FCHC Medical Care, LLC

Welcome to

DMC
Delta Medical Center

Providers:

Dexter L. Phillips, DO
Ann M. Steck, MD
Shelly K. Mills, DO
Nicholas T. Barnes, DO
Rebecca J. Shirley, CNP

Address:

6696 US Highway 20A
Delta, OH 43515

Office hours:

The office is open:

Monday-Friday
7:45 am – 5:00 pm

Main phone number:

(419) 822-3242

Use this number to schedule appointments, answer your general questions and connect you with team members.

Fax number:

(419) 822-9008

Welcome!

Thank you for choosing us to be part of your healthcare team. We look forward to working with you to make sure you receive the care you need and keep you healthy and happy. We hope that the information provided on this guide will answer many of the questions you may have about our practice.

After-Hours Care

If you would like to speak to the clinician on call to help you decide how to treat an illness after hours or to help you decide whether to go to the emergency room, call (419) 335-2015. If you receive care at an emergency room or urgent care center, please let us know by calling (419) 882-3242 within 48 hours so we can assist with follow-up care as needed.

Appointments

If you have an emergency illness or symptom that requires immediate, urgent attention, call 911. If you need an appointment for illness, symptom, check-up, follow-up visit or annual visit call (419) 822-3242.

Patients who are more than 10 minutes late may be required to reschedule their appointments. Patients with 3 no-show appointments may result in dismissal from practice. If you no-show to your initial appointment, you will not be rescheduled and will not be considered a patient at Delta Medical Center. Patients under the age of 18 must be accompanied by a parent or legal guardian at all appointments unless an Assignment of Agent is completed.

Appointment Check List

- Your insurance card.
- Current prescription bottles and non-prescription medications, vitamins and supplements bottles.
- A good description of the problem, how long you have had it and how it affects you.
- A list of questions you would like to discuss with your provider.
- A list of other health care providers you have visited.

Payment Options

We participate in most insurance plans, including Medicare. Be sure to check with your insurance to see if we are an in network provider. Please note that it is your responsibility to ensure that we are a covered provider.

Please be prepared to pay your co-pay and/or patient balance at the time of service. We accept checks, Visa, MasterCard, Discover, American Express and cash.

We are happy to answer questions, discuss payments or your bill anytime by calling (419) 822-3242.

Prescriptions

For refills of prescriptions, please contact your pharmacy. Please allow 48 hours for us to refill your prescriptions. We will contact you only if there is a problem or we have a question about your prescription refill request.

Please remember that refills can only be given to patients who have been seen within the past six months. If you have not been seen for more than six months, you will need to schedule an appointment.

If you have questions about a new prescription or about discontinuing medication(s), please call and speak with your provider's nurse.

FCHC Medical Care - PATIENT REGISTRATION FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE | PAGE 1

LAST NAME	LEGAL FIRST NAME	MI	PREFERRED NAME if different than Legal Name
MAILING ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS	EMAIL ADDRESS

FCHC Medical Care, LLC is asking you to complete the next section to meet the requirements of Section 1557 of the Affordable Care Act. This is not specific to FCHC Medical Care, LLC, all healthcare facilities must comply.

LEGAL SEX:	WHAT IS YOUR GENDER IDENTITY?		WHAT IS YOUR SEXUAL ORIENTATION?	
❒ Female	❒ Female	❒ Trans Female (Male to Female)	❒ Bisexual	❒ Something Else
❒ Male	❒ Male	❒ Other	❒ Heterosexual or Straight	❒ Decline to Answer
	❒ Trans Male (Female to Male)	❒ Decline to Answer	❒ Lesbian, Gay or Homosexual	❒ Don't Know

PREFERRED FORM OF COMMUNICATION FOR APPOINTMENT REMINDERS? ❒ Home Phone ❒ Cell Phone ❒ Text Message

PREFERRED TIME TO CALL FOR APPOINTMENT REMINDERS? ❒ Morning ❒ Afternoon ❒ Evening

PHONE: HOME	MAY WE CONTACT YOU AT HOME? MAY WE LEAVE A DETAILED MESSAGE?	YES YES	NO NO
PHONE: CELL	MAY WE CONTACT YOU ON YOUR CELL PHONE? MAY WE LEAVE A DETAILED MESSAGE?	YES YES	NO NO
PHONE: WORK	MAY WE CONTACT YOU AT WORK? MAY WE LEAVE A NAME & CALL BACK NUMBER?	YES YES	NO NO

WHOM WE ARE ALLOWED TO DISCUSS AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION?

Information in your medical record is confidential and is protected under HIPAA/Ohio Laws. By completing this section and signing the Patient Registration Form consent, you are allowing our office to disclose your protected health information with the following:

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE

ETHNICITY (PLEASE CHECK ONE OF THE FOLLOWING)	RACE (PLEASE CHECK ALL THAT APPLY)		PRIMARY LANGUAGE
❑ HISPANIC OR LATINO	❑ AMERICAN INDIAN OR ALASKA NATIVE	❑ ASIAN	❑ ENGLISH
❑ NOT HISPANIC OR LATINO	❑ BLACK OR AFRICAN AMERICAN	❑ NATIVE HAWAIIAN	❑ SPANISH
	❑ OTHER PACIFIC ISLANDER	❑ WHITE	❑ ASL
			❑ OTHER

EMPLOYER NAME		OCCUPATION	
EMPLOYER ADDRESS	CITY	STATE	ZIP

IF PATIENT IS MARRIED PLEASE COMPLETE THE FOLLOWING INFORMATION

SPOUSE'S INFORMATION

LAST NAME	LEGAL FIRST NAME	MI	PHONE NUMBER
MAILING ADDRESS	CITY	STATE	ZIP
SS#	DATE OF BIRTH	OCCUPATION	
EMPLOYER NAME	EMPLOYER ADDRESS		

IF PATIENT IS A MINOR CHILD PLEASE COMPLETE THE FOLLOWING INFORMATION

PARENT/GUARDIAN'S INFORMATION

LAST NAME	LEGAL FIRST NAME	MI	PHONE NUMBER
MAILING ADDRESS	CITY	STATE	ZIP
SS#	DATE OF BIRTH	OCCUPATION/	
EMPLOYER NAME	EMPLOYER ADDRESS		

PARENT/GUARDIAN'S INFORMATION

LAST NAME	LEGAL FIRST NAME	MI	PHONE NUMBER
MAILING ADDRESS	CITY	STATE	ZIP
SS#	DATE OF BIRTH	OCCUPATION	
EMPLOYER NAME	EMPLOYER ADDRESS		

FCHC Medical Care - PATIENT REGISTRATION FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE

LAST NAME	LEGAL FIRST NAME	MI	

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER

MAILING ADDRESS	CITY	STATE	ZIP

PRIMARY PHARMACY

NAME	PHONE NUMBER

ADDRESS	CITY	STATE	ZIP

IT IS THE PATIENT/GUARANTOR'S RESPONSIBILITY TO COMPLETE THE INSURANCE INFORMATION BELOW AND TO PROVIDE INSURANCE CARD(S) SO FCHC MEDICAL CARE, LCC CAN BILL YOUR INSURANCE APPROPRIATELY.

PRIMARY INSURANCE COVERAGE – IF NO COVERAGE, PLEASE CHECK HERE ❑

INSURANCE COMPANY NAME	GROUP NAME (EMPLOYER)

I.D. NUMBER	GROUP NUMBER

POLICY HOLDER NAME	RELATIONSHIP

POLICY HOLDER'S SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP

INSURANCE COMPANY PHONE NUMBER	EFFECTIVE DATE	PRESCRIPTION CARD? YES NO	COPAY

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY NAME	GROUP NAME (EMPLOYER)

I.D. NUMBER	GROUP NUMBER

POLICY HOLDER NAME	RELATIONSHIP

POLICY HOLDER'S SOCIAL SECURITY NUMBER	POLICY HOLDER'S DATE OF BIRTH

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP

INSURANCE COMPANY PHONE NUMBER	EFFECTIVE DATE	PRESCRIPTION CARD? YES NO	COPAY

CONSENT TO RELEASE MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS

I hereby consent to the use and disclosure by FCHC Medical Care, LLC of medical information to carry out medical treatment. Payment and health care operations as defined by applicable law. MEDICAL TREATMENT includes the provision, coordination and management of my health care and related services, including treatment by other health services and/or their agents to whom I may be referred (and any referring and primary care/family physician which have been or may be involved in my care and treatment). PAYMENT includes all activities relating to the determination of coverage and reimbursement for the provision of health care services and related claims management and review activities. HEALTH CARE OPERATIONS include activities of FCHC Medical Care, LLC relating to medical care and treatment and related assessment, quality improvement and management activities.

I authorize the disclosure of my clinical health information for the duration of my care unless revoked in writing to those listed under **WHOM WE ARE ALLOWED TO DISCUSS AND/OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION?**

I authorize my insurance benefit to be paid directly to FCHC Medical Care, LLC realizing that I am ultimately responsible for any allowable portion of the charge not covered by my insurance plans.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE	DATE
X	

If signed by patient's authorized representative, describe representative's authority:

□ Patient is a minor; I am the patient's parent and natural guardian.
□ Patient is a minor; I am the patient's guardian, appointed by the _____ County Juvenile Court.
□ Patient is a ward; I am the patient's guardian, appointed by the _____ County Probate Court.
□ I am the patient's attorney in fact, as designated in the patient's durable power of attorney for health care.

WITNESS SIGNATURE	DATE

DMC Pediatric Intake/Health History Form

DMC is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential as part of your child's medical record.

CHILD'S NAME: _____ Nick Name _____

DATE OF BIRTH:_____ AGE _____

PARENT(S)/GUARDIAN(S)NAMES_____

CHILD'S PREVIOUS DOCTOR/PRIMARY CARE PROVIDER_____

MEDICINES/VITAMINS_____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: _____

PREGNANCY & BIRTH

Is the child yours by: Birth_____ Adoption_____ Stepchild_____ Other: _____

Where was your child born (Hospital/City)? _____

Delivery by: Vaginal birth_____ Caesarean_____ If Caesarean, why? _____

Please indicate any medical problems during pregnancy: None _____ Specify: _____

Birth weight: _____ Birth length: _____

Please indicate any medical problems during the baby's newborn period: None _____

If premature, How early? _____

Other problems:_____

NUTRITION & FEEDING

Was/is your child breastfed? No Yes If so, how long?_____ _____

Has your child had any feeding/dietary problems? No____Yes ____ If yes, specify:_____

Milk intake now: Type: Cow's milk_____ (Nonfat 1% fat 2% fat Whole milk) Soy Milk _____ Rice Milk____

Average ounces per day (Note 8 ounces = 1 cup)_____

SLEEP

Hours per night_____ Naps (number & length)_____

Any sleep problems?_____

DEVELOPMENT

At what age did your child: Sit Alone_____ Walk Alone_____ Say Words_____ Toilet Train (daytime)_____

Girls only: Age at first menstrual period_____

Any concerns about your child's behavior or development? Yes_____ No_____

If yes, specify_____

IMMUNIZATIONS:

Has your child had immunizations? Yes_____ No_____ Where? _____

Please bring a copy of immunization record to appointment

DENTAL HISTORY:

Has your child been seen by a dentist? No____ Yes_____ Dentist_____

If so, how often? _____ Date of last visit_____ Water Source: City_____ Well_____ Other_____

SCHOOL HISTORY:

Name of School _____ Grade_____

Any concerns about school performance? _____

Any concerns about relationship with: *Teachers* No____ Yes___ *Student* No _____ Yes_____

TV-hours per day_____ Computer hours per day_____ Video games hours per day_____

PAST MEDICAL HISTORY:

Please describe any major medical problems and their dates.

_____

_____

Other Physicians or Specialists your Child sees (Names and specialty)

_____

Hospitalizations/operations (with dates)_____

Broken bones or severe sprains:_____

FAMILY HISTORY:

Please check below if any immediate (parent, sibling, or grandparent) family members have any of the listed conditions:

Alcoholism _____ Stroke _____

High Cholesterol _____ Depression/Suicide _____

Cancer, please specify type_____ Diabetes_____

High Blood Pressure _____ Other_____

Heart Attack _____ Other_____

SOCIAL HISTORY:

Who lives at home?

Name	Age	Relationship	Name	Age	Relationship
_____			_____		
_____			_____		
_____			_____		

Are your child's parents: Married_____ Unmarried_____ Separated_____ Divorced_____

Child care: Parents_____ Daycare_____ Other_____

FAMILY HEALTH HABITS:

Do you feel you live in a safe place? Yes____ No____

In the past year, have you ever felt threatened in your home? Yes _____ No_____

In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you or threatened to hurt you? Yes_____ No_____

Does anyone in your household smoke? Yes_____ No_____

Concerns about your child: None____ Alcohol use____ Drug use____ Tobacco ____ Sexual activity___ Aggressive behavior____

Thank you for taking the time to complete this Intake/Health History Form.

Notice of Privacy Practices

FCHC Medical Care, LLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

• We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.

• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.

• We are not required to agree to your request, and we may say "no" if it would affect your care.

• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.

• We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

• You can complain if you feel we have violated your rights by contacting us using the information on the back page.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

• We will not retaliate against you for filing a complaint

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

• We can use your health information and share it with other professionals who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

• We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

• We can use and share your health information to bill and get payment from health plans or other entities.

Example: *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

• We can share health information about you for certain situations such as:
• Preventing disease
• Helping with product recalls
• Reporting adverse reactions to medications
• Reporting suspected abuse, neglect, or domestic violence
• Preventing or reducing a serious threat to anyone's health or safety

Do research

• We can use or share your information for health research.

Comply with the law

• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

• We can use or share health information about you:
• For workers' compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Rights

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

• Share information with your family, close friends, or others involved in your care
• Share information in a disaster relief situation
• Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

• Marketing purposes
• Sale of your information
• Most sharing of psychotherapy notes

In the case of fundraising:

• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Responsibilities

• We are required by law to maintain the privacy and security of your protected health information.
• We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
• We must follow the duties and privacy practices described in this notice and give you a copy of it.
• We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Privacy Officer: Chad Peter • 419-330-2684 • cpeter@fulhealth.org

I, _____; hereby acknowledge receipt of this policy.

X_____

Patient/Authorized Representative Signature Date

Delta Medical Center

Delta, Ohio

ASSIGNMENT OF AGENT
for
AUTHORIZATION AND CONSENT
for
HEALTHCARE OF A MINOR

The following form is designed for those situations where a minor is unaccompanied by either a custodial parent or legal guardian. This "Assignment of Agent" gives authority to a designated adult to arrange for medical care for a minor. This is extremely important, in that, medical care cannot be provided to a minor without approval by the custodial parent(s) or legal guardian(s), unless there is written consent authorizing an agent to give approval.

I, _____ of _____, _____, _____ and/or _____ of
(Custodial Parent/Guardian) (City) (State) (Zip) (Custodial Parent/Guardian)

_____, _____, _____ attest that I am (we are) the lawful guardian(s) of the child listed below and that
(City) (State) (Zip)
there are no court orders now in effect that would prohibit me (us) from conferring the power to consent upon another person.

Child's Name_____
Date of Birth _____
Sex [] male [] female
Address _____

I (we) hereby authorize and appoint _____, _____ of _____,
(Name of agent) (Relationship to Minor) (City)
_____, _____ as my (our) agent.
(State) (Zip)
In my (our) absence, my (our) agent may give legal consent for my (our) above named child's surgical, dental, developmental, mental health and/or medical examinations or treatment during emergent and non-emergent (routine) circumstances and which are deem advisable by and to be rendered under the general or special supervision of any physician and /or surgeon, licensed by the State of Ohio to practice medicine, whether such diagnosis or treatment is rendered at the office of said physician, at a hospital, or elsewhere. Such treatment may include but is not limited to the following:

1. Transportation by car or ambulance
2. Examinations
3. X-rays
4. Laboratory testing
5. Diagnosis
6. Hospitalization
7. Anesthesia
8. Surgery
9. Medications
10. Transfusion of blood or blood products

My (Our) agent may have access to any and all of my (our) child's confidential medical records, including, but not limited to insurance records regarding any such services.

It is my (our) responsibility to provide Delta Medical Center with photo identification of my (our) agent which shall be part of my (our) child's permanent medical records.

I (We) acknowledge that I (we) remain responsible and liable for all financial costs incurred for care rendered to my (our) child though consented to by my agent in my (our) absence.

This authorization shall remain in effect until revoked by me (us) in writing to the Delta Medical Center.

_____ _____ _____
Custodial Parent/Guardian Signature Date Witness Signature

_____ _____ _____
Custodial Parent/Guardian Signature Date Witness Signature

Home Phone # _____Cell Phone #_____Work Phone #_____

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name: **Date of Birth:** **SSN#**
Address:

By signing this authorization form, you are agreeing to the release or disclosure of your protected health information. Your medical care or payment for care will not be conditioned on the signing of this form.

Please be aware that any information disclosed to a third party pursuant to this authorization may be subject to re-disclosure and no longer protected by our policies and applicable law.

This authorization will expire one year from the date of the signature below. You have the right to revoke this authorization by completing the revocation section below. Revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I authorize_____ to release my records to:

____**Delta Medical Center**
6696 US Highway 20A
Delta, OH 43515
Phone: 419-822-3242
Fax: 419-822-9008

____**Fayette Medical Center**
124 W Main St, PO Box 399
Fayette, OH 43521
Phone: 419-237-2501
Fax: 419-237-2671

____**Fulton County OB/GYN**
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-6377
Fax: 419-335-6807

____**FulCare Behavioral Health**
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-330-2790
Fax: 419-330-2774

____**West Ohio Family Physicians**
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3242
Fax: 419-335-3222

____**West Ohio Orthopedics**
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-2663
Fax: 419-335-9615

____**West Ohio Pediatrics**
725 S Shoop Ave
Wauseon, OH 43567
Phone: 419-335-3333
Fax: 419-337-7845

____**West Ohio Surgeons**
735 S Shoop Ave
Wauseon, OH 43567
Phone: 419-337-7478
Fax: 419-337-7846

The information to be disclosed may include information related to diagnosis and treatment for HIV, alcohol and/or substance abuse and mental illness.

Information and date(s) of service to be disclosed:_____
_____

Purpose for disclosure:_____
_____

Signature:_____Date:_____
(Patient or Representative)

*****Revocation*****
(Sign here <u>ONLY</u> if you wish to revoke this authorization)

I hereby revoke this authorization

Signature:_____Date:_____
(Patient or Representative)

FINANCIAL POLICY

Thank you for choosing Delta Medical Center, a division of FCHC Medical Care, LLC, as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. All patients must complete the required forms and are required to read and sign this Financial Policy prior to any treatment.

Remitting Payment: Please remit payment to FCHC Medical Care, LLC at 735 S. Shoop Ave. Wauseon, OH 43567. For your convenience we accept cash, check, Visa, MasterCard, and Discover.

Insurance Companies: We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy, we will bill your company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed and payment is due upon receipt of bill.

Injury/Accidents: If you are being seen for an injury, please advise the office at the time of scheduling your appointment. You insurance may require additional information.

Regarding insurance plans where we are a participating provider: All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance.** Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

Usual and customary rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.

Minor patients: The adults accompanying a minor and the parents (or guardians of the minor) are responsible for payment. Unaccompanied minors presenting for non-emergency treatment will be denied if there is no authorization or consent to treat.

Missed appointment: If appointments are missed we will move you to the next available opening. Please help us serve you by keeping scheduled appointments.

Late arrival: To help the providers stay on time and to cut back your wait time we have a 10 minute late appointment policy. If arrive more than 10 minutes after your appointment time you will be asked to reschedule. You will be placed at the next available opening. If you have 3 missed appointments in a 1 year time frame you may be terminated from the practice. A warning letter will be mailed to you to prior to termination.

Co-pays and Balances: Co-pays are due at the time of service. You will also be asked to pay any outstanding patient balance at the time of an appointment.

Disability Form Fees: You may be charged a fee for completion of forms. Please complete the Patient portion of the form before submitting it to the office staff.

Insufficient Fund Fee: Checks that are returned will be charged a $30.00 insufficient funds fee.

Please let us know if you have any questions or concerns.

I have read the *Financial Policy* and I understand and agree to its provisions.

_____

Patient Name Patient DOB

_____

Signature of Patient or Guardian Date

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

• **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.

• **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

• **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Delta Medical Center can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Delta Medical Center to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____

Patient Name Patient DOB

_____

Signature of Patient or Guardian Date

_____

Relationship to Patient