CHALLIE A. MINTON, MD PC / SURRY RURAL HEALTH CENTER

Financial Policy

The Financial Policy is to help us provide the most efficient and reasonable health care services to all patients. Therefore, it is necessary for us to have a Financial Policy stating our requirements for payment for services provided to patients. **Patients are responsible for the payment of all services provided.**

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at checkout.

Insurance Policy

If you are an insurance patient, it is our policy to file to your insurance as a courtesy to you. It is your responsibility to make sure we have accurate and complete insurance information so your claim can be filed in a timely manner.

- If we do not have the correct information, you will be the responsible party for the services. Payment for services will be collected at the time of your visit.
- If you pay for services at the time of your visit or are billed for services for your visit due to not providing accurate insurance information, we will not re-file a past claim. You will be responsible for filing the claim for reimbursement from the correct insurance company if you wish to do so.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- You will be the responsible party for deductibles, co-payments, coinsurance, and out-of-network costs.
- You will be the responsible party for out of network services.

Workers Compensation Policy

- If you are a worker’s compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If you are covered under worker's compensation, we will accept the payments from the worker's compensation carrier.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within thirty (30) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

24 Hour Cancelation & “No Show” Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Challie Minton MD PC reserves the right to charge a fee of $25.00 for all missed appointments (“no shows”) that are not canceled with a 24-hour notice. “No show” fees will be billed to the patient. This fee is not covered by your health insurance and must be paid prior to your next appointment. Multiple “no shows” in any 12-month period may result in termination from our practice.

Overdue and Credit Balances Policy

- Over-due balances are to be paid with the agreed amount before you may schedule appointments.
- Over-due patient balances will be sent to collections.

To help with these policies, we ask that you assist us by:

- Providing us with current and updated information on yourself, your insurance company, and understanding your insurance policy. Please familiarize yourself with your co-pay, deductible, and coinsurance amounts.
- Presenting an updated insurance card.
- Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a self-pay patient.
- To provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the providers or clinical staff. Please discuss any account information with the front office manager, front staff, or practice administrator.

By signing below, I am stating that I have received, read, and agree to the Financial Policy.

Signature:

Printed name:

Relationship to patient:

Patient Demographic Form

Demographics					
First Name		**Middle Initial**		**Last**	
Date of Birth	**Sex** ▢**Male** ▢**Female**		**Social Security #**		
Race	**Ethnicity**			**Preferred Language**	
Address					
City			**State**	**Zip**	
Home Phone			**Cell Phone**		
Primary number ▢Home ▢Cell	**Marital Status** ▢Single ▢Married ▢Separated ▢Divorced ▢Widowed				
Email					

Employer Information		
Employment status ▢Employed ▢Unemployed ▢Retired ▢Semi-retired ▢Student		
Employer	**Occupation**	
Employer Address		
City	**State**	**Zip**

Emergency Contact Information	
Name	
Relationship to patient	
Home phone	**Cell phone**

- I acknowledge that providing my phone number(s) gives Challie Minton, MD PC permission to call that number.
- I designate and authorize Medicare payments directly to Challie Minton, MD PC for any benefits payable for services rendered.
- I hereby authorize Challie Minton, MD PC to release any medical information to the insurance company(s) that I designate, and to the agents, to determine benefits or benefit related services. I authorize payment directly to Challie Minton, MD PC for any benefits payable for services rendered. I understand that regardless of whether any insurance is applicable, I am responsible for this account in full, including any copayments or deductibles due at the time of my visit.
- I acknowledge that I have received a copy of Challie Minton, MD PC Notice of Privacy Practices.
- I authorize Challie Minton, MD PC to treat me as a patient. I authorize such care, treatments, and/or diagnostic studies to be performed as are deemed necessary by my healthcare provider.

By signing below, I agree that I have read and understand the above statements.
Signature:
Printed name:
Relationship to patient:

HIPAA Compliance Patient Consent and Medical Information Release Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that: *Protected health information may be disclosed or used for treatment, payment, or healthcare operations. *The practice reserves the right to change the privacy policy as allowed by law. *The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. *The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. *The practice may condition receipt of treatment upon execution of this consent.

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

(List anyone below who you give our office permission to speak to on your behalf)

▢ Spouse____ Phone ___________________________

▢Child____ Phone ___________________________

▢Other____ Phone ___________________________

▢Other____ Phone ___________________________

▢ My information is not to be released to anyone.

This Release of Information will remain in effect unless terminated by myself in writing.

May we leave a voicemail on your phone?

▢ Yes, you may leave a detailed voicemail that may include medical information.

▢ Yes, but only leave a brief message asking for a return your call.

▢ You may NOT leave me a voicemail.

By signing below, I am stating that I have received, read, and agree to the HIPAA Policy.
Signature:
Printed name:
Relationship to patient:

Patient Medical History Form

Name____ Date of Birth___________________

Complete the form the best you can. If you need additional space for any section, please let a staff member know.	
Preferred pharmacy:	
List any of your current medications with dosages:	
List any known allergies you have:	
List any diseases that your family members have been diagnosed with: ***Example: Diabetes, High Blood Pressure, Cancer, Lung diseases, Strokes**	
Family Member	**Disease(s)**
List any surgeries you have undergone with dates:	
Do you smoke? ▢Yes ▢No **Are you a former smoker?** ▢Yes ▢No **If yes to either question: How long?** __________________ **How much per day?** ____________________	
Do you drink alcoholic beverages? ▢Yes ▢No **If yes, how often?** _____________________________	
FOR WOMEN: **Number of pregnancies:** ______ **Number of Miscarriages:** _______ **Last menstrual cycle:** _____________	

Check any of the following problems that apply to you		
▢**Headaches**	▢**Trouble with vision**	▢**Trouble with hearing**
▢**Allergies / hay fever / asthma**	▢**Thyroid issues**	▢**Diabetes**
▢**Skin problems**	▢**Anemia / abdominal bleeding**	▢**Heart problems**
▢**Circulation problems**	▢**High / low blood pressure**	▢**Chest pain**
▢**Lung problems**	▢**Coughing / wheezing**	▢**Liver disease / jaundice**
▢**Gallbladder issues**	▢**Stomach problems**	▢**Change in bowels**
▢**Abdominal pain**	▢**Kidney disease / stones**	▢**Urinary problems**
▢**Female / male issues**	▢**Joint paint / stiffness**	▢**Depression**
▢**Anxiety**	▢**Psychiatric issues**	▢**Fainting**
▢**Stroke**	▢**Weight loss / gain**	▢**Other**
If other, please specify:		