



Macley Family Practice & Walk-in Clinic

Insurance Plans Accepted:

Aetna

Aetna-Medicare Advantage

Ambetter

Beech Street

Blue Cross HMO

Blue Cross PPO

Cigna

Cigna HealthSpring-Medicare Advantage

Coventry

Humana

Humana-Medicare Advantage

Lifewell PPO

Medicaid CMO-CareSource

Medicare

NovaNet PPO

PHCS

Pruitt Health-Medicare Advantage

Tricare Prime HMO

Tricare Standard PPO

United Healthcare

Patient Information	Patient Information			
	Last Name:		First Name:	M.I.:
	Mailing Address:			Apt #
	City/State/Zip:			
	Home Phone:		Cell Phone:	Work Phone:
	Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) <input checked="" type="radio"/> Voice <input checked="" type="radio"/> Text			If Voice, Please Select Preferred Number: <input checked="" type="radio"/> Home <input checked="" type="radio"/> Cell <input checked="" type="radio"/> Work
	Family Physician or Pediatrician:		Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Marital Status:		Social Security #:	
	Employer Name:		Emergency Contact Name:	
	Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party	Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor			
	Last Name:		First Name:	
	Date of Birth:	Social Security #:		Phone:
	Address of Person Responsible:			
	City/State/Zip:		Relationship to Patient:	
	Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)			
	Email Address:		Can we leave a message regarding your medical care & test results? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Decline		Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline	
	Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> Bosnian <input type="checkbox"/> Indian (including Hindi & Tamil) <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Other			
	Preferred Pharmacy Name & Location:			

Insurance Information	Primary Medical Insurance		Secondary Medical Insurance	
	Ins. Co. Name		Ins. Co. Name	
	Policy Holder Name:		Policy Holder Name:	
	Policy Holder's Date of Birth:		Policy Holder's Date of Birth:	
	Policy Holder's Social Security #:		Policy Holder's Social Security #:	
	Patient Relationship to Policy Holder:		Patient Relationship to Policy Holder:	

I certify that I have read and agree to Macley Family Practice and Walk-in Clinic (MFPWC) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to MFPWC all money to which I am entitled for medical expenses related to the services performed from time to time by MFPWC, but not to exceed my indebtedness to MFPWC. I authorize MFPWC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A \$20.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from MFPWC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to MFPWC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Macley Family Practice and Walk-in Clinic's Privacy Notice. (Initials)

Signature of Responsible Party: X _____ Date: _____

Printed Name of Responsible Party: X _____ Date: _____



Macley Family Practice & Walk-in Clinic

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____ hereby states that by signing this Consent I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.



Macley Family Practice & Walk-in Clinic

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, Parent if a minor):

Relationship

Date Signed ____/____/____

Witness: _____



Macley Family Practice & Walk-in Clinic

Financial Policy

Patient Financial Agreement

Macley Family Practice & Walk-in Clinic is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. As a courtesy, Summit Medical Clinic will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

For services outside of our clinic, like radiology, laboratory, surgery centers, physical therapy, hospitals and rehabilitation centers, it is your responsibility to know which facility you are required to use. If you aren't sure, please talk to your insurance member services or one of our staff before scheduling.

For Medicare patients: Medicare Patient's Signature – I authorize payment to be made on my behalf to Macley Family Practice & Walk-in Clinic for any services provided to me by my provider. I authorize my provider to release any information needed to determine my benefits.

I understand that my signature requests payment be made to pay my claim. My signature also authorizes the release of medical information necessary to pay my claim. My signature also authorizes the release of benefits payable and medical information necessary to pay any secondary insurance payer.

Patient Name: (Print) _____

Patient Signature _____ Date _____

I have read and I understand Macley Family Practice & Walk-in Clinic's financial policies and I accept responsibility for the payment of any fees associated with my care.



Macley Family Practice & Walk-in Clinic

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____