QUALITY FAMILY PHYSICIANS, P.A.

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IN ORDER TO BILL YOUR INSURANCE COMPANY-ALL INFORMATION MUST BE FILLED OUT

(PLEASE PRINT)

Today's date:			**Physician (circle one):** Kim • Mullin • Willey
PATIENT INFORMATION			
Patient's last name:	**First:**	**MI:**	**Title:** ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
Birth date: / /	**SSN:**	**Sex:** ☐M ☐F	**Marital status:** ☐ Single • ☐ Mar • ☐ Div • ☐Sep • ☐ Wid
Street address:			**City, State, Zip:**
Home Phone:	**Work Phone:**		**Cell Phone:**
Email Address:	**Race:**	**Ethnicity:**	**Language:**

INSURANCE INFORMATION					
Primary insurance (Company):					**Effective date:** / /
Subscriber's name:	**Subscriber's S.S. no:**	**Birth date:** / /	**Group no:**	**Insurance ID no:**	**Co-payment:** $
Patient's relationship to subscriber: ☐ Self	☐ Spouse	☐ Child	☐ Other:		
Secondary insurance (Company-if applicable):					**Effective date:** / /
Subscriber's name:	**Subscriber's S.S. no:**	**Birth date:** / /	**Group no:**	**Insurance ID no:**	**Co-payment;** $
Patient's relationship to subscriber: ☐ Self	☐ Spouse	☐ Child	☐ Other:		

IN CASE OF EMERGENCY			
Name of friend or relative:	**Relationship to patient:**	**Home phone:**	**Work/cell phone:**

I hereby assign all medical and/or surgical benefits to include: Medicare Major Medical, Blue Cross Major Medical, PA Blue Shield, and all other Blue Shield plans to which I am entitled, including private insurance and any other health plan to: Quality Family Physicians, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize the release of all my information necessary to secure payment.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE CARRIER

In an effort to continue to deliver the highest quality of care on which you have come to rely, we can either limit services or attempt to control costs. We have chosen to pursue the second option. With that in mind, we trust we can depend on your cooperation with the following financial policy.

1.) It is the patient's responsibility to know the details of their insurance policy.
2.) We expect payment of any past due balances at the time of service. If it is necessary to make other arrangements, our office will be glad to work with you and setup a payment plan.
3.) If your insurance requires a copay or deductible, it is expected at the time of service.

As you are aware, the costs involved in maintaining outstanding accounts is escalating. Your insurance policy is a contract between you and your insurance company, and we are not a party to that arrangement. We are attempting to provide the best and most comprehensive care in the area, and expect a mutual respect by adhering to this policy. Your physician may order tests and/or procedures that we deem medically necessary. It is the patient's responsibility to verify coverage with their insurance carrier. Any balances remaining will be the patient's responsibility.

I authorize Quality Family Physicians to release medical information required to process my claim. Initial _____

We have been facing an increasing problem with missed appointments and late cancellations. This prevents us from accommodating patients hoping to be seen for same day appointments. We understand that there are circumstances and/or changes in your schedule that may prevent you from keeping your appointment. If this situation arises, we ask that you call us at least 24 hours in advance and we will gladly reschedule your appointment. Please be advised that failure to give a 24 hour notice may result in a charge of $50.00. This charge cannot be billed to your insurance company and failure to pay will be treated according to our policy on unpaid balances, including the use of a collection agency. Further missed appointments and/or late cancellations may be grounds for dismissal from our practice. Medical care will not be withheld for a medical emergency. Signing below indicates that you have read and agree with the above policy.

I consent to the use or disclosure of ,my protected health information by Quality Family Physicians, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bulls or to conduct health care operations of Quality Family Physicians, P.A.

I understand that my medical information may be electronically submitted to any or all of my treating physicians, hospitals and/or healthcare entities. Initial _____

I have read and understand the HIPAA/Privacy policy for Quality Family Physicians. Initial. _____
I authorize Quality Family Physicians to obtain/have access to my medication history. Initial _____

Patient Signature: X_____ Date: X_____

(**IF** under 18 years of age, signed by parent/guardian)

GUARANTOR INFORMATION: *(List person or insured name responsible for bill - use full legal name, no nicknames)*