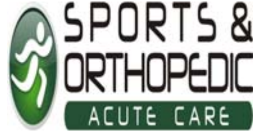

OFFICE USE ONLY

Information is complete

Initials____________________

Mark Mansfield, MD
Richard Maynard, DO

WELCOME TO OUR OFFICE

Patient Name: ____ **Date:** ____________________

Thank you for choosing our office to provide for your health care. We are committed to providing you and your family with the best possible care. Our staff looks forward to assisting you and making your visit a pleasant one.

The information on the front of this form is designed to acquaint you with our financial policies. Inside this form we are asking that you supply us with the information necessary to establish an account with our office and handle the business aspects of your care. All information provided to us is confidential and we appreciate you giving us complete and accurate information.

We have designed our fees to reflect the care and quality of service you should expect to receive. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of your insurance plan and our payment policy. We accept cash, checks, and debit cards, Discover, American Express, Master Card and Visa.

- Payment is due at the time services are rendered. A $7 charge will be added to accounts to redeposit checks for non-sufficient funds. If it comes back a second time, a $15 charge will be added to account for non-sufficient funds. Balances older than 30 days will be subject to additional **finance charges of 1.5%** per month (18% apr) or a minimum of $1.00. . By signing below you agree to be responsible for finance charges and for collection costs to include: a certified mail fee not to exceed $10 to notify you if this account is turned to collections; return check fees up to $20 per occurrence; plus reasonable court costs and attorney's fees should legal action be required to collect this account as agreed. Payment arrangements set up on automatic withdrawal will be given a 5-day grace period from the due date. After 5 days, if the current month's payment is still owing, the account will be charged a $5 late fee.
- We require that all office co-pays be paid on the date of visit prior to the visit. Any co-pays not paid when due will be assessed an $18.00 fee. If your insurance company does not have an office co pay, we require that 20% of each visit be paid at the time of service.
- If you have not met your deductible, we ask for payment in full at the time of service as no insurance benefit will be paid. If your deductible has been met and you have paid your account in full, we will issue a refund check to you upon receipt of the insurance payment. **Please call your insurance prior to your appointment to find out what your deductible is and if it has been met.** This will help you when we are checking you out and will speed things up.
- Does your insurance cover wellness physicals? If you are not sure please call them. If you are here for a wellness exam please notify the doctor so it will be billed out correctly. We **cannot** rebill office exams that have been denied by your insurance company.
- Your insurance is a contract between you and the insurance company. We are not a party to that contract. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, etc.
- If you are being seen due to Workmen's Compensation or an accident, please be sure to inform us of the details of your accident, as well as the name, address and claim number needed to bill for the visit. We will not get involved in a dispute for payment. If not paid in 60 days, it will become patient responsibility.
- Divorce decrees: This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The financial responsibility for minors rests with the accompanying adult.
- Minor patients: The adult accompanying a minor is responsible for payment at the time of treatment. Unaccompanied minors will be denied non-emergency treatment unless pre-authorized by a parent/guardian. Payment is still expected at the time of service.
- A dual visit is when the physician or midlevel provides wellness services and medical care or follow up on the same date. Insurance companies cover and encourage annual wellness visits. Your medical visit has typically been a separate visit where prescriptions are reviewed and refilled, the current status of chronic conditions are evaluated, and new conditions or concerns can be addressed. Most insurance companies also pay for dual visits: one appointment where the physician or midlevel provides wellness care and medical follow up. This is a great convenience to you, our patient. When you are here for your visit, your provider may ask you about a dual visit. It's up to you. You can choose whether to take care of both services at once, or to schedule back at a later date for a separate visit. The services for a dual visit will be billed out separately. For most patients, wellness will be paid at 100% and a co-pay or deductible will apply to the office visit.

We look forward to seeing you and please don't hesitate to call us if you have any problems or questions about the information or our office.

I have read, understand, and agree to the guidelines in this Financial Policy:

Signed and acknowledged: ____ **Date** ______________

Please print name of signature: ____

Pediatric Registration Form

Name (Last, First, Initial): ______________________________ Phone # ______________

Address: ______________________ City __________ State ________ ZIP__________

Birth date: ____________ Sex: ________ Social Security#: ______________________

Race: **(Please circle one)** American Indian Asian African American Native Hawaiian White Hispanic Other

(Please circle one) ***Doctor:*** Mansfield Maynard Language: **(Please circle one)** English Spanish Other ________

Medications: ____________________**Allergies to medications:** ____________________

Illness/Surgeries/Hospitalizations: ______________________________________

Mother's Name: ____________________ Mother's email: ______________________

Father's Name: ____________________ Father's Email: ______________________

Primary Responsible Party: ______________________________ Phone #: ____________

Address, City, State & ZIP: ______________________________ Birth Date: ____________

Sex: ______ Social Security#: __________________________ Cell Phone: ____________

Patient Relationship to responsible party: (0) Same (1) Spouse (2) Child (3) Other

Employer of Responsible Party (Address & Phone#): ______________________________

(1)-Employed full time (2)-Employed part time (3)-Retired (4)-Not employed (5)-Full time student (6)-Part time student

Nearest friend/relative not living at the same address: **(Name, Address, Phone# & Relationship)**:

____

Account Agreement (please read & sign this agreement.)

In signing below, I indicate that the information provided is correct to the best of my knowledge and regardless of insurance coverage I am responsible to Primary Care Specialists for payment of services rendered on this account. I also agree to be responsible for finance charges at the rate of 18% and for collection costs to include: a certified mail fee not to exceed $10 to notify you if this account is turned to collections; return check fees up to $20 per occurrence; plus reasonable court costs and attorney's fees should legal action be required to collect this account as agreed. Payment arrangements set up on automatic withdrawal will be given a 5-day grace period from the due date. After 5 days, if the current month's payment is still owing, the account will be charged a $5 late fee. I further understand that the account information, insurance coverage's, releases, covered patients and financial arrangements indicated are effective until such time as a new account form or notification is provided to the office staff. *I hereby give my consent for medical care provided by Primary Care Specialists.*

Signature of primary responsible party ______________________________ Date ________

Insurance information (Copy of Card Needed)

1) Primary Insurance: ____________________ Employer ______________________

Policyholder's Name: ______________________ Birthdate: ____________ Sex: ____

Policy Number: ______________________ Group #:______________________

2) Secondary Insurance: ____________________ Employer ______________________

Policyholder's Name: ______________________ Birthdate: ____________ Sex: ____

Policy Number: ______________________ Group #:______________________

Assignment of Benefits

I hereby instruct and direct my insurance company to pay by check made out and mailed to: Primary Care Specialists, 110 Vista Dr., Pocatello, Idaho 83201 for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I understand that I am financially responsible for any non-covered services. I also authorize Primary Care Specialists to release any information required to process claims.

______________________________ ____________

Signature of Policyholder (First Insurance) Date

______________________________ ____________

Signature of Policyholder (Second Insurance) Date

Registered by _______

Info Complete ______

Section IV: YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

A. You may request (in writing) a copy of the health information we maintain and utilize in making decisions about your care. (We have a right to deny your request in some very limited circumstances; you have a right to appeal a denial).

B. You have a right to request that we amend (or correct) information documented or created by us and maintained in your chart. We have a responsibility and a right to maintain our patient charts with information that is accurate and appropriate to support good medical treatment of our patients. Any decisions we make regarding your request for amendment of information will be based on careful consideration of these.

C. You have a right to an accounting of disclosures we have made (not including those involved in routine communication with other practitioners involved in your care or to emergency personnel in emergency situations).

D. You have a right to request restriction or limitation of the information we disclose about you for treatment, payment or health care operations. For example, you may ask that we not disclose or submit information to your insurance company about a particular treatment you received. (Such a request should be made in writing and be made prior to your receiving that treatment).

E. You have a right to request confidential communications regarding your health care. For example, you may ask that we only try to contact you at home and never at work.

F. You have a right to receive a paper copy of this notice. Further, we are willing to share with you any more information that you might request and that we have regarding patient privacy policies.

Section V: QUESTIONS OR COMPLAINTS

If you have any questions regarding this Notice or if you wish to receive additional information about our privacy practices, please contact a member of our clinic management staff at (208) 234-2300. If you believe your privacy rights have been violated in any way and want to discuss it with someone outside of the clinic, you may contact the Office of the Secretary of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____________________________________, acknowledge and agree that I have received a copy of Primary Care Specialists' Notice of Privacy Practices.

_____________________________ _____________________ _____________________
Patient Signature or Child's Name Date of Birth Date

_____________________________ _____________________
Patient Legal Representative (if applicable) Date

_____________________________ _____________________
Print Name of Legal Representative Relationship to patient

FOR CLINIC USE ONLY:

Primary Care Specialists made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

PATIENT NOTICE OF INFORMATION PRIVACY PRACTICES AT PRIMARY CARE SPECIALISTS

(Pursuant to the Health Insurance Portability Act, Public Law 104-191)

At Primary Care Specialists, we have always believed our patients are entitled to seek treatment in an environment where they are treated by a professional staff, with dignity, and where their privacy is respected and protected. We are responsible for maintaining such a clinic environment and have historically practiced stringent policies and procedures to ensure that we do so.

Effective in April, 2003, health care practitioners and facilities in the United States are required by regulations provided for in the Health Insurance Portability Act (HIPAA) to notify their patients of the policies and practices they will follow in the safeguarding of patients' private health information at it is used in treatment, obtaining payment (including the submission of insurance claims electronically), and other health care operations within the practitioner's facility.

The Office of the Secretary of Health and Human Services acknowledges in documents posted on its website in December of 2002 that "Health care providers have a strong tradition of safeguarding private health information." However, in today's world of increased computerization and electronic transmission of information, federal regulations have been developed to mandate standards for the protection of patients' private health information as it is used in internal health care facility operations and to govern its transmission or disclosure to entities outside of the practitioners' own facilities.

The following sections of this document describe Primary Care Specialists' practices for safeguarding your private health information. At the end of these sections, you will find an **Acknowledgement of Receipt of Notice of Privacy Practices**. Please sign this acknowledgement and return it to one of our staff members so that we can comply with the new federal regulation and demonstrate that we have notified our patients of our privacy practices and the patient's rights regarding access to his or her private health information.

Section I: ROUTINE USES AND DISCLOSURES OF HEALTH INFORMATION

Primary Care Specialists gathers documents and organizes information about you into records held in our patient charts and our patient accounting system solely for the purpose of providing you with appropriate medical treatment and service and to obtain payment for those services. Provision of treatment sometimes requires that we share information with other physicians (or their employees) who are involved in your treatment and with emergency personnel such as paramedics and hospital emergency room physicians and staff. For sports injuries, this may also include athletic trainers, physical therapists, and coaches.

Section II: OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

Other health care operations we conduct in which we may use or disclose your personal or health information include **patient appointment reminders or notifying you of clinical results and treatment plan instructions by phone.**

There may also be situations in which we are required to disclose information by federal or state law. However, in these situations we are careful to protect the confidential relationship that must exist between a health care practitioner and his or her patient. We will release only what is required by law and are diligent to be certain that we are, in fact, required to disclose information before we will do so.

Section III: USES AND DISCLOSURES PURSUANT TO WRITTEN AUTHORIZATION

Except for the purposes described above in Sections I and II, we will not use or disclose your health information for any other purposes unless we have your specific written authorization. You have the right to revoke that authorization at any time. For example: If you give your written permission to provide medical records related to an auto accident to an attorney, you would have the right to revoke that authorization so that no subsequent treatment records after that date would be given by us to the requesting attorney.