PATIENT INFORMATION

These medical practices are under the legal company name of Generations Family Practice

PERSONAL INFORMATION

Last Name | First Name | M.I.

Street Address | Apt/Unit

City | State | Zip Code

Home Phone | Cell Phone | Work Phone | Ext

E-mail | Date of Birth

Birth Sex

- ☐ Female
- ☐ Male

Sexual Orientation

Gender Identity

Race

- ☐ African-American
- ☐ Asian
- ☐ Hispanic
- ☐ Caucasian
- Other

Social Security

Ethnicity

- ☐ Hispanic
- ☐ Non-Hispanic

Marital Status

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Last Name | First Name | M.I

Street Address | Apt/Unit

City | State | Zip Code

Home Phone | Cell Phone | Date of Birth

PATIENT INFORMATION

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EMERGENCY CONTACT

Last Name

First Name

Home Phone

Cell Phone

Relationship

INSURANCE INFORMATION

Primary Insurance Name

Policy Number

Group Number

Secondary Insurance Name

Policy Number

Group Number

PHARMACY INFORMATION

Name

Phone

Fax

Street Address

City

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICY

I have been provided a copy of the Notice of Privacy Practices which informs me of uses, disclosures, and rights pertaining to my protected health information.

I acknowledge receipt of a copy of Generation Family Practice's Notice of Privacy Practices.

Print Name

Date

Signature

FINANCIAL POLICIES

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FINANCIAL POLICY

Insurance

- Patients must arrive at their scheduled appointment with their insurance card and must be put on file by medical staff. **All co-pays required by a patient's insurance plan must be paid at the time of service.**
- The patient is responsible for all charges associated with their medical care regardless of insurance coverage
- Generations Family Practice participates in a large variety of insurance plans, accepts assignments, and is participating providers with Medicare. If the patient has an insurance plan that our medical practice does not participate with, the patient will be expected to pay **$150** of the charges on the day of the visit. Generations Family Practice will file all out-of-network claims, and the patient will be responsible for any balance due.
- We participate with Medicare; we will file Medicare Advantage plans as a courtesy to our patients. There are some Medicare Advantage plans that we are not contracted with, and you will be responsible for any charges due to being out of network. It is the patient's responsibility to verify their coverage and ensure that our provider is listed as your Primary Care Physician (PCP) when required by your plan.

Self-Pay

- Patients without insurance or those unable to provide proof of insurance at the time of service will be considered self-pay. Self-pay patients are required to make a **$150** payment at the time of service, which serves as a deposit towards the visit.
- Patients with insurance who prefer to utilize our self-pay cash prices must sign an insurance waiver.

No Shows/Deductible

- Missed appointments result in a loss for you, our medical team, and other patients who could have utilized that time.
- A **no-show fee of $35** will be charged for appointments not canceled or rescheduled at least **2 hours** prior to the scheduled time.
- Patients with deductibles will be responsible for paying **$150** of their bill at the time of service. This balance will be toward the patient's responsibility. You will be required to pay any remaining balance as specified by your insurance carrier.

Forms

- All forms such as disability, work, or school forms require an office visit to allow the provider to make the proper assessments and fill in the forms correctly.
- These forms will incur a charge, and it is the patient's responsibility to pay any balance because of the visit.

Billing

- All balances are payable within 30 days of receipt of the patient statement.
- We accept cash, checks, and all major credit cards. Payments can be made in person, or over the phone via our billing department, or via our payment portal. (check your statement for details)

FINANCIAL POLICIES

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TIMELY FILING POLICY

- In order to properly file your insurance claim(s), we require that you provide us with your current health insurance card(s), including coordination of benefits if more than one insurance. If the patient is a child and is covered by both parents, we will need to know which insurance is primary. Usually, the parent whose birthday comes first in the year provides the primary insurance coverage.

- If you provide us with your current insurance card within ten business days of your visit, we will file your claim.

TREATMENT OF A MINOR

- If a patient is a minor (under the age of 18), a parent/legal guardian must be present at each appointment. The patient has a right to not allow the parent/legal guardian in exam room during visit.

- We must have a signed consent form on file if a parent or legal guardian does not accompany a minor child.

- The parent/guardian is responsible for all charges not covered by insurance.

ACKNOWLEDGEMENT

Our family of practices under Generations Family Practice believes that good patient/provider relationships are based on understanding and good communication. If you have any questions about financial arrangements, please feel free to contact the Insurance/Billing Department. We will make every effort to assist you concerning your account.

By signing this form, I acknowledge that I understand the policies outlined within this document. In addition, my signature permits Generations Family Practice to file claims to my insurance (if applicable). I also understand that I accept financial responsibility for all services rendered regardless of insurance coverage.

Print Name

Signature

Date

MEDICAL RECORDS RELEASE FORM

These medical practices are under the legal company name of Generations Family Practice

PATIENT INFORMATION

Patient Name: _____ **Chart Number:** _____

Address: _____

Phone: _____ **Date of Birth:** _____

Social Security: _____

CONSENT TO RELEASE RECORDS

I do hereby consent and authorize Generations Family Practice to **RELEASE** copies of my medical records.

Name of Provider or facility to Release Records: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

CONSENT TO OBTAIN RECORDS

I do hereby consent and authorize Generations Family Practice to **OBTAIN** copies of my medical records.

Name of Provider or facility to Obtain Records: _____

Address: _____

Phone: _____ **Fax:** _____ **Email:** _____

Reason for request (Select one of the following):

- ☐ Continued care
- ☐ Personal
- ☐ Attorney
- ☐ Insurance

Information Needed (select from below)

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Emergency Room Visit
- ☐ Labs
- ☐ Radiology (images & Reports)
- ☐ Operative Note/Procedure Note
- ☐ Consult
- ☐ Other encounter/visit
- ☐ Immunization/Vaccination _____

Please select how you would like the records to be released:

- ☐ Fax
- ☐ US Mail
- ☐ Pick up (Paper)
- ☐ Email

MEDICAL RECORDS RELEASE FORM

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PATIENT PATIENT RIGHTS

Patient Rights- I understand that:

1. I can cancel my permission at any time. I must cancel in writing and send or deliver the cancellation to releasing facility.
2. This is a full release including information regarding alcohol/substance abuse, genetic testing, mental health, HIV/AIDS, & other sexually transmitted diseases unless indicated above.
3. Our medical practice will not share or use my health information without my permission other than listed in the Notice of Privacy Practices as required by law.
4. A fee may be charged for providing my protected health information by releasing facility/clinician.

Signature	**Date**	**Staff Initials**

PATIENT REPRESENTATIVES

When someone other than patient signs, the following must be completed:

I, _____ hereby certify that I am the duly authorized personal representative of the above patient, and that I have the lawful authority on behalf of such individual. Proof of this authority may be requested.

Signature of Representative	**Date**	**Relationship to patient**

This authorization will automatically expire in one year from the date signed unless revoked or another date is specified.

ACCOUNTABLE CARE ORGANIZATION

Disclaimer:

Generations Family Practice is a participant in an Accountable Care Organization. Participating in an ACO helps us fulfill our mission to improve the health of the communities we serve. One of the most important benefits of an ACO is that your doctors and other providers can communicate and coordinate your care. Securely sharing your data helps make sure all the people involved in your care have access to the information they need, to get you the care you need. Medicare protects the privacy of your health information. If you don't want Medicare to share information with your health care providers for care coordination, call 1-800-MEDICARE (1-800-633-4227). Medicare may still share general information to measure provider quality. For more information on how Medicare uses your information, visit Medicare.gov and search for "privacy."

HIPAA AUTHORIZATION

These medical practices are under the legal company name of Generations Family Practice

This authorization outlines how your medical information may be shared.
Please read it carefully

The privacy of your medical information is important to us. Our Notice of Privacy Practices outlines how we may use or disclose your medical information on a regular basis. This authorization is for situations not included in the Notice. This authorization allows the individual(s) listed to have access to all or part of your information as specified below. This authorization will remain in effect for a period of one year from the date signed.

Who may receive your health information?

Name:		**Relationship**	
Name:		**Relationship**	
Name:		**Relationship**	
Name:		**Relationship**	

Limitations:

I understand that once disclosed to the individual(s) named above, our medical practice cannot guarantee that the individual(s) will maintain the confidentiality of such information as described by law.

Revocation

This authorization will remain in effect for a period of one year from the date signed. However, you have the right to revoke this authorization at any time as long as the revocation is made in writing and is received and acknowledged by Generations Family Practice. Such revocation will restrict disclosures of your medical information, but cannot affect past disclosures underway at the time of receipt.

Patient/Guardian (PRINT NAME)

Patient/Guardian Signature

Date

CONSENT TO TREAT

These medical practices are under the legal company name of Generations Family Practice

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that

(1) You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended;
and
(2) You consent to treatment at this office or any other satellite office under common ownership.
The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name (Print)		**D.O.B**	
Patient/Guardian Signature		**Date**	