LAKEWOOD FAMILY MEDICINE

PATIENT INFORMATION SHEET

Date of Birth ___/___/___ Social Security # ____-____-_____ Male ☐ Female ☐

Name

_____
First *Middle* *Last*

Address

_____
Ave/Street/Drive/Blvd *City* *State* *Zip*

Home Phone (Landline) _____ Work Phone _____

Cell Phone _____

Which phone would you like listed as your primary contact? Home ☐ Work ☐ Cell ☐

Employment

Employed ☐ Not Employed ☐ Retired ☐ Self Employed ☐

Employer Name: _____

***If Self Employed Name of Business:_____

Email Address _____

*One email address per patient

Insurance Information

Primary Insurance: _____
Name of Insurance Company Employer Group #

_____
Policy Holder Name Policy Holder Date of Birth Policy Holder Social Security #

_____
Relationship to Patient Address of Policy Holder, if different than patient Phone Number

Second Insurance: _____
Name of Insurance Company Employer Group #

_____
Policy Holder Name Policy Holder Date of Birth Policy Holder's Social Security #

_____
Relationship to Patient Address of Policy Holder, if different than patient Phone Number

Primary Care physician at Lakewood Family Medicine is Dr. _____

THANK YOU FOR CHOOSING LAKEWOOD FAMILY MEDICINE

Lakewood Family Medicine

Protected Health Information Disclosure Preference- Confidentiality Form

This form details how you wish Lakewood Family Medicine to disclose Protected Health Information (PHI) to you and specific individuals you may name below. This PHI Disclosure Preference form will be kept on file and remains effective until amended or revoked. This disclosure may be amended or revoked at any time. Such amendment or revocation must be in writing, signed and dated. ***Detailed Information***: Includes any type of information regarding your care including (but it is not limited to) scheduled appointments at LFM, referral appointments, lab and test results, and financial information. This may include Mental Health and STD testing.

Patient's Name (Please Print): _____ Date of Birth: _____

Please check/complete ONE box, and then sign and date. Thank you.

☐ I give my permission for LFM to provide **Detailed information* to me, or with any person answering the phone.

A **Detailed information* message may be left on my voice mail, or answering machine. I also give my permission for LFM to speak to anyone that may call, or anyone that LFM needs to speak to on my behalf. This may include **Detailed information*.

Signature of Patient/Legal Guardian: _____

Date: _____

☐ LFM is to speak only with me, or to those I have listed below.

When LFM calls, they will not leave any health related information on voice mail, or answering machine. A message may be left indicating that LFM has information for me, and that a return call to LFM is needed. (A direct line, or extension number may be provided for me to call back). Also, a message may be left confirming my LFM appointments, but the nature of the appointment will not be disclosed.

*****PLEASE BE AWARE THAT IF YOU SELECT THIS OPTION, THIS DOES LIMIT WHO LFM MAY SPEAK WITH, AND UNLESS YOU LIST SOMEONE BELOW, LFM MAY SPEAK ONLY WITH YOU.**

I give my permission for LFM to speak with these people listed below regarding ANY of my healthcare information. (These may be a husband, wife, adult children, parents, other family members, or significant others).

Name_____ Relationship_____ Phone _____

Name_____ Relationship_____ Phone _____

Name_____ Relationship_____ Phone _____

Name_____ Relationship_____ Phone _____

Name_____ Relationship_____ Phone _____

Signature of Patient/Legal Guardian: _____

Date: _____

Lakewood Family Medicine
Acknowledgement of Receipt of Privacy Notice

Name Patient _____ Date of Birth _____

I acknowledge that Lakewood Family Medicine's “Notice of Privacy Practices” has been offered and/or provided to me.

I understand I have a right to review Lakewood Family Medicine's Notice of Privacy Practices prior to signing this document. Lakewood Family Medicine's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Lakewood Family Medicine. The Notice of Privacy Practices for Lakewood Family Medicine is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Lakewood Family Medicine’s duties with respect to my protected health information.

Lakewood Family Medicine reserves the right to change the privacy practices, in observance with Federal laws that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Lakewood Family Medicine’s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative _____ Date _____

Name Personal Representative _____ Relationship _____

Witness _____

Lakewood Family Medicine

Signature Authorization & Assignment of Benefits

Patient's Name: _____ **Patient's Date of Birth:** _____

Release of Information

I authorize the release of any medical information necessary; 1) to process claims, 2) to be referred to a specialist for medical care, 3) to obtain services for lab, x-ray, and other diagnostic services. I also authorize that this information may be faxed, if necessary.

Assignment of Benefits

I authorize that insurance payments of medical benefits be paid directly to Lakewood Family Medicine for the services rendered.

If I am covered by Medicare:

I request that payment of authorized Medicare benefits be made to Lakewood Family Medicine. I authorize any holder of medical information about me needed to determine those benefits payable for related services, to be released to the Centers for Medicare and Medicaid Services, or its agents. I authorize Medicare to send Explanation of Medicare Benefits information to my Medicare supplement and benefits to be paid to Lakewood Family Medicine.

Responsibility of Payment

I authorize and accept responsibility for payment of any balance; 1) remaining after payment of insurance benefits, 2) due to finance charges, 3) deemed not covered by workman's compensation, 4) deemed not covered by auto insurance, 5) not covered by insurance for whatever reason.

I agree, in order for Lakewood Family Medicine to service my account or to collect any amounts I may owe, that Lakewood Family Medicine and its Business Associates and Covered Entities/Service Providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Lakewood Family Medicine and its Business Associates and Covered Entities/Service Providers may also contact me by sending text messages or e-mails, using any e-mail address I have provided to Lakewood Family Medicine. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I understand that a copy of this signature is as valid as the original.

Date: _____

Signature of Patient, Parent or Legal Representative: _____

Relationship to patient: _____

Date: _____

Signature of Spouse: _____

Date: _____

Signature of Parent; of patient 18 years and older: _____

***Patient that is 18 years and older MUST also sign this form in the patient field above.

Lakewood Family Medicine

FINANCIAL POLICY

INSURANCE: Please remember that your insurance coverage is a legal contract between you and your insurance company. We are not party to that contract. You are responsible to know your contract and its coverage. We will submit claims to your insurance carrier. You must provide us with accurate and current information about your insurance. You must present a current copy of your insurance at each visit and communicate any changes in your personal information. Your co-pay amount is due at the time of service. If a physician at LFM is not listed as your Primary Care Provider with your insurance company, your insurance company may require you to pay a higher copay amount. We are committed to providing exceptional medical care. This care may not always be covered by your specific insurance plans benefits.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses and coding are based on medical information, not on coverage by insurance companies. To request a coding change based solely for the purpose of securing reimbursement from an insurance company is inappropriate and is considered insurance fraud.

SELF-PAY ACCOUNTS/PLANS WE DO NOT PARTICIPATE WITH: Payment in full is due at the time of service unless arrangements have been made with the Billing Department before the scheduled appointment. Payment plans are available to assist our patients who are having financial difficulties.

NON-COVERED SERVICES/DEDUCTIBLES/CO-INSURANCES: Non-covered services are services which your insurance company has deemed services they do not cover under any circumstance. You are responsible for the entire fee for a non-covered service. If we participate with your insurance company, we will accept payment for covered services after you have paid any deductible, co-insurance or other out of pocket cost shares required by your insurance company.

MINOR PATIENTS: The parents or guardian of a minor are financially responsible. Statements will be sent to the parent(s) or guardian with whom the child resides. Both parents are responsible for a minor's financial balance. An adult accompanying a minor to a visit must have permission to seek treatment from a parent or guardian and come prepared to make the appropriate payment that may be due.

MISSED APPOINTMENTS: Your visit to our office is important. We understand that situations arise in which it may become necessary for you to change or cancel your appointment. We request that you notify us at least 24 hours in advance. Failure to notify our office of the cancellation of your appointment 24 hours in advance could result in a Missed Appointment Charge being applied to your account. You are responsible for payment of this charge. Multiple missed appointments may result in discharge from our practice.

MEDICAL RECORDS/FMLA/DISBILITY FORMS: We charge an administrative fee for processing medical records, FMLA forms, and disability forms.

I have read and agree to this FINANCIAL POLICY.

_____ _____

Signature of patient or patient's representative **Date**

_____

Relationship to patient

_____ _____

Patient's printed name **Patient's Date of Birth**