

FALLS MEDICAL SPECIALISTS: DEMOGRAPHIC FORM

Last name: _____ First name: _____ DOB: _____ Sex: M F

Address: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Social Security #: _____

Emergency contact: _____ Phone: _____

Referring physician: _____ Phone: _____

Primary care physician: _____ Phone: _____

List any other providers who should receive your records: _____

Race: _____ Ethnicity: _____

Preferred language:

Preferred pharmacies (please also list mail order and specialty pharmacy if applicable):

Local: _____ Phone: _____

Mail order/specialty: _____ Phone: _____

ACKNOWLEDGEMENT: I have been offered a copy of Falls Medical Specialists' Notice of privacy practices

Signature: _____ Date: _____

AUTHORIZATION: I authorize Falls Medical Specialists to apply for benefits on my behalf for services rendered. I request payment from my insurance company be made directly to Falls Medical Specialists. I certify that the insurance information I have provided is correct and authorize the release of any necessary information for claims. I permit a copy of this to be used in place of the original. I understand that I have the primary responsibility and obligation to pay for medical services provided when a statement is rendered.

Signature: _____ Date: _____

FALLS MEDICAL SPECIALISTS, LLC FINANCIAL POLICY

We would like to thank you for choosing the physicians at Falls Medical Specialists as your providers of medical care. We pride ourselves on providing all patients with excellent service. To keep you informed of our current financial policies, please read and sign the following.

Insurance

The physicians of Falls Medical Specialists participate with many insurance plans. It is the patient's responsibility to provide our office with a copy of your current insurance card, and to inform us of any changes in insurance. Failure to notify us immediately of changes of demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier. Although we file claims for insurance plans on your behalf, you are ultimately responsible for payment of your bill. It is your responsibility to verify that the physician is currently under contract with your insurance plan and that you have obtained the necessary referrals BEFORE your scheduled appointment. Failure to confirm this may result in your responsibility for any and all charges.

Co-pays, Co-Insurance, Deductibles and Non-Covered Services

Co-pays are payable at the time of service. We accept cash, check or credit card (Visa, Discover, MasterCard and American Express). Co-pays, co-insurance and deductibles cannot be waived by our practice as they are requirements placed on you by your insurance carrier. You are responsible for any non-covered services as determined by your insurance plan. Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company. If you have an insurance plan with whom we do not participate, you are responsible for our bill in full.

Past Due Balances

You will be asked to pay any past due balances when making appointments or before seeing the physician. If your balance is especially high, a payment plan can be set up with the office manager.

Returned Checks

A \$25 charge will be added to your account for any check returned by your bank.

MISSED APPOINTMENTS/NO SHOWS/LATE FOR APPOINTMENT

We understand that you may not be able to keep all your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other Falls Medical Specialists patients. They also affect our ability to serve other patients in need of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment. If you must cancel or re-schedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. We reserve the right to charge you \$100.00 for any no-show if permitted by law and your insurance contract. Payment of the missed appointment will be required prior to scheduling another appointment. Falls Medical Specialists reserves the right to terminate any patient with more than two no-show appointments upon 30 days written notice to the patient to seek medical help from another practice. If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more than 15 minutes late for an appointment, Falls Medical Specialists, may reschedule your appointment and refuse to see you at the originally scheduled time.

Finance Charge

If your bill is over 90 days old, we will impose a finance charge of \$15. We will continue to impose \$15 monthly fees until your account is paid in full. These fees will help offset the excessive monthly costs involved in continuing to send overdue bills. If you are on a payment plan, and meet your monthly payment obligation, a finance charge will not be assessed.

Collection Fees

If after 120 days a balance remains unpaid, we will send the account to our collections attorneys. We will impose a collections fee of one third of the outstanding bill to cover the fee charged to us by the collection agency.

Signature _____ Date _____

Printed Name _____