Meridian
FAMILY MEDICINE

Welcome to Meridian Family Medicine

PATIENT INFORMATION

Last Name:	First Name:	MI:	Preferred Name:
Mailing Address:	City:	State:	Zip:
Home Phone: □ Primary	Cell Phone: □ Primary		
Date of Birth:	Age:	Birth Sex: □ Male □ Female	Gender: □ Male □ Female □ Other:
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: □ Minor □ 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:

PARENT/GUARDIAN INFORMATION FOR MINORS / PRIMARY INSURANCE HOLDER INFORMATION

Last Name:	First Name:	MI:	
Mailing Address:	City:	State:	Zip:
Home Phone: □ Primary	Cell Phone: □ Primary		
Date of Birth:	Age:	Birth Sex: □ Male □ Female	Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnership □ Separated
Relationship to Patient:	Email Address:		

COMPLETE ONLY IF PATIENT IS A MINOR

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

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FINANCIAL INFORMATION

Primary Insurance

Subscriber Name _____

Insurance Company _____

Subscriber ID # _____

Group # _____

Secondary Insurance

Subscriber Name _____

Insurance Company _____

Subscriber ID # _____

Group # _____

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.

PAYMENT 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. For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Billing Specialist at **Precision Billing 208-296-5880.**

How may I pay?
We accept payment by cash, credit card, and/or checks. Returned checks will be assessed a $25.00 service charge.

Which Plans Do You Contract With?
Blue Cross, Blue Shield, Aetna, United Healthcare and the Primary Health Network.
We accept many other insurance plans; please check with the receptionist if you have any questions. Or call you insurance to verify your policy. **We do not accept Medicaid for ages 19+ nor Medicare plans for all age groups.**

What Is My Financial 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.

Will Interest Be Charged If I Fail to Make Timely Payments?
We reserve the right to charge interest in the amount of **2%** per month as allowed by state law beginning 60 days from the date of service.

What If My Child Needs to See the Physician?
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.

Do you accept Medicare?
We no longer accept any Medicare plans. Patients nearing age 65 who are preparing to transfer to Medicare coverage should plan ahead (at least 6 months in advance) regarding transfer of care to a Medicare provider.

ACKNOWLEDGMENT

*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**: _____/_____/_____

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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 PRIVACY POLICY

Uses and Disclosures of Health Information
We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care you receive. Subject to certain requirements we may use, or disclose this health information about you without your authorization for several reasons. Reasons may include public health issues, auditing, research studies and emergencies. We also provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing and identifiable health information about you. Such information may be shared by paper mail, fax, or other methods. Please be aware that we may change our policies at any time. You will be notified of any changes, and may request these changes in writing.

Individual Rights
In most cases, you have the right to look at, or get a copy of your health information that we use to make decisions concerning you. If you request copies, we require five working days after your request before this may be processed. Your first copy of your own records will be of no charge, any additional copies of your records will result in a $50.00 photocopy fee. If you are concerned that we have violated your privacy right, or you disagree with a decision we made about access to your records, you may contact us. You may also send a written complaint to the U.S. Department of Health and Human Services.

Our Legal Duty
We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

Idaho Health Data Exchange
Meridian Family Medicine has chosen to participate in the Idaho Health Data Exchange (IHDE). If you do not want to participate in the IHDE and you do not want to have your health care information shared with other medical providers involved in your care, you can opt out of the participation. To opt out, you must complete and sign the IHDE "Request to Restrict Disclosure of Health Information" form and mail or fax it to IHDE. You will receive a letter of confirmation upon completion of your request. This will restrict your information from being released through the exchange only (you will need to contact direct any facility you wish to also restrict your information with). This is a secure statewide internet-based health information exchange, with the goal of improving the quality and coordination of health care in Idaho.

AUTHORIZATION FOR RELEASE OF INFORMATION

The following person(s) have the right to access my medical records per my permission:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

ACKNOWLEDGEMENT

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

Signature: _____ **Date**: _____/_____/_____

Printed Name of Patient/Responsible Party_____

*If signing for a minor, what is your relationship to the patient? _____

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APPOINTMENT CANCELLATION / NO SHOW AGREEMENT

Our goal is to provide quality medical care in a timely manner. In order to achieve this, we have implemented a cancellation/no-show policy. 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 **$50 cancellation fee.**

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 **$50 No-Show fee.**

Three **(3)** or more missed appointments (as described above) within a 12-month period can end your ability to make appointments and may lead to **dismissal** from our practice.

PATIENT RESPONSIBILITY
The cancellation, no show, and rescheduling fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

ACKNOWLEDGEMENT

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

Signature: _____ **Date**: _____/_____/_____

Printed Name of Patient/Responsible Party _____