NCH Healthcare Group

I CAME HERE TODAY TO SEE DR._____

DATE: _____

PARENTS' INFORMATION

Mother's Name: _____
Street Address: _____
APT/UNIT #: _____
City/State/Zip: _____
Home Phone #: (___) _____
CELL #: (___) _____
Date of Birth: _____
Marital Status: ☐Single ☐Married ☐Other_____
Social Security Number: _____
Email Address: _____
Employer: _____
Employer's Phone #: (___) _____
Nearest Relative/Phone/Relationship: _____
_____

Father's Name: _____
Street Address: _____
APT/UNIT #: _____
City/State/Zip: _____
Home Phone #: (___) _____
CELL #: (___) _____
Date of Birth: _____
Marital Status: ☐Single ☐Married ☐Other_____
Social Security Number: _____
Email Address: _____
Employer: _____
Employer's Phone #: (___) _____
Nearest Relative/Phone/Relationship: _____
_____

Pharmacy: _____ **Phone # and/or Location:** _____

CHILD'S/CHILDREN'S INFORMATION (PLEASE PRINT PATIENT'S COMPLETE LEGAL NAME.)

1) **Name:** _____ **DOB:** _____ ☐Male ☐Female **SSN #:** _____
2) **Name:** _____ **DOB:** _____ ☐Male ☐Female **SSN #:** _____
3) **Name:** _____ **DOB:** _____ ☐Male ☐Female **SSN #:** _____

INSURANCE INFORMATION (COMPLETE IF THE POLICYHOLDER IS NOT THE PATIENT ON ANY POLICY.)

Insurance Company: _____ **Group #:** _____
Claim Address: _____ **Policy/ID #:** _____
Policyholder's Name: _____ **Date of Birth:** _____
Policyholder's Social Security Number: _____ **Gender:** ☐Male ☐Female

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By signing below, I acknowledge the following:

1) I hereby authorize this provider to treat my child and attest that the personal and financial information given above is true and that no information has been falsified.
2) I hereby authorize NCHMD, Inc. to contact me using my email address if I supply it on this form.
3) A parent or guardian responsible for payment of the bill is accompanying the child at the time of service unless a separate permission form has been signed. NCHMD, Inc. cannot be bound by any divorce or other family relationship contracts.
4) I hereby authorize insurance benefits, including Medicare benefits, to be paid directly to the physician providing services and recognize it is my responsibility to pay for all non-covered services. I also authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid (CMS) and its agents, any other third party liability or insurance carrier, any information needed to determine these benefits or the benefits payable for related services.
5) I authorize NCHMD, Inc. to apply any funds received under this assignment which exceed the amount necessary to pay my charges to any unpaid NCHMD, Inc. bills of myself or an immediate family member.
6) I have reviewed and understand all the information on the back of this document, including HIPAA Notice of Privacy Practices Statement, as indicated with my signature and date below.

Guarantor Signature _____ **Date** _____

WELCOME TO NCH HEALTHCARE GROUP!
THANK YOU FOR CHOOSING US AS YOUR HEALTHCARE PROVIDER.

We believe it is important for our patients to fully understand our Financial Policy and acknowledge that they have read our Notice of Privacy Practices. Please review the Financial Policy below and the separate Notice of Privacy Practices document carefully. To avoid any misunderstanding regarding either policy, it is necessary for you to read both and sign on the first page of this document, before treatment is rendered. Please ask us any questions you may have regarding either document and take a copy of both policies home for future reference if necessary.

OUR FINANCIAL POLICY

This policy covers office visits, lab or radiology testing and therapy services performed at NCH Healthcare Group (NCHMD, Inc.) facilities. By signing on the first page of this document, I am agreeing to the terms of this Financial Policy.

Medicare Patients: We are participating physicians with Medicare. This means that you will be responsible for the 20% of the approved Medicare fee for covered services, the current yearly deductible and full payment of any non-covered services. Non-covered services include, but are not limited to, most annual physical exams, most labs and diagnostic tests performed for screening purposes.

Payment is due at time of service: Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate (please see insurance below). You will be charged a $35 service fee for any returned checks, no exceptions.

Insurance: Patients will be asked to present their insurance card to the receptionist for copying upon check-in at the office each time they are seen for medical services. Please make it a point to bring your insurance card with you each time you visit our office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those patients covered by insurance plans with which we **ARE** participating providers, all co-payments, deductibles and non-covered services are due at the time of service. We will file a claim to the insurance company on your behalf. In the event that you are covered by (or your coverage changes to) a plan with which we **ARE NOT** participating providers, we may require payment in full at the time of service. Any charges that are not paid by your insurance are your responsibility. Your insurance policy is a contract between **YOU** and your insurance company. Any pre-certification of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.

Surcharge for Missed Appointments: Patients may be subject to a surcharge for missed appointments if cancellation is not received at least 24 hour before the time of the appointment. Check with your provider regarding their policy.

Lab Specimens: Lab specimens may be sent to Naples Community Hospital, LabCorp or Quest and you may receive additional statements from one of these labs. These charges are based on the type of specimen(s), further studies needed to complete the test, and the type of insurance coverage you may have. Your signature on page one acknowledges that you understand this.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES STATEMENT

I have been given the opportunity to review NCHMD, Inc. Notice of Privacy Practices (a separate document) prior to signing this acknowledgement. NCHMD, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained from this office or by forwarding a written request to the Compliance Coordinator at the NCH Healthcare System Quality Management Office, 350 7th Street N., Naples, FL 34102.

By signing on the first page of this document, I hereby acknowledge that NCHMD, Inc. may use and disclose my protected health information to carry out treatment, payment and healthcare operations. NCHMD, Inc. Notice of Privacy Practices provides a complete description of such uses and disclosures. Uses and disclosures not listed in the Notice of Privacy Practices will require my prior written authorization. NCHMD, Inc. is authorized to use my personal information to secure payment for services rendered and will comply with all reasonable measure to follow the FTC guidelines regarding identify theft. I understand that I can require that medical information not be disclosed to a health plan if I pay for those services out of pocket. I may make restrictions to the use and disclosure of my protected health information or revoke a previous request for restriction at any time except to the extent that the practice has already made disclosures in reliance upon my prior authorization to do so. Both Requests for Restriction and Revocations must be in writing. By signing on the first page of this document I am acknowledging that I have received NCHMD, Inc. Notice of Privacy Practices and understand my rights to modify how my information is used and disclosed. If NCHMD, Inc. determines that my restrictions make it impossible for them to carry out my treatment, payment and healthcare operations, they may refuse to accept me as a patient.