Pembroke Family Medicine

Patient Demographic Form

In order to best serve you please complete this form in its entirety

Patient Information

Last Name ____ First Name ____

Street Address ____

City ____ State ____ Zip Code ____

Mailing Address ____

City ____ State ____ Zip Code ____

Home Phone # ____ Cell Phone # ____

Email Address ____

Social Security # ____ Date of Birth __ / __ / ____ Sex ☐ M ☐ F

Pharmacy ____ Pharmacy Phone # ____

Pharmacy Location ____

Race ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

Preferred Language ____

Ethnicity ☐ Spanish/Hispanic Origin ☐ Not of Spanish/Hispanic Origin ☐ Unknown

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Insurance Information: All insurance cards must be presented at each appointment

Primary Insurance ____ Member ID ____

Name of Policy Holder ____ Policy Holder SS# ____

Policy Holder Date of Birth __ / __ / ____ Relationship to Patient ____

Policy Holder Employer ____

Secondary Insurance ____ Member ID ____

Name of Policy Holder ____ Policy Holder SS# ____

Policy Holder Date of Birth __ / __ / ____ Relationship to Patient ____

Policy Holder Employer ____

Continued on Other Side

Guarantor: If different from patient the guarantor is the person responsible for payment of any portion of the bill not covered by insurance.

Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐

Street Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ State ☐☐ Zip Code ☐☐☐☐☐☐☐

Home # ☐☐☐☐☐☐☐☐☐☐ Cell # ☐☐☐☐☐☐☐☐☐☐

Relationship to Patient ☐☐☐☐☐☐☐☐☐☐☐

Social Security # ☐☐☐☐☐☐☐☐☐ Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

- *I certify that the above information is true and correct to the best of my knowledge.*
- *I authorize the release of my medical information necessary to process insurance claims, to insurance companies or their agencies, for the purpose of payment.*
- *I authorize payment to Mary Obear MD PLLC.*
- *I understand that I am responsible for any unpaid balance for services rendered and any billing and collections fees incurred by Mary Obear MD PLLC dba Pembroke Family Medicine.*
- *I understand that I am responsible for notifying Pembroke Family Medicine immediately if any of the above information changes.*
- *I have received copies of Pembroke Family Medicine's Financial Policy and Missed Appointment Policy.*
- *I have read and understand the Financial Policy and Missed Appointment Policy, and agree to abide by said guidelines for each policy.*

Signature: ____

Date: ☐☐ / ☐☐ / ☐☐☐☐

Pembroke Family Medicine
860 Main Road 319 West Main 3399 Buffalo Street
Corfu, NY 14036 Batavia, NY 14020 Alexander, NY 14005

Phone (585)599-6446
Fax (585)599-3166

Authorization of Notice of Privacy Practices

Patient Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

I have received Pembroke Family Medicine's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my Protected Health Information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted to or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of the other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual right with respect to protected health information and a brief description of how I may exercise these rights with relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to the requested restriction.
    - The right to receive confidential communications of my protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

We offer different ways to contact you. In accordance with our Notice of Privacy Practices, **we will contact you by telephone, mail, and/or with who answers the number you have supplied us with regarding appointment reminders, and by telephone and/or mail regarding medical information.**

If you would like to select *additional contact options*, please indicate with a **YES** on each line.

Leave appointment message on:

Office Voice Mail __________

Send via Email __________

Leave medical information on:

Office Voice Mail __________

Send via Email __________

Please Continue to the Other Side******

Form Not Valid Unless Signed

Emergency Contact

Name: ______________________________

Relationship to Patient: ______________________________

Address: ______________________________

____

Home Phone: ______________________________

Cell Phone: ______________________________

Include the above on Hipaa? __ Yes __ No

I grant permission to the following individuals to speak to or to receive medical information in regard to myself:

Name: ______________________________

Relationship to Patient: ______________________________

Address: ______________________________

____

Home Phone: ______________________________

Cell Phone: ______________________________

Name: ______________________________

Relationship to Patient: ______________________________

Address: ______________________________

____

Home Phone: ______________________________

Cell Phone: ______________________________

Name: ______________________________

Relationship to Patient: ______________________________

Address: ______________________________

____

Home Phone: ______________________________

Cell Phone: ______________________________

Signature: ______________________________ Date: ______________________________
Of Patient
or Personal Representative

Form Not Valid Unless Signed

Pembroke Family Medicine www.pembrokefamilymed.com

860 Main Road
Corfu, NY 14036

319 West Main
Batavia, NY 14020

3399 Buffalo Street
Alexander, NY 14005

Mary Obear MD, PhD ~ Ashton Raduns ANP
Lily Snyder MD ~ Lisa Feitshans ANP, PNP ~ Larraine Wende FNP
Matthew Fernaays MD ~ Shelly Bish FNP ~ Christina Sobczak PNP

Ph: (585)599-6446 Fx: (585)599-3166

Authorization for Release of Protected Healthcare Information

Name of Patient ______________________________

Date Of Birth ______________ SS# ______________

Address ______________________________

City ______________ State ______ Zip Code ______________

I hereby request and authorize Pembroke Family Medicine to **obtain** protected healthcare information of the patient named above **from**:

Name ______________________________

Address ______________________________

City ______________ State ______ Zip Code ______________

Phone ______________ Fax ______________

Specific information to be released:

☐ Entire Medical Record, including patient histories, office notes, test results, radiology studies, films, consults, and records sent to you by other health care providers and facilities.

Include: **(Indicate by Initialing)**

_______ Alcohol/Drug Treatment
_______ Mental Health Information
_______ HIV Related Information

☐ Medical Records from (insert date) ______________ to (insert date) ______________

☐ Other: ______________________________
____

Reason for release of information:

☐ Transferring Care ☐ Other: ______________________________

1. I understand that this authorization will expire one year after it is signed. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Pembroke Family Medicine at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I have the right to request for a photocopy of this form after I sign it.
7. Definition: Sexually Transmitted Diseases (STD) as defined by law, RCW70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL,chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Syndrome) AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient ______________________________ Date ______________

OR

Parent/Legal Guardian/Authorized Person ______________________________ Date ______________

* * *

Updated: March 26, 2012
Effective date: October 26, 2007

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these law are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Pembroke Family Medicine, 860 Main Road, Corfu, NY 14036, by calling our office at (585) 599-6446, or emailing us at office@pembrokefamilymed.com

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Also, we may inform you of your results and/or medical conditions by phone and/or mail. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Optional Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment by telephone and/or mail, also by leaving a message with whomever answers the phone number you have supplied us with.

5. Optional Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Optional Health Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health related benefits or services that may be of interest to you.

7. Optional Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures Required by Law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. Use and Disclosure of your PHI in Certain Special Circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks**. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury, or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or

medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:

   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
   - Concerning a death we believe has resulted from criminal conduct,
   - Regarding criminal conduct at our offices,
   - In response to a warrant, summons, court order, subpoena or similar legal process,
   - To identify/locate a suspect, material witness, fugitive or missing person,
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator).

5. **Optional Deceased Patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Optional Organ and Tissue Donation.** Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Optional Research.** Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

   - The use or disclosure involves no more than a minimal risk to your privacy based on the following:
     - an adequate plan to protect the identifiers from improper use and disclosure;
     - an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
     - adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

   - The research could not practicably be conducted without the waiver,

   - The research could not practicably be conducted without access to and use of the PHI.

8. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including vetrans) and if required by the appropriate authorities.

10. **National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct invistigations.

11. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary:
    - for the institution to provide health care services to you,
    - for the safety and security of the institution,
    - to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs.

E. Your Rights Regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must **indicate such requests on the HIPAA Authorization form** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must indicate your requests on the HIPAA Authorization form. Your request must describe in a clear and concise fashion:

    - The information you wish restricted,

    - Whether you are requesting to limit our practice's use, disclosure, or both,

    - To whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Pembroke Family Medicine, Attn: Medical Records 860 Main Road, Corfu, NY 14036 or by fax to (585) 599-3166 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Pembroke Family Medicine, Attn: Medical Records 860 Main Road, Corfu, NY 14036 or by fax to (585) 599-3166. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion:

   - accurate and complete;
   - not part of the PHI kept by or for the practice;
   - not part of the PHI which you would be permitted to inspect and copy;
   - not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Pembroke Family Medicine Attn: Medical Records 860 Main Road, Corfu, NY 14036 or by fax to (585) 599-3166. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Pembroke Family Medicine Medical Records Department at (585) 599-6446.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Pembroke Family Medicine Attn: Business Manager 860 Main Road, Corfu, NY 14036 or by fax to (585) 599-3166. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by

applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

9. **Personal Representatives.** Pembroke Family Medicine will treat an individual's personal representative as the individual with respect to uses and disclosures of the individual's protected health information. Personal representatives are indicated as follows:

If the Individual Is:	**The Personal Representative Is:**
An Adult or an Emancipated Minor	A person with legal authority to make health care decisions on behalf of the individual. *Examples: Health care power of attorney* *Court Appointed Legal Guardian* *General Power of Attorney*
An Unemancipated Minor	A parent, guardian, or other person acting in *loco parentis* with legal authority to make health care decisions on behalf of the minor child. *Exceptions: See A below for further explanation*
Deceased	A person with legal authority to act on behalf of the decedent or the estate (not restricted to health care decisions) *Examples: Executor of the estate* *Next of Kin or other family member* *Durable power of attorney*

A) Parents and Unemancipated Minors. In most cases, the parent is the personal representative of the minor child and can exercise the minor's rights with respect to the protected health information, because the parent usually has the authority to make health care decisions about his or her minor child. The Privacy Rule specifies three circumstances in which the parent is not the "personal representative" with respect to certain health information about his or her minor child. These exceptions generally track the ability of certain minors to obtain specified health care without parental consent under State or other laws, or standards of professional practice. In these situations, the parent does not control the minor's health care decisions, and thus under the Privacy Rule, does not control the protected health information related to that care. The three exceptional circumstances when a parent is not the minor's personal representative are:

- When state or other law does not require the consent of a parent or other person before a minor can obtain particular health care service, and the minor consents to health care service;
  - Minors may give consent to receive reproductive health services and family planning service. This includes gynecoloigical exams, pap tests, contraceptives (including emergency contraceptives), pregnancy testing, pregnancy options counseling, counseling on sexual decision-making, and treatment for vaginal infections. Pregnant teens may give consent to medical, dental, health, and hospital services related to prenatal care.
  - Minors may consent to their own testing and treatment for sexually transmitted diseases (STDs).
  - Minors may consent to their own pregnancy termination. The youth has no obligation to report the pregnancy or termination to his or her personal representative.
  - Minors may obtain mental health treatment without the consent of his or her personal representative.
  - Minors may consent to alcohol abuse and substance abuse services if treatment is deemed necessary for the child's best interest.
- When a court determines or other law authorizes someone other than the parent to make treatment decisions for a minor;
- When a parent agrees to a confidential relationship between the minor and the physician.

For further questions or information please contact our office by phone at (585) 599-6446, by mail at 860 Main Road, Corfu, NY 14036-9753, or by email, at office@pembrokefamilymed.com.

Patient Copy: Please Take With You

PEMBROKE FAMILY MEDICINE

MISSED APPOINTMENT POLICY

Pembroke Family Medicine will charge a rescheduling fee for each appointment that is missed without adequate notice ("no showed"). A no show is an appointment that is:

- missed without notice
- missed with **less than 2 hours** notice
- missed due to **arriving 15 minutes or more** beyond the scheduled appointment time

If you must miss a scheduled appointment, please notify our office by phone 2 hours prior to the appointment time or 24 hours before a new patient appointment.

For new appointments, we request 24 hours notice in order to have adequate time to reschedule the appointment time. If you miss any new appointment without any notice, we will be unable to continue your care at this practice. This means you will be discharged from the practice.

No Shows are tracked. Upon the event that an appointment is missed 3 times within a twelve month period, your account will be up for review for possible dismissal from our practice.

The fees for No Shows are as follows:

New patient appointment 30 minute $40.00
OBI/Med Clearance/CPE/Well Woman/Inpatient Fup $40.00
Return appointment (standard) $20.00
Return appointment (extended) $40.00

A one time grace period is allowed in which you can no show for an appointment without a Rescheduling Fee. Rescheduling fees must be paid prior to your next scheduled appointment. You will be notified via your statement by mail of no show fees. You are responsible for any no show fees you are charged; your insurance company will not be billed .

In an effort to provide the best care possible, Pembroke Family Medicine reserves the right to make changes to this policy without advanced notice.

Patient Copy: Please Take With You

Pembroke Family Medicine Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this financial policy. Please read it and ask us any questions you may have.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. We require to see a copy of your insurance card at every visit. **Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage**

2. **Co-payments and deductibles**. All co-payments must be paid at the time of service. **This arrangement is part your your contract with your insurance company.** Failure on our part to collect co-payments and deductibles from patients can be considered **fraud**. Please help us in upholding the law by paying your co-payment at each visit. Deductibles will be billed to you after we have received payment from your insurance company.

3. **Non-covered services**. Please be aware that some and perhaps all of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit.

4. **Proof of Insurance**. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information within the insurance timely filing periods, we will not submit the claim. You will be responsible for the balance.

5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.**

6. **Coverage changes**. If your insurance changes, please notify us before your next visit, so we can make the appropriate changes to help you receive your maximum benefits.

7. **Nonpayment.** You will receive monthly statements noting any balance you may have on your account that you are responsible for. If you do not agree with the balance owed, please contact the billing department to discuss it. Payment is expected in full within 30 days. If the balance on your account is not paid you will receive statements as a reminder of the balance. A $5.00 finance charge will be imposed for all balances over 30 days. Balance is due upon receipt and is past due if not paid within 30 days. If after 120 days your account is still not paid, we may refer your account to our collection agency and/or you and your immediate family members may be released from the practice.

8. **Missed appointments**. Our policy is to charge for missed appointments not canceled with at least 2 hours notice, 24 hours notice is required for new patient appointments. These charges will be your responsibility and billed directly to you. Charges for missed appointments are due within 30 days or prior to your next appointment, whichever comes first. Please help us to serve you better by keeping your scheduled appointment.

9. **Late arrivals**. Appointments will be rescheduled if you arrive 15 minutes or later past your scheduld time.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.