West Salem Family Practice Associates, LLC

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PLEASE PRINT & COMPLETE ALL ENTRIES

Patient's Legal Name (Last-First-Middle Initial)	Patient's Maiden Name	Sex ☐M ☐F	Driver's License Number
Address City State		Zip Code	Home Phone ( )
Mailing Address, if Different From Above State		Zip Code	Cell Phone ( )
First name you prefer to be called by:	E-mail address:		
Race: (optional) ☐ Caucasian ☐ Native American ☐ Latino ☐ Asian ☐ African American ☐ Other			
Marital Status (please check one) ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	Social Security Number	Age	Birth Date
Patient Employed By			Employer Phone ( )
Responsible Party or Spouse Information (if Different from Above)	Birth Date		Home Phone ( )
Employed By			Employer Phone ( )
Do you have Medical Insurance? ☐ No ☐ Yes	Is Today's Visit Work Related or the Result of a Motor Vehicle Accident? ☐ No ☐ Yes		If yes, Date of injury?
Name of Primary Insurance (Provide copy of ID card to attach)			
Name of Policy Holder	Policy Holder's Date of Birth	Group Number	ID Number, Including Alpha Letters
Do you have Secondary Medical Insurance? ☐ No ☐ Yes	Name of Secondary Insurance (Provide copy of ID card to attach)		
Name of Policy Holder	Policy Holder's Date of Birth	Group Number	ID Number, Including Alpha Letters
Emergency Contact	Phone ( )		Relationship

INSURANCE AUTHORIZATION AND ASSIGNMENT

ASSIGNMENT AND RELEASE

I, the undersigned, have health insurance with: _____

Name of Insurance Company

and assign all medical insurance benefits directly to West Salem Family Practice Associates or its physicians.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

I have also been notified of the Missed Appointment Policy and understand that I am financially responsible for all charges under this policy.

_____ _____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to WSFPA/Dr. _____ for any services furnished by this doctor. I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated on any approved CMS claim form or electronically submitted claim, my signature authorizes the release of the information to the insurer or agency shown.

_____ _____

Beneficiary Signature Date

February 2003

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, authorization and referral information, if required, and to notify our office of any information changes when they occur. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments at the time of service, co-insurance and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

It is also your responsibility to verify that services that you receive at our office are covered by your insurance carrier and, if not covered, that you will take financial responsibility for receiving non-covered services.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files, and or summaries.

I have read and understand the above financial policy. I agree to assign insurance benefits to West Salem Family Practice Associates, LLC whenever applicable. I also agree, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

*Signature of Insured or Authorized Representative: _____

*Please print your name: _____

*Date signed: _____

*Additional family members (if any) on your account for which you are financially responsible:

_____