Hometown Family Medicine

Forty Five Eighty One Gravois Rd • House Springs, MO 63051
ph 636.671.9980 • fx 636.671.9981

Health Insurance Portability and Accountability Act (HIPAA)

Patient's Name (Please Print):____

Social Security Number:____________________ Date of Birth:______________________

Home Address: ____

Mailing Address if different: ____

Insurance Plan:____

Policy Holders Name:_____________________ Policy Holders DOB:__________________

Policy Holders Address:_________________________ Policy Holders Ph #____________

Policy Holders SSN# (Required for insurance purposes) ____________________________

I authorize Hometown Family Medicine to leave messages:

________ Sent through my personal email ______________________ (For patient portal access)
Initials Email Address

________ On my cell phone as a voice message _____________________
Initials Cell Phone Number

________ On my home answering machine/voice mail number:___________________
Initials Home Phone Number

________ On my work answering machine/voice mail number: ___________________
Initials Work Phone Number

____
Signature of Patient or Patient Representative Relationship Date

I authorize Hometown Family Medicine to discuss my health information to the person(s) I have named below:

Print Name	Relationship	Telephone Number

________ I do not want any medical information released to any family or friends.
Initials

Hometown Family Medicine
Forty Five Eighty One Gravois Rd • House Springs, MO 63051
ph 636.671.9980 • fx 636.671.9981

NOTICE OF PRIVACY PRACTICES

Patient Name: ____ Date: ___________________

Patient DOB: __________________________

I have received or I have been provided the opportunity to receive a copy of the Notice of Privacy Practices that explains when, where and why my confidential health information may be used or shared. I acknowledge that Hometown Family Medicine, the physicians, or nurses and/or Hometown Family Medicine staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Hometown Family Medicine operations and responsibilities.

____ ______________________________

Patient or Guardian Signature Relationship

Hometown Family Medicine

Forty Five Eighty One Gravois Rd • House Springs, MO 63051

ph 636.671.9980 • fx 636.671.9981

PAYMENT POLICY

Welcome to our office, where our professional staff are happy to help you meet your medical needs. Our business office is able to assist you in meeting your financial obligations that go along with medical care. It is our office policy to receive payment in full at time of service.

Payment is expected for all office service **AT THE TIME SERVICES ARE RENDERED** unless special arrangements have been made with the office manager in advance. If you have insurance, it is your responsibility to present us with current copies of your insurance card and we will file your claim with your insurance company. Please provide a current insurance card at the time of every office visit in order to avoid a delay in timely filing. A delay in timely filing with your insurance company could lead you to being responsible for the entire balance.

INSURANCE We participate in many insurance plans. If you are not insured with a plan we do business with, payment is expected at the time of service.

COPAYMENTS AND DEDUCTIBLES All copayments and deductibles must be paid at the time of service by all patients. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from payments can be considered fraud.

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 your insurance. It is the patients' responsibility to be aware of their individual insurance coverage. You can contact your customer service representative for your specific insurance benefits if you have any questions about covered services.

PROOF OF INSURANCE In order for us to process your insurance claims for you it is necessary to have current copies of your insurance card as well as the name, date of birth and social security number of the insurance card holder and the patient. Failure to give accurate demographic information may result in patient responsibility of the entire balance of a claim.

CLAIMS SUBMISSION We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may require you to supply certain information directly. It is your responsibility to comply with their request. Failure to do so may result in patient responsibility of the entire balance of the claim. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company and we are not party to that contract.

COVERAGE CHANGES If your insurance changes, it is your responsibility to contact us or the billing office as soon as possible. Delaying could lead to untimely filing causing you to be responsible for the entire balance.

STATEMENTS AND NONPAYMENT The account balance information is presented at the time of a current office visit and statements are mailed monthly to those patients with balances due. Payment of that balance is due on receipt. If your account remains past due a late charge of 1.5%per month and a minimum charge of $5.00 will be assessed on Statements. We may refer you to a collection agency and you and your immediate family members may be discharged from this practice. Fees for this agency will be in addition to the existing bill. If this is to occur, you will be notified by mail that you have 30 days to find alternate medical care. During that 30 day period, we will only be able to treat you on an emergency basis and no controlled substance prescriptions will be written.

APPOINTMENTS Every effort is made to remind patients of upcoming appointments. Missed New patient and Well Physical appointments cancelled less than 24 hours in advance will have a $50 fee applied. Missed follow-up appointments cancelled less than 24 hours in advance will be $25.00 fee. To avoid this fee, 24 hour advanced notice must be made. If you No-Show 3 appointments without any notice, you will be terminated from the practice.

We do discharge patients for failure to keep scheduled appointments, non-compliance of medical treatment and failure to pay. If you have any further questions, please feel free to discuss with the office staff.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________	______________________________	__________________
Signature (Responsible Party)	Patient Name	Date

Patient Financial Agreement

This is a Patient Financial Agreement for:
Hometown Family Medicine

Hometown Family Medicine requires all patients to make financial arrangements with us before we provide treatment.

1. I understand that full payment is due at the time of service for myself and any party for whom I am financially responsible.

2. I understand that it is solely my responsibility to confirm which treatments or procedures are covered and/or paid by my insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums.)

3. I understand that as a courtesy, Hometown Family Medicine will attempt to verify my insurance coverage from information that I provide and will file two claims per appointment. I am required to pay in full, before treatment is performed, the estimated portion of any procedures or treatment that will not be covered by my insurance.

4. I understand that insurance claims will only be filed if I provide Hometown Family Medicine with my insurance identification numbers. If I choose not to provide Hometown Family Medicine with my insurance identification numbers, I understand that I must pay in full for all services rendered. It is Hometown Family Medicine's policy to require a copy of government-issued picture identification (driver's license) for recordkeeping purposes even though that may not be the policy of my insurance carrier.

5. I understand that although I pay my estimated patient balance on the date of services, the insurance estimate may differ from what my insurance carrier ultimately pays. I will be responsible for any amounts not paid by my insurance for any reason, and I may receive a bill/statement for a balance due which will be immediately payable upon receipt.

6. I understand that if I fail to pay my account upon it becoming due, Hometown Family Medicine will send the account to an outside collection agency. I understand that I will be responsible for all collection fees.

7. I understand that I will be charged the maximum service charge allowed by law for any returned check, electronic authorization or any debit sent or provided to Hometown Family Medicine for payment.

8. I understand that I must inform Hometown Family Medicine in writing, of any concerns, questions, or disputes I may have concerning my treatment or charges in a timely manner but not more than 30 days from either the completion of the procedure or awareness of dispute.

9. I understand that unless patient records are sent directly to another provider, the charge for copies of medical records is $20.00 and treatment information is $20.00 or the maximum amount allowed by law or my insurance carrier. These fees are subject to change without notice.

10. I understand that Hometown Family Medicine currently charges $50.00 for Well Exam appts. And $25.00 for any other appt for a missed or cancelled appointment unless 24 hours advance notice is given. This fee is subject to change without notice. If you No-show 3 appointments without notice you will be terminated from the practice.

11. I understand that it is my responsibility to immediately notify Hometown Family Medicine of any changes to my address, phone number, work contact information, work status, insurance changes, etc.

12. I understand that if I discontinue treatment for a requested procedure, I remain responsible for paying all related costs for materials and services that were incurred before I discontinued treatment. All related costs will be deducted from any refund to which I may be entitled for discontinued treatment and I may receive a bill/statement for a balance due.

I have thoroughly read, understand and agree to the above terms and conditions.

_______________________________________ _____________________

Printed Name Date

____

Signature of Patient (or authorized guardian)

9/2014; Rev 1/2019

Renee L. Willer APRN, BC-FNP
Heather Krafve APRN, BC-FNP
Linda Rene Winterberger D.O.

4581 Gravois Rd. House Springs, MO 63051 • Ph 636.671.9980 • x 636.671.9981

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Hometown Family Medicine
4581 Gravois Road
House Springs, MO 63051

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☒ All healthcare information

☒ Other: Labs, ECGs, Immunization Records, Office notes, Radiology etc.

I understand that:

- This Authorization is valid for one year from date signed, unless I revoke/withdraw this Authorization or unless an earlier date is specified here: _________________________. I may revoke/withdrawal this Authorization, except to the extent that action has been taken prior to receipt of the revocation/withdrawal, by mailing or faxing my written request along with a copy of the original Authorization to the clinic or department where my Authorization was made or given.
- Authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. Any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal or state privacy laws.
- The medical information release may contain information related to HIV, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.

Patient Signature:____ Date Signed:________________________