Findlay Family Practice, Inc.

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FINANCIAL POLICY

Your health insurance coverage is a contract between you and your insurance company. Your services will be submitted to your health insurance company as long as you have provided us with proper information to do so. It is your responsibility to present your insurance card to the receptionist prior to seeing the physician each time you visit our office.

All co-pays, patient percentages (10%,20%, etc.) and /or deductibles are due at the time of service. Failure to pay the co-pay at the time of service may result in additional charges. Payment may be made by cash, check, or Visa/Mastercard.

Regardless of insurance status, any date of service over 90 days will be switched to patient responsibility and will show up on your monthly statement as patient due. This will prompt you to investigate why insurance payment has not been made and resolve any problems which may exist. You may need to set up a payment plan to keep your account from falling into collection while resolving insurance issues. Patients whose accounts are sent to our collection agency will not be readmitted to the practice.

Signature of Patient (or person responsible for account)

Date:

FINDLAY FAMILY PRACTICE
PATIENT INFORMATION

Please Print Clearly

Patient Name: Last, First Middle ______________________

Birthdate: ____ - ____ - ____ (MO DAY YEAR) **Sex: M F** (Circle One)

Address: Street, R.D. #, Apt. # ______________________

Marital Status: M S W D SEP (Circle One)

City State Zip Code ______________________

Phone: Home: ______________________

Work: ______________________

Cell: ______________________

Patient Social Security # ____ - ____ - ____

Person Responsible for Account: ______________________ Relationship: __________

Driver's License #: ______________ State: ______

____ - ____ - ____
Responsible Party Social Security # (if not patient)

Employer: ______________________

Address: ______________________

City/State/Zip: ______________________

Address (if different from patient):

____

____

Medicare/Medicaid Number or Primary Insurance Company ______________________

Policy Holder Name: ______________________ Group #: __________ ID #: __________

Family Members Within Household:

	Name: Last, First Middle	*Birthdate (Mo/Day/Yr)*	*Relationship*
1.			
2.			
3.			
4.			
5.			
6.			

Others living in your home: ______________________

Closest Relative NOT living with you: ______________________ Relationship: __________

Address: ______________________ Phone: __________

MEDICAL HISTORY: Circle one:

1.	Are you taking any medication (prescription or over the counter)?	Y	N	List:
2.	Do you have any chronic disease(s)?	Y	N	List:
3.	Do you have any allergies?	Y	N	List:
4.	How much do you smoke?			
5.	How much do you drink?			
6.	Do other members of your family have any health problems?	Y	N	List:
7.	Is there other health information the doctor should know (including surgeries)?	Y	N	List:

Signature (person completing form): ______________________

Relationship, If not patient: ______________________

Date Form Completed: __________

Findlay Family Practice, Inc.

Patient Name:____Birth date:________
(Please Print)

Address:____________________________ City:____________Zip:_____________

Patient SS#:________________________

Email: ____

PATIENT CONFIDENTIALITY

In general, the HIPAA privacy rule gives individuals the right to request to restriction on uses and disclosures of their protected health information ("PHI"). The individual is also provided the right to request confidential communications or that a communication of protected health information be made by alternative means.

I authorize the offices of Findlay Family Practice to leave medical information pertaining to my care by the following methods and I will assume responsibility for notifying the office of Findlay Family Practice whenever this information changes.

I wish to be contacted in the following manner (check all that apply):

Verbal communication:

___ Home telephone #____________________ May leave message with detailed information: **Y N**
___ Cell phone # ____________________ May leave message with detailed information: **Y N**
___ Work phone # ____________________ May leave message with detailed information: **Y N**

Appointment reminders:

___ Text cell phone # ____
___ Leave message on land line # ____________________________________

I permit the Practice to discuss and disclose my PHI (Protected Health Information) to the following individuals:

Name: ______________________________Relationship:____________________
Name: ______________________________Relationship:____________________
Other: ____

Emergency Contact Name: ________________________ Phone: ________________

Insurance Company: ____

Name of person insurance is through, and relationship: ____________________________

Employer that the insurance is through: ____________________________________

If under the age of 18 years old, parent or guardian must sign.

Patient/Guardian Signature: ____________________________ Date: _______________

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS — Single Married Other; Employed, Full-Time Student, Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)

a. INSURED'S DATE OF BIRTH — SEX M F

b. OTHER INSURED'S ... MM DD

Please sign, date & sign where highlighted

...ME

c. EMPLOYER'S NA...

...AM NAME

d. INSURANCE PLA...

...T PLAN?

...urn to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER — SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION — a. b.

33. BILLING PROVIDER INFO & PH # ( ) — a. b.

PHYSICIAN OR SUPPLIER INFORMATION

Findlay Family Practice, Inc.
Notice of Privacy Practices for Protected Health Information
Acknowledgment of Receipt of Notice of Privacy Practices

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name: ____

Date of Birth: ____________________

Patient Signature: ______________________________ Date: ____________

Enter Practice Name

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not described within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12 month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided at right under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests, to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at

William E. Hopkins MD _ Findlay Family Practice, INC
1D3 ... Suite A
Findlay, OH 45840

We will not retaliate against you for filing a complaint.

Effective Date 5-5-17

Publication Date 5-5-17

FINDLAY FAMILY PRACTICE INC

1725 WESTERN AVE SUITE A FINDLAY OH 45840 419-423-4994 FAX: 419-423-4110
1450 MANOR HILL RD FINDLAY OH 45840 419-420-7855 FAX: 419-420-7859

Limited Patient Authorization for Disclosure of Protected Health Information

Form 7.31
Revised 9.15

Please print all information. Form must be signed and dated each year.

Patient Name: ______________________________

Address: ______________________________

City: ____________ **State:** ______ **Zip:** ______ **Phone:** ____________

SSN (last four digits): ________ **Date of Birth:** ____________

Entity Requested to Release Information: ______________________________

____

____

____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information (list the individual/entity who is to receive your PHI):

Individual/Entity Name: ______________________________

Address: ______________________________

Phone: ______________________________

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:
(only 2 years will be sent unless otherwise indicated.)

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays;
- ☐ financial history report (previous 3 years only).
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only send the following: ______________________________

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Other (please specify): ______________________________

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: ____________.
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

______________________________ ____________
patient or representative signature date

You have the right to receive a copy of signed authorizations upon request.
***May be a fee for records**