FAMILY HEALTH & WELLNESS
ROBIN WEST ARNP FNP BC

CREDIT CARD POLICY

I understand it is the policy of Family Health and Wellness to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with all the provisions of the U.S. law.

If, after a claim has been submitted to my insurance carrier:

- The claim is denied for any reason, or the insurance company fails to respond to the claim: or
- There is patient liability (i.e. Deductible, co-insurance, copay, et. Al)

The office will send a statement notifying me of the balance due. If this amount is not paid within 15 days from claim submission, then my credit or debit card will be charged the entirety of the balance owed for services previously rendered to me or my dependent.

I understand my insurance company will provide notification of these charges with an explanation of benefits, and it is my responsibility to review my explanation of benefits. The total amount may also include but is not limited to “No Show”/”Late”/”Cancellation”/Finance charges. In the event the amount exceeds $250.00, the office will provide a courtesy call to the phone number I provided on my patient demographics, leaving a message if I cannot be reached.

I understand that in the event my credit or debit card has been charged for medical treatment or services, and then my insurance carrier subsequently makes payment for those charges, the office will issue a credit to my credit or debit card.

Patient Name: _____

Type of Credit or Debit Card: ☐ Visa ☐ Mastercard ☐ Other

Name of Card Holder: _____

16 Digit Number on Card: _____

Expiration Date: _____ Security Code: _____ Billing Zip: _____

I understand I am financially responsible for the medical services provided to me and my dependents and if the account Is not paid in full within 30 days, it may be turned over to a collection agency or attorney for collection, and I will be responsible for all collection fees and or legal fees to the extent allowed by applicable law. I have read, understand and agree to the financial policy.

Signature of Patient and or Responsible Party: _____ Date: _____

FINANCIAL AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however, you are responsible for your copay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days of your date of service, you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired during my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

FEES: There will be a $35.00 fee plus handling for the following: Electronic copy of medical records to a patient or insurance company, all documents (FMLA, Jury letters, et al.) completed by HealthCare Provider. There will be a $50.00 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashier's check, money order, certified check or cash). If you need to cancel a scheduled appointment, please contact our office at least 24 business hours before your appointment time. Due to high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. A $50.00 fee will be assessed for all missed appointments not cancelled within at least 24 business hours advance notice. All product sales are final, products are non-refundable or exchangeable.

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon the patient's request.

Print Name: _____ Signature: _____ Date: _____

I authorized this facility to release information to (Please check all that apply):

- ☐ SPOUSE (name & phone number) _____
- ☐ CHILDREN (name & phone number) _____
- ☐ OTHER (name & phone number) _____
- ☐ No One

MESSAGES MAY BE LEFT AT THE FOLLOWING LOCATIONS (Check those that apply)

☐ Home ☐ Cell ☐ Work

FAMILY HEALTH & WELLNESS
ROBIN WEST ARNP FNP BC

HIPAA Release Form
Authorization to Release Protected Health Information

Mail or fax completed forms to:
Family Health and Wellness 1938 NW Copper Oaks Circle 1938 NW Copper Oaks Circle Blue Springs, Missouri 64015
Fax: (816) 988-8451

Primary Client Information

Last Name:	First Name:	MI:
Street Address:	City/State:	Zip:
DOB:	Phone:	Email Address:

HIPAA Release
My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearing house, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to _____

Fax Number _____ to disclose protected health information (as defined in HIPAA) to Family Health and Wellness (FHW): Robin West ARNP FNP BC for the purpose of authorization for Continuation of Health Services.

☐ Please provide all medical records, office notes, laboratory results, radiology reports for the last two (2) years

☐ Please provide recent hospital records, to include discharge summary, radiology, laboratory reports

☐ Please provide results diagnostic study of: _____

Authorization of HIPAA Release
I understand that I have the right to refuse to sign this form and that my refusal will not result in the healthcare provider conditioning the provision of declining healthcare services. I also understand that this release will allow the provider to share my medical information with insurance companies to facilitate healthcare services. I understand that I may revoke this authorization at any time by notifying FHW in writing.

Parent/Guardian Name:_____

Name: _____ Signature: _____ Date: _____

PRIVACY NOTICE
ROBIN WEST, LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

- As a condition of providing treatment to you, our office must obtain your consent to use and disclose protected health information about you to carry out treatment, payment and the health care operations.

- You may revoke this consent at any time by notifying our office in writing, except to the extent our office has acted action on your consent.

- Please refer to the “Privacy Notice” posted on our website or provided upon request for a full description of the uses and disclosures of your protected health information. You have the right to review the “Privacy Notice” prior to signing this consent.

- Our office has reserved the right to change its privacy practices describe in the “Privacy Notice”. You may request a current copy of the “Privacy Notice” in writing or in person.

- You have the right to request our office to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment or health care operations; however, our office is not required to agree to such restrictions.

I hereby consent to the use and disclosure of my protected health information by Robin West, LLC, it’s staff and its business associates for purposes of treatment, payment and health care options.

_____

Signature

_____

Signature of Personal Representative of Patient

_____

Description of Representative’s Authority to Act for the Patient

Date: _____