Patient Responsibility Acknowledgement 2020

Patient Name _____ **DOB**_____

Address _____

_____

Phone_____ **Email**_____

Emergency contact_____**Relationship**_____ **Phone**_____

New Diagnoses or surgeries in the last year?___**Yes / No**_____

Every attempt is made to comply with insurance company's requirements. Since policies and benefits differ among every type of insurance and the plans within them, we are unable to know the specifics of your policy. Insurance companies inform all participants that it is ultimately **the patient's responsibility** to verify benefits and coverage information prior to having any services rendered.

Gartenberg Family Medicine, PLLC dba Modern Family Medicine cannot guarantee the cost of services performed will be covered by your insurance. To limit the charges that you may be responsible for, please ensure that we always have up to date information regarding your insurance coverage and any name/address/phone/employment changes.

Please initial each response acknowledging our updated policies:

_____**Initial** I understand that I must bring my current INSURANCE CARD and IDENTIFICATION CARD to each and every appointment. Failure to do so may result in cancellation of my appointment and subject me to same day cancellation fee.

_____**Initial** I understand that I am responsible for payment in full at the time of service. This includes co-pays, and any other patient responsibility such as deductibles, and /or any coinsurance amount if it applies. MFM collects based on the contracted allowed amount we have with my insurance. The entire Medicare deductible is due. This amount may vary after a claim is made through insurance. I agree to give my credit card information to keep on file for any balance owed or credited to me. The office will notify me 24 hours before running my card. If my card is declined, I have 5 business days to submit a new one before incurring additional late fees.

_____**Initia**l For any amount due and not paid at the time of service, a $25 administration fee will be added. An additional $15 will be added monthly. Any non-current account will be sent to collections after 90 days.

_____**Initial** Non-payment of past due amounts may result in my scheduled appointment being rescheduled to a later time until I bring my account to current, or make payment arrangements. If I do not pay my account within 90 days of receiving my bill, I understand that I will be dismissed from the practice, my account will be

sent to collections and my insurance company will be notified. Failure to pay my medical bills may affect my credit score rankings and ability to apply for future medical, life and disability insurance.

_____Initial If any uncollected balance is not paid in full within 90 days of the statement sent, I understand that MFM reserves the right to turn my account over to a collection agency with added late fees. The responsible guarantor of the account will be responsible for all collection fees, including legal expenses. If the account has an unpaid balance, I, the patient, will be considered dismissed from the practice until my account is current.

_____Initial I understand that I am fully responsible for billed amounts from my office visits in the event that MFM is not contracted with my insurance plan, if I do not have insurance, if my coverage has lapsed, if there is a claim denial from the insurance company or if the amount collected at the time of the visit is less than the contracted amount.

_____Initial I understand that if I have a credit due on my account, the credit will remain on the account unless I fill out a credit request form and allow for processing. This process can take up to 6 months due to insurance claim processing. All credit requests must be submitted on the credit balance form and reviewed by the biller.

_____Initial I understand that certain procedures performed in the office are not included under the standard office visit. These procedures are billed separately and in addition to office visit charges.

_____Initial I understand that any problems discussed with/or discovered by my provider at a "wellness visit" must be billed for an additional problem-focused visit. Copays, Coinsurance and deductible fees will apply and will be collected at the time of the visit.

_____Initial I understand that all medication refills, referrals, and tests ordered require an office visit. MFM can not generate any lab or radiology orders without an associated documented visit.

_____Initial I understand it is my responsibility to confirm any testing I have done has been received by the physician and it is my responsibility to schedule a follow up appointment to review any tests ordered by the physician or to make a follow up appointment if my symptoms persist. I understand that results will not be discussed over the phone unless initiated by the physician.

_____Initial I understand that MFM does not accept faxes from third party pharmacies for refill requests. I will schedule an office visit BEFORE I run out of my medication. The physician will prescribe enough refills until I am due back for a follow up visit. It is my responsibility to comply with medical care and to make my follow up appointments within 2 weeks of needing a medication refill.

_____Initial I understand that my provider will order tests that are deemed medically necessary and code appropriately for the tests. I do not hold Modern Family Medicine or it's providers responsible for any charges billed to me by any third party vendor including; outside laboratories, radiology centers or other vendors. I will contact the vendor's billing department directly with any billing questions.

_____Initial A $75 fee will be applied to my account should any check I write be returned by the bank. Additional fees will be reported to collections if unpaid.

_____Initial I agree to pay with credit, debit or HSA whenever possible. I understand that MFM does not accept checks or cash. Any payments made in cash that is not properly recorded, is my own responsibility. I agree to keep my credit card on file for bills owed. MFM will inform me prior to running my card.

_____**Initial** I understand that there is a $35.00 fee for FMLA forms, disability paperwork, sports physical forms, prior auth requests, any added documentation for physician dictated letters for personal use that is not requested at an office visit. Any forms more than 1 page, will be charged $15 per page. An office visit is usually required to fill out most forms. FMLA and disability paperwork may require several office visits to document care properly.

_____**Initial** NO SHOW/ CANCELLATION POLICY: I understand that I will be charged $50.00 fee if I fail to show up for my appointment and $25.00 fee for cancelled appointments with less than a 24 hour notice. Monday appointments must be cancelled by the Friday prior to the appointment. Payment must be received before scheduling the next office visit. I agree to give Modern Family Medicine permission to run my credit card and keep it on file for future payments. If I have extenuating circumstances, I will contact the office immediately. Failure to pay the cancellation/no show fees may result in my dismissal from the practice.

_____**Initial** I understand that all medical record requests require a signed Medical Record Release form from our office. Any medical records sent to a non-medical facility (including FMLA, disability, Life Insurance, Attorneys, etc) require a minimal $50.00 charge prior to records being processed. These fees are usually paid by the third party. Please allow up to 60 days for processing after payment is received. Expedited copies will be charged additional fees. Legal paperwork will incur additional charges.

_____**Initial** I understand that all controlled substance prescriptions require adherence to the AZ Prescription Monitoring Program, review of all medical records, random urine drug screening and a signed controlled substance contract with our office. All controlled substance prescriptions require monthly office visits.

_____**Initial** I understand and consent to sending communication to me in the HIPAA protected patient portal and that I can not be properly evaluated or treated through the portal or via telephone. If I am having symptoms, I need to schedule an appointment to be properly evaluated and treated with a physical exam.

_____**Initial** In order to ensure confidentiality and privacy, I agree not to use any type of camera, camera phone or recording device while at the facility.

_____**Initial** I authorize the release of my medical records to my insurance company or their third party representative upon their request. I understand that there may be charges incurred for release of medical records to a third party.

_____**Initial** I give Modern Family Medicine permission to release my medical records directly to a referred physician or hospital for continuity of my medical care. If I decide to switch medical offices, I understand I will need to sign a medical record release form prior to my records being sent.

By signing this form, I agree to all the information listed above,authorize the release of any medical records,information necessary to process my claims and authorize payment of medical benefits to Gartenberg Family Medicine, PLLC dba Modern Family Medicine for services rendered..Except for emergency care, I understand that if I do not sign this consent evidencing the consent to the uses and disclosures described to me above and contained in this agreement, then Modern Family Medicine will not treat me.

Signature_____Date_____