Family Health and Wellness Center

Patient Communication Authorization

Patient Name: ______________________ Date of Birth: ______________

I authorize Family Health and Wellness Center to contact me to provide updates, promotions, or other relevant content based on the below preferences:

- ☐ I consent to receive phone calls from Family Health and Wellness Center for appointment reminders, marketing messages, and general two-way communication.
- ☐ I consent to receive SMS text messages from Family Health and Wellness Center for appointment reminders, marketing messages, and general two-way communication. Message frequency varies. Message and data rates may apply.
  Reply HELP for support. Reply STOP to opt out of messages.
- ☐ We are not responsible for any charges, errors, or delays in SMS delivery caused by your carrier or third-party service providers. By opting in, you confirm you are the owner or authorized user of the phone number provided and that you are at least 18 years old.

Phone Number: __________________ Okay to leave written or voice messages? Y N

Send my portal invitation to email: _________________________

I authorize Family Health and Wellness Center to release information to

- ☐ Spouse; Name and Contact Information: ______________________________
- ☐ Children; Name and Contact Information: _____________________________
- ☐ Other; Name and Contact Information: ________________________________
- ☐ Do Not Speak to Family Members

Billing Communication:

- ☐ I agree to have my statement emailed or text to me
- ☐ I agree to communicate billing issues via email

Email Address: ____

This authorization can be revoked or modified by notifying us in writing at any time.

Patient Signature: _________________________ **Date:** _______________

Financial Policy

All insurance information must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.

The 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. 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 $50.00 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. A $50.00 fee will be assessed for all missed appointments and those 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:** ______________

Credit/Debit 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
- There is patient liability (ie. Deductible, Co-Insurance, Copay, et. al)

The office will send a statement notifying the patient 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 ENTIRE 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 No Show/Late Cancellation fees and 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/debit card has been charged for medical treatment/services, and then my insurance carrier subsequently makes payment for those charges, the office will issue a credit to my credit/debit card.

Patient Name: ___________________________________

Type of Cedit/Debit Card: Visa Mastercard Other

Name of Card Holder: ____

16 Digit Number on Card: ____

Expiration Date: __________________ **3 Digit 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 legal fees to the extent allowed by applicable law. I have read, understand, and agree to the financial policy.

Signature of Patient/Responsible Party: ______________________________ **Date:** _______________

HIPAA Release Form

Authorization to Release Protected Health Information

Mail or fax completed forms to:

Address: Family Health and Wellness Center 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 (HIPPA), I, the undersigned, grant permission to ____

Fax Number _______________________ to disclose protected health information (as defined in HIPPA) to Family Health and Wellness Center 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 FHWC in writing.

Date:	**Parent/Guardian Name:**	**Date Authorization Effective Until:**
Name (print):	**Signature:**	**Date:**