***Notice of Privacy Practices,*** please contact us at 843-815-5211.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

Date Received:_____Time Received: _____

FOR FACILITY USE ONLY

We attempted to obtain written acknowledgement of patient's receipt of our ***Joint Notice of Privacy Practices***, but acknowledgement could not be obtained from the patient for the following reason:

- ☐ Individual Refused to Sign
- ☐ Emergency Situation Prevented Signature
- ☐ Patient Requested Above Individual Sign on His/Her Behalf
- ☐ Other (please specify) _____

Registration Representative Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices

Frost Family Medicine

Assignment of Insurance Benefits/Eligibility Certification MRN: _____

Primary Insurance Plan		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date

Other Insurance Coverage for Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to Frost Family Medicine for any medical or surgical services rendered by its affiliated medical groups to me or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

_____

I understand that I am eligible for benefits through my HMO policy. I understand that my assigned IPA/Medical Group chosen for my benefits is Frost Family Medicine. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me), will pay in full all such charges.

_____

_____ _____

Signature of Patient /Responsible Party Date

Name of Patient/Responsible Party (please print) Relationship to Patient

Frost Family Medicine

MRN: _____

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

Frost Family Medicine

MRN: _____

Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must give us an alternative address or other method of contacting you. ***Some method of contact must be provided.***

We will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

This request supersedes any prior request for communication of information I may have made.

Extended Authorization

Please list any persons you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker or other family member:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Restrictions on Communication Methods

Our methods of communicating with you may be through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail. Please indicate below any ways in which you do **NOT** want to receive communications:

- ❑ No restrictions
- ❑ No calls to phone number(s): _____
- ❑ No messages or voice mails left on phone number(s): _____
- ❑ No mail to the following address(es): _____
- ❑ Other (please specify): _____

_____	_____
Signature of Patient /Responsible Party	Date
_____	_____
Name of Patient/Responsible Party (please print)	Relationship to Patient