ORMOND FAMILY MEDICAL CENTER, PLLC

Patient Name: _____ **DOB**:_____

SS#:_____ Insured Party:_____ Date: _____

Address:_____ City:_____

State: _____ Zip Code: _____ Phone: _____ Cell: _____

Email:_____ Ethnicity: _____ Preferred Language: _____

Marital Status:_____ Spouse: _____

Employer: _____ Employer Phone: _____

Emergency Contact: _____ Relationship: _____ ContPhone: _____

☐ I consent to receive SMS text messages from Ormond Family Medical Center. This is used for appointment reminders, announcements, and general two-way communication. Msg frequency varies. Msg&data rates may apply. Reply STOP to opt out, HELP for support. Review our Privacy Policy/Terms and Conditions at https://ormondfamilymedicalcenter.com/privacy-policy-%2F-t%26c Initial ____

Financial Policies and Procedures

Thank you for choosing us as your primary care office. The goal of the healthcare providers and staff of Ormond Family Medical Center is to provide the best possible medical care for you and to develop and maintain a relationship with you that will grow and strengthen through the years ahead. Along with our medical relationship, we will be establishing a financial relationship. In order to successfully maintain this relationship, we want you to have a clear understanding of our financial policy. We ask that you read, understand and sign this policy statement **prior to any treatment.**

Insurance Verification

It is your responsibility to verify with your insurance carrier that our providers and/or office (Ormond Family Medical Center) are listed as participating providers with your specific plan **prior to your appointment**. As a patient, you are responsible for **thoroughly understanding** your insurance benefits. This includes what items your insurance will or will not cover and **any special facilities that need to be utilized for labs and x-ray services** that the provider might order for you. This is important as **Ormond Family Medical Center cannot be responsible for services provided at non-contracted facilities.** As a courtesy to our insurance patients, we will bill both primary and secondary medical insurance. However, in order for us to bill for an appointment, you must submit **proof of current insurance coverage** at the time of the visit. **Without current proof of coverage, payment for the services will be required at the time the service is rendered.** If insurance information is submitted after the date of service, we will be glad to bill your insurance and refund your payment. Additionally, Please note that there are 2 practices here at 545 W. Granada Blvd., Ormond Beach. Ormond Medical Center (chiropractor) and us, Ormond Family Medical Center (Medical). These are 2 separate business with 2 different identification numbers when it comes to insurance participation. These 2 practices have different staff, different policy and procedures , so be sure that when you do insurance verification, you are searching for participation with Ormond **FAMILY** medical Center (tax ID starts with 89) and not Ormond Medical Center.

Cancellation Policy

A specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, **please give us at least 24 hours notice** so that we may reschedule your appointment and offer the reserved time to another patient. It is our policy to charge for appointments that have been scheduled in advance and are cancelled with less than 24 hours' notice. **A no show fee will be applied to appointments that are not cancelled 24 hours prior. $45 for regular office visits, $75 for CPE (Complete Medical Exam), Annual wellness visits, and hospital follow ups.** Initial _____

Payments and Self Pay

All Co-Payments and deductible must be paid at time of service. If you are not insured by a participating insurance plan or do not have an updated insurance card, you will be required to pay for services in full. **For Self-Pay, an Office Visit is $155, Hospital Follow Up is $250, and CPE/New Patient is $200. All payments are due the day of service. Please note any labs or procedures in office may incur an additional charge.** We do have payment plan options. Please inquire with the office manager to see what can be offered to you for this option. Initial _____

I have read and understand the financial policies of Ormond Family Medical Center.

_____ _____

Patient Signature Date

Patient Name: _____ DOB:_____

Maintaining a Respectful Environment

The providers and staff strive to treat our patients with courtesy and respect. It is also important that we insure that our staff is also treated with respect from our patients. We feel very strongly that our staff should be able to work in an environment free from verbal and physical abuse. **Angry outbursts against our staff will not be tolerated and may result in your discharge from the practice.**

Referrals and Authorizations

We are required to follows the guidelines of your managed care plan which mandates that you must be seen in office for a referral to a specialist and we must refer to the providers on your plan. Please understand that some of these referrals take a bit of time and we will contact you as soon as we have all the necessary authorizations required.

Claim Submission

We will submit your claims and assist you any way we reasonably can to help get your claims paid. If we participate with your insurance we will file with them. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

Patient Billing

You will be sent notices of your financial responsibility of any money due after payment and/or explanation of benefits is received from your insurance company. After the third and final notice, your account may be forwarded to collections. Please let us know if you have any difficulties resolving your bill. In the event the insurance company should happen to send the payment to you, the patient, we expect that your would forward it to our office to be applied to your balance. Please be advised some services your receive may not be covered by your insurance plan, Therefore you will be responsible for the payment for these services.

I have read the above policy regarding my financial responsibility to Ormond Family Medical Center, PLLC for medical services provided. I agree to pay Ormond Family Medical Center, PLLC any balance unpaid by my insurance carrier for myself or the person named above. Initial _____

Assignment of Benefits

I, the undersigned, certify that I (or my dependents) have coverage with my insurance as presented and assign directly to Ormond Family Medical Center, PLLC all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the provider to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions.

_____ _____

Patient Signature Date

ORMOND FAMILY MEDICAL CENTER, PLLC.
545 West Granada Blvd.
Ormond Beach, FL 32174
(386) 672-6243 – FAX (386) 677-7463

HIPAA CONSENT FORM

Patient Name _____ DOB_____ Phone_____

HIPAA Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of Privacy Practice Notice is to explain how Ormond Family Medical Center, PLLC may use disclosure of your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Ormond Family Medical Center PLLC has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received such Notice of Privacy Practice.

I hereby acknowledge that I have received a copy of Ormond Family Medical Center, PLLC's Notice of Privacy Practice. Patient Initials or Guardian Initials: _____

Permission to Share Medical information

My medical information may be obtained and exchanged verbally to: _____

Relationship: _____ Phone:_____ Patient/Guardian Initials:_____

Signature of Patient/Guardian: _____ Date: _____

THIS IS A CONDENSED VERSION OF OUR SUMMARY OF NOTICES OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please read it carefully**.
We understand that your medical information is personal to you and we are committed to protecting the information about you. As our patient, we create medical records about your heath, our care for you and the services and/or items we give to you as our patient. By law, we are required to make sure that your protected health is kept private.

How will we use or disclose your information? Here are a few examples:

For medical treatment
To obtain payment for our services
In emergency situations
For Appointment and recall reminders
To run our practice more efficiently and ensure our patients receive quality care
For Research
To avert a serious threat to health and safety
For organ and tissue donation
For workers compensation programs
In response to certain requests arising out of lawsuits and other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complain with the Practice, contact our Office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

How will we use or disclose your information? Here are a few examples:

- The right to inspect and copy
- The right to request restrictions
- The right to amend
- The right to accounting of disclosures
- The right to paper copy of this notice
- The right to request confidential communications

Signature Patient/Guardian: _____ Date:_____