**PATIENT INFORMATON**

**Patient Name:**

*First Middle Initial Last*

Previous Name:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_

**Home #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_Cell #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_**

**Patient’s SS#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ **Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s state of birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race:** White (Non-Hispanic) \_\_\_ Hispanic \_\_\_ Black \_\_\_ Asian \_\_\_ American Indian \_\_\_ Pacific Islander \_\_\_ Other \_\_\_

**Marital Status:** Married / Single / Widowed / Divorced

**EMPLOYMENT STATUS:** Full / Part-time / Unemployed / Disabled / Retired

**If EMPLOYED:** Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT:** ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: **\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_** Relationship: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RESPONSIBLE PARTY/INSURANCE SUBSCRIBER:** (*If Minor /Responsible Party*)

**Responsible Party Name** (if different than patient): *First Middle Initial Last*

**Responsible Party Date of Birth:** \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ **SS#**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We reserve the right to charge a no-show fee of $100.00**

**(for a missed office visit or less than 24 hour notice)**

**$100 (for a missed Surgical/Procedure/Ultrasound visit) if you fail to notify our office of your cancellation within 48 hours of your appointment. Insurance will not cover this fee.**

Wyoming Medical Associates Financial Policy

We recognize the need for definite understanding between patients and physicians regarding financial arrangements for medical care. We have established the following financial policy in response to this need. It is our hope that you will understand that these payment collection practices are a necessary part of assuring the financial resources required to provide the best medical care possible to our patients and community. We bill all insurances as a courtesy to our patients. You, the patient or responsible party, should facilitate the payment process by providing our office with current insurance information including the correct insurance responsible for payment at the time service is rendered, billing address, phone numbers, member ID numbers, employer information, and effective dates for all insurances. ***Please bring your insurance cards with you to each visit, and remember to notify staff at time of check in to any changes to insurances.*** You should also cooperate fully with our office and/or your insurance company in providing additional information as needed for reimbursement. **Ultimately, the patient or responsible party is responsible for payment when insurances fail to pay clean claims, or when accurate insurance information was not provided at time of service.** We will allow a reasonable amount of time for claim processing by insurance; (**no longer than 90 days**), once this time has passed, payment will be expected from the patient.

**Copays:** Your copay is determined by your contract with your insurance company. This is a requirement of your insurance company, and is due at the time of services rendered.

**Deductibles & Allowed Amounts:** We will also collect any deductible or allowable amount the patient is determined to be responsible for according to their insurance contract at the time of services rendered. A summary of these charges will be given for each visit and/or service which should be kept by patient for their records. ***Payment plans may be arranged for deductible or allowed amounts, and will NOT be subject to interest charges. These payments may be made up to a maximum of 12 months.*** A contract must be signed for any payment plan arrangements, and a copy will be given to patient for their records.

**Self -Pay Patients:** We offer discounted fees on many services to our self-pay patients. Please inquire with staff regarding discounted rates. ***A down payment is required before all elective procedures. This down payment is to be 10% of the fee for the anticipated service, and may increase or decrease if the actual service performed is more or less extensive than anticipated. The remaining balance is to be paid in monthly installments as arranged by contract at time of service, and not to exceed 12 months. Evaluation and management, or office visit fees are due in full at the time of service.*** Cosmetic procedures are required to be paid in full at time of service.

**Unpaid Charges:** Additional charges determined to be owed after filing claims with a patient’s insurance company will be billed in a statement sent to patient. Once our efforts to collect unpaid balances are exhausted, we will refer these accounts to the collection agency of our choice for collection of payment and reporting to credit agencies. ***A collections preparation and submission fee of $200 will be added to the patient balance at the time the account is turned over to the collection agency. In addition, an interest charge of 6% per year from the time of service will be added to the total balance to be collected by the collection agency.*** From this point, unpaid accounts will be referred to court mediation.

**Miscellaneous Fees:**

### Returned Checks: $35

**Medical Records:** $25 for electronic transfer or $1.00 per page if printed

### Family Medical Leave Act or Disability Paperwork: $25

**Missed Office Visit Appointments** (when office is not notified 24 hours beforehand): $100

**Missed Surgical/Procedure/Ultrasound Appointments** (when office is not notified 48 hours beforehand): $100

**Workman’s Compensation:** We will provide treatment for work related injuries using Workman’s Compensation ***for emergency situations only.*** We do require all appropriate paperwork and authorizations needed to process these claims. Without required information and authorizations, the patient will be treated as a self-pay patient.

**Referrals and Prior-Authorizations:** If your insurance requires referral from a primary care physician (PCP), you are required to have prior authorization from your PCP and insurance company prior to your visit. If this authorization is not provided, you will be asked to reschedule your appointment or otherwise be responsible for exam fee payment. We will be happy to assist you in obtaining this

authorization if we are notified prior to exam and make an effort to determine if your insurance requires referral prior to your exam. If your insurance requires prior authorization for any upcoming procedures, we will follow all prior authorization protocols with your insurance company to obtain the authorization, along with providing them with the required information. If your insurance company denies the request, it is ultimately your responsibility for payment.

\*\*We reserve the right to refuse treatment to any person who does not adhere to our financial policy\*\*

I have read and understand Wyoming Medical Associates. I agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient Name:

Patient Signature:\_

Date:

Responsible Party Member’s Name Relationship to patient

Responsible Party Member’s Signature