LAKEWOOD FAMILY MEDICINE
PATIENT INFORMATION SHEET FOR MINORS

Name _____
First *Middle* *Last*

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

DOB:_____ ☐ Male ☐ Female

Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Other
*If Separated or Divorced; Who Does Child Reside With: ☐ Father ☐ Mother

FATHER

Name _____

Address (if different than patient)

_____

_____

Home (Landline) Phone #_____

Work Phone # _____

Cell Phone #_____

SS #: _____

Birth Date: _____/_____/_____

MOTHER

Name _____

Address (if different than patient)

_____

_____

Home (Landline) Phone #_____

Work Phone # _____

Cell Phone #_____

SS #: _____

Birth Date: _____/_____/_____

Which phone number should be listed as primary contact for the patient?

☐ Landline ☐ Father Work ☐ Mother Work ☐ Father Cell ☐ Mother Cell

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INSURANCE INFORMATION

Primary Insurance: _____
Name of Insurance Company Employer Group #

_____
Policy Holder Name (Relationship to Patient) Policy Holder Date of Birth Policy Holder's Social Security #

Second Insurance: _____
Name of Insurance Company Employer Group #

_____
Policy Holder Name (Relationship to Patient) Policy Holder Date of Birth Policy Holder's Social Security #

Primary Care physician at Lakewood Family Medicine is Dr. _____

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**