Colbert Family Health & Wellness

Confidential
Registration Information
Please Print

___ New Patient
___ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

Date ___/___/____ Email Address: _____ Home Phone:_____ Work Phone:_____

Last Name_____First Name_____MI___ Cell Phone: _____

Street Address: _____ Mailing Address_____

City: _____ State _____ Zip_____

Gender: Male___ Female___ SSN: _____ - _____- _____ Birth-date ____/____/_____

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other _____

Patient Employed by: _____

Business Address_____

Business Phone: _____ Occupation _____

Name of Spouse/Responsible Party (If patient is minor): _____
Last First MI

Spouse/Responsible party Employed by: _____

Business Address: _____

Business Phone: _____ Occupation _____

Responsible Party/Spouse SSN: _____-_____-_____

Do you have medical Insurance? Circle One: No Yes If yes, please fill in the following information:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

Name of Secondary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____
*This information is required by HIPPA

In case of an emergency, who should be notified? _____

Relationship _____Phone: _____

Preferred Pharmacy: _____ How did you hear about us? _____

Patient Financial Policy

Colbert
Family Health & Wellness

Thank you for choosing the practitioners of **Colbert Family Health & Wellness** as your family health care providers. We are committed to providing you with quality family health care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. If you have any questions about our fees, our policies or your financial responsibilities, please do not hesitateto ask the office staff or contact us at **(937) 529-4376**. Please take time to carefully review the following information and return this form to the front desk with your signature and today's date.

We require that all patients complete our Patient Financial Policy prior to seeing the practitioner. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

INSURANCE

- It is the patient's responsibility to provide our office with current insurance information. We will ask for and copy your insurance card at your first visit. Please bring your current insurance card to each visit. We will ask to verify the card.
- If current information is not obtained at the time of service, it will become the patient's responsibility to pay the entire balance until current information is provided to our office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, and pursuant to contractual obligations, we file all your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

CO-PAYS

- Co-payments are due at the time you check in **PRIOR** to your being seen by our practitioners.

DEDUCTIBLES and CO-INSURANCE and ESTIMATES for in-office procedures:

- Balances related to unmet deductibles and estimation of co-insurance, as per the contract you have with your insurance, is to be paid at the time of service.
- For in-office procedures, an estimation of patient responsibility will be provided to you and is to be paid **in full** PRIOR to services being rendered.
- Additional balances due, if applicable, will be billed to you after the insurance carrier has processed the claim.

UN-PAID/OUTSTANDING BALANCES – (Collection Agency/Bankruptcy)

- Payments are to be made at the time of service unless prior arrangements have been made through the practitioner's office staff in advance of your appointment.
- Any overdue balances may be processed to a collection agency for additional collection efforts. ***If the account is referred to a collection agency, this may result in referral from the practice and/or the inability to schedule an appointment.***
- All balances not paid by your insurance carrier will be billed to you. Questions about how your claim was processed are to be directed to your insurance carrier or you may call our business office at (937) 529-4376.
- Filing of bankruptcy, resulting in the waiving of balances due to the practitioner, constitutes a breach in our financial policy and could result in referral from the practice or delay in scheduling an appointment.

Forms of payment accepted:

Cash, checks, Visa, and Mastercard.
(Contact our billing office at (937) 529-4376 for additional information)

RETURNED CHECKS ***(FEE APPLIED)***

- The charge for a returned check is **$25.00** payable by cash, money order or charge (no checks accepted). This will be applied to your account in addition to the insufficient funds amount.

DISABILITY FORMS ***(FEE APPLIED)***

- Disability, Life Insurance and other forms are often requested to be completed by the practice. Many of the forms require review by the practitioners and completion of detailed medical history questionnaires. Please allow 5-7 days for completion of any requested forms. The charge for this service is **$20.00**. The fee for document completion must be paid in full when forms are submitted to our office. We will not satisfy requests for completion or release of these documents until we are paid in full.

MISSED APPOINTMENTS ***(FEE APPLIED)***

- Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment we request, at minimum, a **24 hour notice**. Failure to provide notice will result in a **$25.00** missed appointment charge. This charge is the responsibility of the patient and is not covered by any insurance carrier.

CREDIT BALANCES

- If your account reflects a credit balance of ***$25.00 or less***, Colbert Family Health & Wellness' policy is to carry the balance on the account until your next appointment or your transfer from the organization. If your account reflects a credit balance of ***more than $25.00***, Colbert Family Health & Wellness will maintain your credit until our Accounts Receivable staff processes your credit or a request is made by you, the patient, to receive a refund. All refunds are reviewed and processed every 45 days, if you make a request please allow ample time for review of your entire account and processing through our accounting department. Refunds are not issued when outstanding insurance claims are still "in processing" with your insurance company. Please call (937) 529-4376 with questions.

MEDICAL RECORD COPIES - Please reference the details below regarding the cost associate with the copying of a patient's medical record according to the Ohio State Medical Board Regulation.

Ohio Practice: Ohio State Medical Board Regulation [§ 3701.74.1]

If you request a copy of your medical records you will be charged the following fees:

a) With respect to data recorded on paper, the following amounts apply:
   - i) $3.07 per page for the first ten (10) pages;
   - ii) $0.64 per page for pages eleven (11) through fifty (50);
   - iii) $0.26 per page for pages fifty-one (51) and higher
   - iv) $2.10 per page with respect to data resulting from X-ray, MRI, or CAT scan, recorded on paper or film

b) With respect to data recorded other than on paper (I.e. electronic copy):
   - i) Eight dollars ($8.00) per flash drive required
   - ii) The actual cost of any related postage incurred by Colbert Family Health & Wellness

If a request is made other than by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

a) An initial fee of eighteen dollars and ninety-one cents ($18.91), which shall compensate for the records search;
b) With respect for data recorded on paper, the following amounts apply:
   - i) $1.24 per page for the first ten (10) pages;
   - ii) $0.64 per page for pages eleven (11) through fifty (50);
   - iii) $0.26 per page for pages fifty-one (51) and higher
   - iv) $2.10 per page with respect to data resulting from X-ray, MRI, or CAT scan, recorded on paper or film
c) The actual cost of any related postage incurred by the health care provider or medical record company.

Like all businesses it is our intention to thoroughly explain our financial policies and set forth our expectations. Your assistance and cooperation is appreciated.

We are pleased to have the opportunity to meet your health care needs and encourage you to contact (937) 529-4376 with any questions or concerns.

I have read the Patient Financial Policy and acknowledge my responsibilities by affixing my signature below.

_____ _____
Patient Name (please print) Patient Date of Birth

_____ _____
Patient/Responsible Party Signature Date

_____Colbert Family Health Rep Initials

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to me for his/her
(Provider's Name)

services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____
(Provider's Name)

will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to Marquetta D. Colbert, CNP Colbert Family Health & Wellness for any services furnished to me by APC. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services, Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Beneficiary Date

Financial Policy

I have read and understand the financial policies of Colbert Family Health & Wellness By my signature I agree to the terms outlined in the financial policies.

_____ _____
Signature Date

Consent for Treatment

I (or my legal guardian/parent) authorize Colbert Family Health & Wellness to provide medical care reasonable by today's standards.

_____ _____
Signature of Patient/Legal Guardian Date

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			

NAME_____ DATE_____