KING OF PRUSSIA MEDICINE REGISTRATION FORM

FREDERIC S. BECKER, MD **ANN G. TILL, MD** **MELISSA R. COGNETTI, MD** **WENDY OLINICK, DO**

860 FIRST AVE. ST. 4B KING OF PRUSSIA, PA 19406 T: 610-265-1251 F: 610-265-1252 www.kingofprussiamedicine.com

Name: _____ **DOB:** _____ **Gender:** _____

Social Security: _____ - _____ - _____ **Marital Status** (Circle One): *Single Married Divorced Widowed Partner Other*

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____ **Consent to Text:** Yes / No

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Race: _____ **Ethnicity** (Please Circle): Latino / Non-Latino **Language:** _____

Employment Status: _____ **Employer:** _____ **Occupation:** _____

EMAIL: _____ **Access to Patient Portal?** Yes / No

Do you see any other Providers / Specialist? (Please list below):

INSURANCE INFORMATION

Primary Insurance Carrier: _____ **Policy ID:** _____

Group #: _____ **Policy Holder:** _____ **Policy Holder DOB:** _____

Secondary Insurance: _____ **Policy ID:** _____

Group #: _____ **Policy Holder:** _____ **Policy Holder DOB:** _____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

Preferred Lab: _____ **Preferred Imaging Facility:** _____ **Phone #:** _____

Patient/ Guardian Signature: _____ **Date:** _____

I HEARBY AUTHORIZE KING OF PRUSSIA MEDICINE THROUGH ITS APPROPRIATE PERSONNEL TO PERFORM OR PERFORM UPON ME, OR THE ABOVE-NAMED PATIENT APPROPRIATE ASSESSMENT AND TREATMENT PROCEDURE. I FURTHER AUTHORIZE KING OF PRUSSIA MEDICINE TO RELEASE TO APPROPRIATE AGENCIES ANY INFORMATION ACQUIRED IN THE COURSE OF MY OR THE ABOVE PATIENTS EXAMINATION AND TREATMENT.

KING OF PRUSSIA MEDICINE STATEMENT OF PATIENT FINANCIAL RESPONSIBLITIES

EFFECTIVE January 2015

PATIENT NAME: _____ **DOB:** _____

King of Prussia Medicine appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure **payment in full of our fees.** As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co- insurance as determined by your contract with your insurance carrier. **We expect these payments at time of service.** Many insurance companies have additional stipulations that may affect your coverage. **You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, you will be responsible for your balance in full.**

I have read the above policy regarding my financial responsibility to King of Prussia Medicine for providing medical services to me or the above names patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to King of Prussia Medicine, the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Additional Financial Fees: **$30.00** fee for returned checks, patient balances not paid in full **AFTER** 60 days will incur a **$10.00** per month billing charge. Any accounts referred to our Collection Agency will incur an **ADDITIONAL $50.00** fee per account.

Patient/Guardian Signature: _____ **Date:** _____

SELF PAY

I DO NOT HAVE HEALTH INSURANCE and will be responsible for services rendered here at King of Prussia Medicine. I agree to pay King of Prussia Medicine, the full and entire amount of treatment given to me or the above-named patient at the **time of visit.**

Patient/ Guardian Signature: _____ **Date:** _____

CO PAY – DEDUCTIBLE CO-INSURANCE POLICY

Some health insurance carriers require the patient to pay a **Co-pay / deductible / Coinsurance** for services rendered. It is **expected and appreciated at the time the service** is rendered for the patients to pay at each visit. Thank you for your cooperation in this matter.

Patient/ Guardian Signature: _____ **Date:** _____

CANCELLATION / NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, if you need to cancel or reschedule your appointment, **we strongly urge you to call 24-hours prior to your scheduled visit.** Furthermore, **we reserve the right to charge a fee for no show appointments or continued same day cancellations.**

I understand if I NO SHOW or Same day cancel for two consecutive appointments; No Show/ Same day cancel for more than three non-consecutive appointments; I may be discharged from care. The Practice will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information and agree to the terms described.

Patient/ Guardian Signature: _____ **Date:** _____

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FREDERIC S. BECKER, MD ANN G. TILL, MD MELISSA R. COGNETTI, MD WENDY OLINICK, DO

CONSENT TO DISCLOSE HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name: _____ **DOB:** _____

Many of our patients allow family members such as their spouse, parents, siblings, or others to call on their behalf to request medical or billing information. Under the requirements of HIPPA we are not permitted to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to any family members or friends, you must sign the consent below. By signing this consent, you are authorizing King of Prussia Medicine to share information to the individuals listed below ONLY.

I authorize King of Prussia Medicine to share/ release my medical or billing information with the following individuals:

- _____ Relation to Patient: _____
- _____ Relation to Patient: _____
- _____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by Federal or State Law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient/ Guardian Signature: _____ **Date:** _____

KING OF PRUSSIA MEDICINE ANNUAL PREVENTATIVE- WELLNESS EXAM GUIDELINES

If you are scheduled for an Annual Wellness, Preventative, or Physical Exam, the visit will be submitted to the insurance company as a **PREVENTATIVE EXAM**. Depending on the patient's individual insurance policy, an Annual, Preventative, Wellness Exam may be **FULLY** covered by the insurance plan every calendar year from the date of service of the previous year visit. However, some insurance policies may only cover a **PORTION** of the exam. It is the **MEMBER'S RESPONSIBILITY** to know their insurance policy benefits and coverage of service.

PREVENTATIVE CARE:

When a service is performed specifically for preventative screening with no other illnesses, symptoms, or new concern, the service is considered **PREVENTATIVE CARE**, subject to age and gender guidelines, the health status of the person and the individual benefit plan.

DIAGNOSTIC CARE:

Services are considered **DIAGNOSTIC CARE** when medical treatment for the specific health conditions, on-going care, lab or other tests necessary to manage or treat a medical issue or health conditions; (i.e., hypertension, diabetes, orthopedic pain,), these services are **NOT PREVENTATIVE CARE.** Therefore, if during a Preventative Exam a medical condition is addressed/discussed and documented, the visit may be sent to your insurance as an office visit addressing the medical condition in addition to the Preventative Exam. This is a requirement by both the Federal Government and private insurance companies and may result in a collection of a co-pay or charges against a deductible if applicable.

Please be aware that each insurance policy varies in coverage or partial coverage of any tests which may considered routine (i.e., blood draw, EKGs, urine test, imaging studies, vaccines) ordered by the physician. Any services/tests not covered by your policy may result in **YOUR RESPONSIBILITY** for the costs.

Finally, all insurance companies require that the physician assign diagnosis codes to each type of service provided, whether it is for Preventative/Wellness Exam, routine Office Visit, or other. Once the physician submits the code for the services rendered to the insurance at the end of the visit/day, the code **CANNOT AND WILL NOT** be altered by the physician or office staff.

We are required to follow these guidelines in order to comply with current regulations. Therefore, we are informing you of this policy and ask that you sign and acknowledge you understand the explanation of services.

Sincerely,

King of Prussia Medicine

Patient Name: _____ **DOB**: _____

Patient/Guardian Signature: _____ **Date:** _____

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FREDERIC BECKER, MD **ANN G. TILL, MD** **MELISSA R. COGNETTI, MD** **WENDY OLINICK, DO**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize: _____
(Name of Provider/ Institution)

Telephone: _____ Fax: _____

to release medical information for:

Patient Name: _____ **Date of Birth:** _____

The above listed patient authorizes the release of Health Information regarding:

- _____ Medical History, Examination Reports
- _____ Coverage Period of treatment FROM: _____ to _____
- _____ Hospital Records/ Reports
- _____ Surgical/Radiology/ Lab Reports
- _____ Entire Medical Record
- _____ Other: _____
Please specify

I understand that any information released pursuant to this request will not include any information related to treatment for AIDS/HIV, psychiatric care and treatment, drug and alcohol abuse treatment unless specifically checked below:

____ **AIDS/HIV** _____ **Psychiatric Care/Treatment** _____ **Treatment for Drug or Alcohol use/ abuse**

Purpose of requested information: *(Please circle)*

Legal **Personal** **Continuation of Care** **Transfer of Care** **Other**

I understand I may revoke this authorization at any time I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. UNLESS OTHERWISE REVOKED THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE:

_____.

If I fail to specify an expiration date this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed as provided in CFR 164.524. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/ Guardian Signature: _____ **Date:** _____

King of Prussia Medicine I Date Faxed/ Mailed: _____

KING OF PRUSSIA MEDICINE HIPPA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize King of Prussia Medicine, Frederic Becker MD PC, its health practices, and providers including physicians, medication assisted treatment team, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending health practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures.

PRIVACY NOTICE: I acknowledge receipt of the Health Information Privacy Notice for King of Prussia Medicine.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized health benefits is made on my behalf directly to the provider of service(s) furnished to me. I authorize King of Prussia Medicine to release any health information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to King of Prussia Medicine, Frederic Becker MD PC. I hereby authorize that photocopies of this form to be valid as the original.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through KOP Med health practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a billing statement whether it is an interim or final bill. If I fail to make full payment or fail to comply with other payment arrangements made with King of Prussia Med approval, I understand that appropriate collection measures may be initiated.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient health information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. King of Prussia Med has a system-wide electronic health record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient, or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated King of Prussia Med and other the primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. King of Prussia Medicine and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

PATIENT PORTAL: Access to the secure patient portal is an optional service which I may suspend or terminate it at any time for any reason. I understand that my access to the patient portal will not affect the level of care that I receive. I understand that it is my responsibility to notify the office if there is a change in my email account or if I feel that my secure password has been breached.

ELECTRONIC PRESCRIBING: I understand that King of Prussia Med health practices and Providers may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that King of Prussia Med providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this health information.

IMMUNIZATION REGISTRY: I understand that King of Prussia Med participates in the Pennsylvania Department of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that King of Prussia Med offices provide no facilities for safekeeping of valuables. I do hereby release King of Prussia Med from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to the office.

Consent to Electronic Communication

I consent and authorize King of Prussia Medicine- Frederic Becker MD PC DBA, including but not limited to schedulers, billing, and other staff to use automated telephone dialing systems, SMS text messaging, and electronic mail to (1) provide messages (including prerecorded messages or text

messages) to me about my account, payment due dates, missed payments, information for or related to medical goods and/or services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that I may opt out by calling King of Prussia Medicine at 610-265-1251.

HEALTH INFORMATION EXCHANGES: King of Prussia Med may make your health information available electronically through a state, regional, or national Health Information Exchange (HIE) service or through Wellcentive/ CCD to facilitate the secure exchange of your health information between and among several health care providers or other health care entities for your treatment, payment, or other healthcare operations purposes. This means we may share information we obtain or create about you with a HIE, which will be made available to outside entities (such as hospitals, doctors offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information) so each entity can provide better treatment and coordination of your healthcare services. In cases where your specific consent or authorization is required to disclose certain health information to others, we will not disclose that health information without first obtaining your consent. Information that requires additional consent in order to be shared includes psychotherapy notes, treatment for substance or alcohol abuse, and records of tests or treatment for sexually transmitted diseases.

We also participate with the Health Share Exchange (HSX), which is a non-profit organization responsible for facilitating data sharing between healthcare providers. For example, if you were to visit an unfamiliar Emergency Department, the ED doctor will be able to access your health record to see your medical history, including allergy information. Access to your health information during an emergency can be lifesaving, especially if you are unconscious, and unable to relay your important health information to the doctor. If for any reason you are uncomfortable with this type of data sharing, you have the option to opt out. This is your responsibility. Note: if you choose to opt out of HSX, then it is important for you to know that your information will not be available to view, even in emergency situations.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

Patient Name: _____ **DOB:** _____

Patient/ Guardian Signature: _____ **Date:** _____

Consent for "Virtual" (Non-In-Person) Visits

Patient Name: _____ Date of Birth: _____

I, _____ hereby voluntarily consent to receive "virtual" care. I understand that this consent form will be valid and remain in effect for as long as I am receiving medical care at _____.

Examples of the virtual services offered pursuant to this consent include:

Virtual check-ins: You and your treating provider may have a brief phone call to determine whether an in-person visit or other appropriate treatment is necessary.

E-visits: You may communicate with your treating provider through your patient portal or secure email.

Telehealth visits: You and your treating provider can use real-time interactive audio and video communication that permits real-time communication (such as FaceTime, Skype or What's App) to conduct a visit while you and your treating provider are in different locations.

"Virtual" or "Telehealth Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Because this type of consultation may be different from that with which you are familiar, it is important you understand and agree to the following statements:

- My treating provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the provider. _____ (initials)
- I understand that my voice and image may be recorded to assist in my treatment and I consent to any such audio and video recording. _____ (initials)
- I understand there are potential risks associated with this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are limitations to this type of care and that I may seek alternatives. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if either party determines that the videoconferencing connections are not adequate for my situation. _____ (initials)
- I understand that I may be disconnected before all my medical problems are known or treated. It is my responsibility to make such conditions or symptoms known to the medical personnel and to make arrangements for follow-up care. _____ (initials)
- I understand that standard deductible and coinsurance amounts apply to these "Virtual" or "Telehealth Visits" and I consent to virtual treatment. _____ (initials)

I have read and fully understand this **Consent for "Virtual" (Non-In-Person) Visits** and agree to its contents.

Signature of Patient or Person Authorized to consent for patient:

_____ _____

Signature Date

_____

Printed Name (if other than patient)

☐ This Consent for Virtual (Not-In-Person) Visits has been provided verbally by the Patient.

King of Prussia Medicine Acknowledgment and Authorization Consent

Name: _____ **DOB**: _____

(Print Name)

Please review and initial authorization consent below:

- I have read and understand the HIPPA/Privacy Policy for King of Prussia Medicine. _____
- I hereby assign my insurance benefits to be paid directly to the healthcare provider. _____
- I authorize King of Prussia Med to release medical information required to process my claim. _____
- I authorize King of Prussia Med to access, share info to Wellcentive & treatment purposes. _____
- I have read and understand the Financial Policy for King of Prussia Medicine. _____
- I authorize King of Prussia Medicine to obtain/have access to my medication history. _____
- I authorize my provider's office to contact me by my mobile phone. _____

HIPAA: Acknowledgement of Receipt of Notice of Privacy Practices

I have received/offered a copy of this practice's Notice of Privacy Practices. (Copy of HIPPA available upon request)

HIPAA: Consent for Use and Disclosure of Health Information

Notice of privacy practices: You have a right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. Please read this notice prior to signing this consent. This practice reserves the right to change policy practices as described in our Notice of Privacy Practices. If changes are made, a revised Notice of Privacy Practices containing the modifications will be issued. These changes may apply to any of you protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our HIPPA Security Officer or Office Manager at (610) 265-1251. You have the right to revoke this Consent for use and Disclosure of Health Information at any time by giving us written notice of your revocation submitted to the office. This revoke will not affect previous consent. We reserve the right to provide further treatment in your behalf or that of your dependents if this Consent is revoked.

I have had opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, to use and disclose my protected health information to carry out treatment payment activities and health care operation.

Signatures below indicate that I have read this entire document and fully understand the contents of this Consent/Authorization/Acknowledgement. I have been provided with the opportunity to ask questions and obtain further clarification.

Signature Date

If signature provided represents the patient's guardian or "personal representative" please complete info below:

Patient Name: _____ **Patient DOB**: _____