Entrance Application

Welcome! We are honored you chose us to evaluate your health. So we may better serve you, please fill out the personal information below. If you need assistance, please inform a front desk team member.

First Name_____Middle_____Last_____
Gender □ Male □ Female Home Phone_____ Cell Phone_____
Email Address (for statements and patient portal)_____
Address_____
City_____ State_____ Zip_____
Social Security Number_____-_____-_____ Name You Go By_____
Birthdate_____ Age_____ Marital Status S M W D
Employer_____ Occupation_____
Race □ White □ Hispanic □ African American □ Asian □ Other

Spouse's Name_____ Spouse's Birthdate_____
Social Security Number_____-_____-_____ Phone Number_____

In case of emergency, whom should we contact?_____
Phone Number_____ Relationship to Patient_____

Please list the preferred pharmacy to send any medication_____

Insurance Information

Insurance #1

Company_____
Group#_____
Contract#_____
Name of Insured_____
_____
Relationship to Patient_____
_____
DOB_____
Sex_____
SSN_____

Insurance #2

Company_____
Group#_____
Contract#_____
Name of Insured_____
_____
Relationship to Patient_____
_____
DOB_____
Sex_____
SSN_____

Patient Informed Consent

I, _____, the undersigned, consent to care at Rocket City Family Medicine. I understand that I have the opportunity to discuss with the doctor and/or with other office personnel, the nature and purpose of my healthcare needs. I hereby request and consent to the performance of all medical procedures, including minor surgeries, office visits, and any wellness or preventative services my doctor recommends or deems necessary on me (or on the patient above, for whom I am legally responsible) by the doctor and support team at Rocket City Family Medicine. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and there are some risks. Risks include, but are not limited to: aggravating and/or temporary increase in symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor's judgment, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to be treated at Rocket City Family Medicine.

Guardian/Patient Signature_____

HIPAA Patient Authorization Form
Notice of Privacy Practices

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. ***You have the right to review our Notice before signing this Authorization and you are advised to do so.***

By signing this form, you authorize our use and disclosure to third parties, including but not limited to your billing and scheduling software provider, FlexMedical, of your PHI for treatment, payment, and health care operations as described in our Notice of Privacy Practices. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.

Due to Federal Privacy Laws relating to HIPAA regulations we are unable to provide any patient information to anyone except to the patient without specific patient permission. If you would like to give Rocket City Family Medicine permission to release your patient information, please list them below:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

The patient understands and agrees that:

Rocket City Family Medicine has a Notice of Privacy Practices and that you, the patient, have been offered and/or reviewed a copy of this Notice before signing this Authorization.

Rocket City Family Medicine reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

All of the patient's medical records and protected health information may be disclosed or used for treatments, payment, or health care operations.

Patient or Representative Signature	Date
Witness Signature-Clinic Representative	Date

Statement of Patient Financial Responsibility and Policies

Our doctor at Rocket City Family Medicine appreciates the confidence you have shown in choosing them to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill and for knowing your insurance coverage and benefits.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer.

Co-Pay Policy

Most health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated that you pay the fee required by your insurance each visit *before* the service is rendered at the time of service. If you do not know your co-pay we will collect a fee of $30.00. If you have a coinsurance or an outstanding deductible, we will collect a minimum of $50 *before* you are seen by a provider. Our billing department will bill or credit your account accordingly after your insurance carrier pays their portion. Our office will notify your insurance company in writing if you fail to pay your co-payments. We require any old balances to be paid in full before being seen for another appointment or having any medication refills completed.

Cancellation/No Show Policy

We understand there may be times when you must miss an appointment due to emergencies or obligations to work or family. However, due to a high demand for appointments, we require at least a 24-hour notice on all canceled appointments. Our office charges a fee of $30.00 for most missed appointments. If the appointment was for a physical or a special surgical procedure, the fee will be $75.00. Your insurance company will not pay this charge, and it will be your responsibility.

Returned Phone Call Policy

Our goal at Rocket City Family Medicine is to take the best possible care of our patients; however, we do ask that you kindly give the office 24-hours to return most phone calls. We will call all patients back at the soonest possible opportunity. If your call is an emergency and cannot wait 24-hours, please advise the receptionist.

Form Completion

We have a fee for all form completions. This fee is $10.00 for most simple forms. Multiple or complex forms may be given a fee of $25.00. This fee is due upon the pick-up of the completed form. Allow 5-7 days for all forms to be filled out.

Cash Pay

You have the right to request that Rocket City Family Medicine not file your insurance and to be a cash pay patient for any office visit. A cash pay appointment must be paid in full at the time of the appointment.

Consent to Contact Debtor

You agree that in order for us to service your account or to collect any debt you may owe, we and/or our agents may contact you by telephone, email, or by direct mail using any information associated with your account. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable. There may be an additional cost/fee added to your bill for collections, attorney fees, and/or court costs necessary to collect any debt. We do require you to provide your social security number in order for you to establish as a patient at this office due to collection practices. If you are adamant about not providing it, we will allow you to establish as a patient. However, if you do not provide your social, we will **immediately** discharge you after refusing to pay any balance after the first notification sent to you by the due date.

I have read this disclosure and agree that Rocket City Family Medicine, its employees and/or agents may contact me as described above. I acknowledge that I have read and understand that the above mentioned policies are a condition of my care.

_____ _____

Signature of Patient/Guardian **Date**

_____ _____

Witness **Date**

HIPAA EMAIL CONSENT

• HIPAA stands for the Health Insurance Portability and Accountability Act. HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.

• Most popular email services (ex. Gmail, Hotmail and Yahoo) do not utilize encrypted email.

• When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

• Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA, the federal government provided guidance on email and HIPAA. The information is available on the U.S. Department of Health and Human Services website at https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providersto-use-email-to-discuss-health-issues-with-patients/index.html.

• The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

UNENCRYPTED EMAIL

Please check one:

_____ I understand the risks of unencrypted email and do hereby give permission to Rocket City Family Medicine to send me personal health information via unencrypted email.

_____ I do not wish to receive personal health information via email.

_____ _____

Signature (parent or guardian if patient is a minor) Date

_____ _____

Patient Name (please print) Email

Rocket City Family Medicine

Preventative Visit vs. Office/Sick Visit vs. Both

Preventative Visit: This is a visit for a routine physical exam, and in-depth history, and a review of recommended preventative tests. Most (but not all) insurances cover one preventative visit per year. Insurance benefits are dependent on your plan. Covered visits are sometimes subject to copays but are generally covered at 100% by most insurances.

Office Sick Visit: This is a visit for a new acute problem, flair-up of a chronic problem, or follow-up on a chronic problem such as but not limited to diabetes, high cholesterol, or high blood pressure that require lab and/or medical review or treatment. Depending on your insurance, covered office visits are generally subject to deductibles and copays/coinsurance.

Combination Visit: Most insurances will allow both above visits on the same day thus allowing us to avoid patients coming in for additional visits. For example, if you are coming in for your preventative visit but have a new problem you would like addressed or chronic medical problems are addressed, it is considered a combination visit and must be billed differently than if you came in solely for your "Well Visit". Most insurance plans will completely pay for the preventative visit but will then require that you pay a copay/coinsurance/deductible for the office/sick visit that was provided.

Will my doctor only address what my health plan covers for a physical/wellness visit? No. Your doctor does not know your plan benefits and treats you for what they feel is medically necessary and not what will necessarily pay. **<u>You are responsible for knowing what service are covered under your health plan.</u>** You may receive a bill for a copay in the mail as the front desk will not be aware prior to the visit what will be discussed with your provider.

I have read and understand the above information:

_____ _____

Patient's Printed Name DOB

_____ _____

Patient's Signature Date