Aurora Family Medicine Center, P.C.

Patient Name(Please print):_____D.O.B._____

Patient Address:_____Home Phone:_____

City, State, Zip _____

Family Members	Sex	D.O.B.	Relationship	Primary Dr.

NAME OF PRIMARY INS. COMPANY and POLICY HOLDER_____

Other Insurance Coverage? YES NO

Are all members covered on the above insurance? YES NO

IF NOT, NAME OF OTHER INS. COMPANY:_____

I authorize payment of medical benefits to the undersigned physician or supplier for these services and all future claims.	I authorize the release of my medical information necessary to process this claim and all future claims.
X	X

The Practice contacts Patients for a variety of reasons. In an effort to protect your privacy, we have developed a policy for leaving medical information. Please fill out the information below so we may be able to better serve you.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO

- We will NOT leave messages with anyone except the patient or legal guardian.
- We will NOT leave any health information on an answering machine or voicemail.

Please read below and let us know what you prefer:

I, _____give the Aurora Family Medicine Center my permission to leave phone messages regarding my medical care and test results with the following individual(s). I fully understand that this consent will remain until revoked in writing.

My cell voicemail: #_____initials_____

My home answering machine: #_____initials_____

My office/work voicemail: #_____initials_____

My spouse: #_____initials_____

Other: #_____initials_____

Please list who you give us permission to talk to regarding your medical care:

_____ _____

The Practice of Aurora Family Medicine Center, P.C. is committed to safeguarding PHI in transit by using encryption whenever emailing PHI outside of the Practice via patient portal. However, in situations where the Practice is being **requested** to email PHI directly to the patient, the Patient understands the Practice will only be able to send unencrypted email to the Patient. This means there may be **some level of risk** that the information in the email could be read by a third party. If this risk is acceptable to the Patient, please initial here _____, otherwise we will use the patient portal only.

Email Address: _____

Signature:_____Date:_____

Parent/Guardian Signature:_____

Aurora Family Medicine Center, P.C.

FINANCIAL / PRIVACY POLICY

INSURANCE BILLING: It is your responsibility to provide us with current and accurate personal and insurance information. As a courtesy, we will bill your insurance company, however, you are ultimately responsible for all charges incurred. Your insurance policy is a contract between you and your insurance company. It is essential that you are aware of the details of your policy. We will accept assignment from your insurance company based on our contract with them.

CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES assessed by your insurance company are required at the time of service if specified. If you are unable to pay this at the time of a visit, a $20 billing fee may be assessed. Co-insurance and deductible are applied, based upon your specific plan provision, at the time your claim is processed by your insurance company.

ANNUAL PHYSICAL EXAM: Most insurance companies cover wellness assessments and general health screenings with no deductible or copay. This would include things like height, weight, body mass index, and review of medical history. Evaluation and treatment of specific symptoms, medical problems, or illness may NOT be covered under your wellness exam and MAY be subjected to a deductible, copay, or co-insurance. This could include specific symptoms, (i.e. abdominal pain, back pain, fever) medical problems, (i.e. high blood pressure, cardiac issues, diabetes, high cholesterol, thyroid issues, depression) or illnesses (i.e. cough, viral symptoms, sore throat, urinary tract infection.) Note that it is your responsibility to know your insurance plans' benefits and exclusions. You are responsible for payment on any service that is not part of your physical, including any co-payment, co-insurance or deductible.

SKIN LESIONS/BIOPSIES: Treatment for removal of skin lesion(s) and/or skin tag(s) may not be deemed medically necessary by your insurance company and will require payment in full from you. It is your responsibility to be aware of the details of your policy.

RETURN CHECK POLICY: We will assess a $20 fee for all returned checks. Your financial institution may assess additional fees as well. Returned checks may result in our refusal to accept checks as a form of payment, and require cash or credit card only for services provided to you. Collection of a returned check will be pursued according to state statutes.

COLLECTION POLICY: Any charges incurred and not covered by insurance will be the patient's responsibility, including, but not limited to co-pays, co-insurance, and deductible amounts. As a courtesy, we send statements for balances due. Payment is due upon receipt of a statement. Payment arrangements are available by speaking to our Billing Department. Unpaid balances will be assessed a fee and may be referred to an outside collection agency.

APPOINTMENT CANCELLATION POLICY: We require at least 24 hours' notice to cancel a scheduled appointment. If you do not show up for your appointment, or do not cancel at least 24 hours prior to your appointment, a $25 fee may be assessed for the missed appointment. A reminder call before your scheduled appointment is provided as a courtesy; However, there are no guarantees that you will receive a reminder call.

APPOINTMENT TIMES: We ask that you arrive 10 minutes prior to your scheduled appointment time to allow for any paperwork that needs to be completed, even if you are already an established patient. If you arrive late for your appointment, your appointment may be rescheduled and a $25 fee may be assessed for the missed appointment.

LABS/PATHOLOGY: During the course of your care, you may need to have your blood drawn or have other specimens collected and sent to an outside lab for processing. We bill for the collection and handling of these specimens and the lab will bill for the testing they perform. You will receive a separate statement from the lab for these services. You are responsible for letting us know if your insurance has a specific lab that must be used.

IMMUNIZATIONS/INJECTIONS: During the course of your care, you may need immunizations or injections as part of your treatment/care for either yourself or your child/children. If an immunization or injection given is not a covered benefit, or if your insurance company denies the charge, you will be responsible for the cost and administration of the vaccine/injection.

HIPPA: By signing below, you acknowledge that you have been provided with a copy of Aurora Family Medicine Center, PC HIPPA Policies & Procedures.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE AURORA FAMILY MEDICINCE CENTER, P.C. FINANCIAL AND PRIVACY POLICY:

_____ _____

Date **Signature of Patient/Parent/Guardian**