Meridian FAMILY MEDICINE

Welcome to Meridian Family Medicine

PATIENT INFORMATION

Last Name:	First Name:		MI:
Preferred Name:	Previously Used Names (Maiden):		
Address:	City:	State:	Zip:
Date of Birth:	Birth Sex: ☐Male ☐Female	Gender: ☐Male ☐Female ☐Other:	
Home Phone: ☐ Primary	Cell Phone: ☐ Primary		
Social Security No: *(not applicable for minors)*	Email Address:		
Race: ☐White ☐ Asian ☐Black or African American ☐Other:	Ethnicity : ☐Non-Hispanic or Latino ☐Hispanic or Latino ☐Other:		
Language: ☐English ☐Spanish ☐Russian ☐Other:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnership ☐Separated		
Occupation:	Employer:	Work Phone:	

PHARMACY INFORMATION

Pharmacy Name:	Cross-Streets:	City:

EMERGENCY CONTACT

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

FINANCIAL RESPONSIBILITY / PRIMARY INSURANCE HOLDER INFORMATION *(if different from patient)*

Last Name:	First Name:		MI:
Mailing Address *(if different from above)*:	City:	State:	Zip:
Date of Birth:	Birth Sex: ☐Male ☐Female	Social Security No:	
Phone:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnership ☐Separated		
Email Address:	Relationship to Patient:		

FAMILY INFORMATION / MINOR SIBLINGS ESTBALISHING CARE

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

FINANCIAL INFORMATION

PRIMARY INSURANCE ☐ Self-Pay

Subscriber Name _____

Insurance Company _____

Subscriber ID # _____

Group # _____

SECONDARY INSURANCE

Subscriber Name _____

Insurance Company _____

Subscriber ID # _____

Group # _____

FINANCIAL POLICY

We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Payment is expected at the time of service. As a courtesy to you, we will bill your insurance. Please remember the insurance company's contract is with you. You are responsible for making sure your visit is covered by your insurance plan. Please see below policies. If you need further information about any of these policies, please ask to speak with our Billing Specialist at Precision Billing 208-296-5880.

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

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

RESPONSIBILITY FOR SERVICES
Your financial responsibility depends on a variety of factors, explained below. Please remember you may be responsible for a co-pay as well as a deductible or coinsurance. Remember, all insurance plans require some financial obligation from you. We will make every attempt to keep you current on your obligation, both with statements and on arrival in the office. As a courtesy to you, we will bill your insurance carrier. If no payment is received within 60 days, we will look to you for full payment.

INTEREST CHARGES FOR LATE PAYMENTS
We reserve the right to charge interest in the amount of ***7% per month*** as allowed by state law beginning 60 days after all payments and adjustments have been posted to claim (or second statement notice). In the event that any unpaid balance is assigned to a third party for collections, an additional ***35% collection fee*** will be added to the unpaid balance amount.

PAYMENT RESPONSIBILITY FOR MINORS
A parent or legal guardian must accompany patients who are minors on the patients' first visit. This accompanying adult is responsible for payment of the account, according to the policy described above.

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

ACKNOWLEDGMENT

I certify that I, and/or my dependent(s), have insurance coverage with the aforementioned Insurance Company and assign directly to Meridian Family Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Meridian Family Medicine may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one when I end my relationship with Meridian Family Medicine. I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to Meridian Family Medicine. I authorize Meridian Family Medicine to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Signature: _____ **Date**: _____

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

HIPAA NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICE

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information or any changes made, follow the information practices that are described in this notice, obtain your acknowledgement of receipt of this notice, and to notify affected individuals following a breach of unsecured health information. This notice, effective December 06, 2006, summarizes our duties and your rights concerning your information set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our notice that is currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices at any time, and to make the new notice provisions effective for all protected health information that we maintain. If we materially change our privacy practices, we will prepare a new Notice of Privacy Practices, which shall be effective for all protected health information that we maintain.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use or disclose your health information without your written authorization for certain purposes, including the following: Treatment - We may use or disclose your information for purposes of treating you such as disclosing your information to another healthcare provider for coordination of care. Payment - We may use or disclose your information to obtain payment for services provided to you such as disclosing information to your health insurance company or other payer to obtain payment for treatment. Healthcare Operations - We may use or disclose your information for certain activities that are necessary to operate our practice and ensure quality care such as using your information to train staff or make decisions affecting the practice. We may use or disclose your health information without your authorization for other purposes allowed by 45 CFR 164.512 or other applicable laws and regulations, including, but not limited to: For emergency circumstances - such as incapacity, a circumstance requiring emergent treatment, or to avert a serious threat to the safety or health of you or others. For compliance reasons with legal authority or as required by law - such as reporting abuse or neglect to appropriate federal or state law enforcement agencies, in response to a judicial or administrative proceedings such as a court order, warrant or subpoena, to identify, locate or catch a suspect, fugitive, material witness or missing person, to provide information about the victim of a crime, to alert law enforcement that a person may have died as a result of a crime, for national security reasons, to report a crime, to military command authorities if in the military, to law enforcement or correctional facilities if an inmate or under the custody of law enforcement, or to coroners or medical examiners to help fulfill their legal duties in identifying a deceased person or determine cause of death. For research, reporting, or public health reasons - such as reporting certain communicable diseases to the appropriate government agency or person at risk of contracting or spreading the disease or condition, reporting information necessary to prevent or control disease, injury or disability, reporting births or deaths, reporting limited information for FDA activities, disclosing information as authorized by law to governmental health oversight agencies to help perform audits, investigations or inspections, or disclosing information for research studies.

Unless instructed otherwise, we may use or disclose your information without authorization for reasons as described: We may disclose your health information to individual's granted access to your healthcare information or payment for your healthcare. We will limit the disclosure to the information relevant to that individual's involvement in your healthcare or payment. Meridian Family Medicine participates in one or more Health Information Exchanges (HIE) which allows disclosure of your electronic health record via electronic transfer to other facilities and providers for your treatment purposes. Your health information and basic identifying information regarding your visits may be shared with the HIEs for the purposes of diagnosis and treatment including health information for your continuing care, as well as care you may seek at other locations. Other providers participating in these HIEs may access this information as part of your treatment.

We will obtain a written authorization from you before using or disclosing your protected health information for purposes other than those summarized above. Examples of where your authorization would be required include, but are not limited to: disclosure of psychotherapy notes, marketing purposes that require authorizations, or if any of your health information would be sold. Any other uses and disclosures of your health information not described in this notice will be made only with your written authorization. You may revoke your authorization by submitting a written notice. The revoke of the authorization will not be effective for disclosures we have already made while the authorization was in effect.

INDIVIDUAL RIGHTS CONCERNING PROTECTED HEALTH INFORMATION

You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are not required to agree to the requested restriction except in limited situations in abidance of state and federal laws. You have the right to access or obtain a copy of your health information or request a copy of your protected health information be given to a third party. This information may be shared by paper mail, fax, or other methods. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others or for other reasons as permitted by state and federal law. If you request copies, we require 30 working days to fulfill your request. The first copy of your own records will be of no charge and any additional copies of your records will result in a $50.00 fee. You have the right to request amendments to incorrect or incomplete protected health information. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete. You have the right to request and receive an accounting of disclosures of your protected health information. We normally contact you by telephone, text, mail, portal, and possibly by e-mail if you have provided your e-mail address. We will accommodate reasonable requests to contact you by alternative means or at alternative locations. You may obtain an electronic copy of this notice on our website and a paper copy upon request. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact us at (208)888-1199 and send a written notice to Meridian Family Medicine ATTN: PrIvacy Officer at 1525 E Leighfield Dr, #150, Meridian, ID 83646 or to the U.S. Department of Health and Human Services. We will not retaliate against individuals for filings of complaints.

AUTHORIZATION FOR RELEASE OF INFORMATION

The following individual(s) have been granted the right to access my medical records:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

ACKNOWLEDGEMENT

Please sign, print name, and date this document in acknowledgement of this notice.

Signature: _____ **Date:** _____

Printed Name of Patient/Responsible Party:_____

Relationship to Patient: _____

MISSED APPOINTMENT POLICY

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

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

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

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

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

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

ACKNOWLEDGEMENT

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

Signature: _____ **Date**: _____