Patient Financial Responsibility Acknowledgement *2023*

Patient Name ___________________________________ **DOB**______________________________

Address ____

____

Phone________________________ **Email**____

Emergency contact______________________________**Relationship**_____________ **Phone**___________________

New Diagnoses or surgeries in the last year? Yes / No____

New Family History?____

New Job? Yes/No New relationship status? Yes/No Any new life changes? Yes/No _________________________

Allergies to Medications____

Vaccinations:____

Medications:____

____

Last colonoscopy: ____________ **Last Lab work:**_____________ **Women: Last mammogram**___________________

Bone Density___________ **Any new doctors seen in the last year? Yes/No Who?**____________________________

Every attempt is made to comply with the 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.

Notice of Privacy:

We participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiency of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purposes of treatment, payment or the health care operations of this organized health care arrangement.

By signing below, I agree to the following:

I understand that I must give my current INSURANCE CARD and IDENTIFICATION CARD at each and every appointment. Failure to do so may result in cancellation of my appointment and subject me to same day cancellation or no show fees. I must give updated insurance information before my scheduled visit in order for it to be processed appropriately. I am responsible for any billing issues associated with not providing correct insurance information. I am responsible for any payments not paid by my insurance.

I understand that I am responsible for initial payment estimate at the time of service. This includes co-pays, and any other patient responsibility such as estimated 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 credit card processing fees to be added and agree to give my credit card information to keep on file for any balance owed or credited to me. The office will notify me before running my card. If my card is declined, I have 5 business days to submit a new one before incurring additional late fees. After eligibility of benefits are processed, I agree to pay off balance in full. If the account has an unpaid balance, I, the patient, will be considered dismissed from the practice until my account is current.

For any amount due and not paid at the time of service or after EOB is processed a $25 administration fee will be added. An additional $25 will be added monthly in addition to credit card processing fees.. Any non-current account may be referred to our legal team for which all legal fees will be my responsibility. Modern Family Medicine does not participate in any payment plans and can not reduce or waive copays or deductibles deemed by your insurance contract..

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 of potential insurance fraud. Collections and potential legal action may result.

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, if the insurance company requests repayment of paid services or if the amount collected at the time of the visit is less than the contracted amount.

I understand that if I have a credit on my account, the credit will remain on the account and be applied to future visits, unless I submit a credit balance request form and allow time for processing. This process can take up to 6 months due to insurance claim processing. All credit requests must be submitted on the proper forms and reviewed by the biller. Credits will be reimbursed to the credit card on file minus credit card processing fees or by check.

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.

I understand that any problems discussed with/or discovered by my provider at a free “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.

I understand that all medication refills, referrals, and tests ordered require a physician visit. MFM providers can not generate any lab or radiology orders without an associated documented visit. Some advanced testing including orders for MRIs or CT scans may require multiple visits dependent on insurance requirements.

I understand it is my responsibility to confirm any test results I have done has been received by the providers and it is my responsibility to schedule a follow up appointment to review any tests ordered by the providers or to make a follow up appointment or to notify the doctor if my symptoms persist or worsen.

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 provider 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.

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; laboratories, radiology centers or other vendors. I will contact the vendor’s billing department directly with any billing questions.

I understand that writing a bounced check or disputing a credible charge with my credit card company, may result in legal action against me. I understand that I will be held responsible for all legal fees.

I agree to pay with Zelle, credit, debit or HSA whenever possible. I understand that MFM does not accept checks or cash. Any payments made in cash that are not properly recorded, is my own responsibility. I agree to keep my credit card on file for bills owed and give permission for MFM to charge it.

I understand that there is a $60 reservation fee for new patients that is non-refundable. This fee will be applied to any office visit fees. If it is unused, I may request a refund after 1 year by filling out the credit balance request form and review by the biller.

I understand that there is a $160.00 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 longer than 1 page, will be charged $50 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.

NO SHOW/ CANCELLATION POLICY: I understand that I will be charged $60.00 fee if I fail to show up or not answer my phone for my scheduled appointment and $30.00 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.

I understand that I will check in 15 minutes prior to my scheduled appointment. If I am more than 10 minutes late for my appointment, my appointment may be cancelled and I may be subject to the SAME DAY CANCELLATION fee of $30.00. I understand that if my appointment is rescheduled for the same day, I will be worked into the provider’s schedule and may have to wait on stand by to be seen.

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 $75.00

charge prior to records being processed. These fees are usually paid by the third party. Please allow up to 90 days for processing after payment is processed. Expedited copies will be charged additional fees. Legal paperwork will incur additional charges. Due to increased paperwork demands, the timeline for processing may be extended.

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.

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. I understand that any communication I initiate outside of the patient portal may not be HIPAA protected. I will not email any medical related requests or questions or through the patient portal. I agree to call the office and schedule an appointment when I am due for refills or have medical questions.

I authorize MFM to use their telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private. I agree to come into the office to be evaluated in person if the provider requests.

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 or record my televisits.

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.

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 or move, I will notify the office. I understand I will need to sign a transfer of care form or medical record release form prior to my records being sent.

I give permission for providers at MFM to discuss anything regarding my medical care with the following person

Name________________________________DOB______________Phone_____________________

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_____________________