Franklin Clinic

Demographics

Last Name: _____ First Name: _____Middle: _____

DOB: _____ Driver's License # _____ Social Security # _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone # Home: _____Cell: _____Work: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Email: _____ Ethnicity/Race: _____

Your email will allow you to receive appointment/medical reminders and your medical records via patient portal.

Occupation: _____ Employer Name: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Pharmacy

Preferred Pharmacy: _____ Address: _____

Mail Order Pharmacy: _____ Phone: _____

Are you self-pay? YES NO

Primary Insurance

Insurance company: _____

Address: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship to Patient: _____

Secondary Insurance

Insurance company: _____

Address: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship to Patient: _____

Franklin Clinic

Insurance: _____ **Today's Date:** _____

Name: _____ **Date of Birth:** _____

List all Medications you take including supplements	Dosage or strength	How often do you take this?	What is this prescribed for?

**************If you need more space please use back of form**************

Medication Allergies?		
Do you use tobacco products?		**Do you consume alcohol regularly?**
Circle or list any condition you have been diagnosed with:	☐ Chronic Pain	☐ Thyroid Disorder
	☐ Gastrointestinal Disease	☐ COPD/Lung Disease
☐ Diabetes	☐ Heart Disease	☐ Vascular Disease
☐ Autoimmune Disease	☐ Skin Disease	☐ Hypertension
☐ Depression	☐ Anxiety / PTSD	☐ Seizures/Neurological Disease
Cancer:	Other:	Other:
Other Mental Health Condition:		
List all surgeries you have had:		
Have you been hospitalized in the last 12 months?		
*If yes, where & what for?		
Most recent primary care provider?		
Reason for change?		
List any other doctors you are seeing and why:		

**************If you need more space please use back of form**************

How did you hear about us? _____

Franklin Clinic Policies

We would like to thank you for choosing Franklin Clinic as your healthcare provider. We are committed to providing you with the best possible medical care. Understand that payment for your care is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many insurance companies and government agencies including Medicare. Our billing office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance requires a referral it is your responsibility to get with your PCP to obtain a referral. Please bring your insurance card(s) with you at the time of your appointment.

If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each service is required until we can verify your coverage.

Co-Payments and Deductible:

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. If you are unable to pay your co-payment your appointment will be rescheduled.

Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. These amounts are due at the time of service. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you.

Coverage Changes:

If your insurance changes, please notify us at least 48 hours before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Any charges incurred by you because of failure to provide any necessary information with be your responsibility.

For our Patients with No Medical Insurance:

If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit.

Late Arrivals:

A patient who arrives more than 15 minutes after his/her check in time is considered a late arrival. A late arrival may be seen under Urgent Care and is subjected to the Urgent Care Fees or rescheduled for a later time.

Appointment Rescheduling and No-Shows:

Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". A no-show patient may be charged $50.00, as set by the practice. A patient who fails to present three times for scheduled appointments is considered a chronic no-show and may be dismissed from the practice. Any annual wellness appointment rescheduled less than one week in advance will be charged a $25 rescheduling fee. Any patient who fails to show for their annual wellness appointment will be charged a no-show fee of $50.

Delinquent Balance Appointment:

Patients with a delinquent balance are required to make payment in full at time of service. A delinquent account is defined as a patient balance in excess of 90 days where the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused. I agree to pay any costs incurred by Franklin Clinic in collecting any amount due including, without limitations collection agency fees and attorney's fees.

Patient Communication System:

Patients are enrolled in our communication system for appointment/medication reminders and health records access. These reminders are sent via phone call, text message and email/patient portal. If you choose to opt out of one of these please notify the office promptly.

By signing below, I acknowledge and agree to the terms and responsibilities laid out in this document.

Patient Signature_____ Date: _____

Guarantor Signature_____Date: _____

Annual Wellness Visit

In order to provide the best patient care that you deserve, the Franklin Clinic has adopted the guidelines for the Annual Wellness Visit (AWV), a standard that has been extensively researched and approved by the Center for Medicare Services (CMS). Most insurance plans have assumed this standard as it ensures patients have the most current medical care and clinicians have the information they need to partner with their patients. We ask that all patients schedule their Annual Wellness Visit with follow up visit. You may have co-payment, coinsurance and/or deductible amounts required by your insurance carrier. A rescheduling fee of $25 will be assessed for any appointment rescheduled less than one week in advance. A no-show fee of $50 will be assessed for any appointment not kept.
By signing Below, I acknowledge and agree…

Patient Signature_____ Date: _____

Accountable Care Organization and Blue Button

Your doctor or primary care provider is participating in Alliance ACO, our Medicare Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and health care providers working together with Medicare and other insurance providers to give you high quality care, if you are Medicare beneficiary, we need your permission to access the Medicare Blue Button which is your health and claims data information on MYMEDICARE.GOV.

Patient Signature_____ Date: _____

Authorization and Agreement for Treatment
HIPAA Acknowledgement and Consent:

Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my health information for its treatment, payment, healthcare operations, and other de-scribed and permitted uses and disclosures, I understand that I may contact the Privacy Officer on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and discloser of my information for the purposes described in the practice's Notice of Privacy Practices.

Release of information. I hereby permit the practice and the physicians or other health professionals involved in the inpatient or out-patient care to release healthcare information for the purpose of treatment, payment, and healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or other purpose related to benefit payment. Healthcare information may also be released to my employer's designed when services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid claim, I authorize the release of healthcare information to the Social Security Administration or this intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psycho-logical and /or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and State laws may permit this facility to participate in organizations with other healthcare providers, insures and / or health care industry participants and their subcon-tractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposed; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic in-formation, chemical dependency conditions and/ or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Patient Signature_____ Date: _____

Guarantor Signature_____Date: _____

I _____, give permission for my protected health information to be disclosed for purpose of communicating results, findings and care decisions to the family members and others listed below:

Name _____Relationship _____ Contact Number _____

Name _____Relationship _____ Contact Number _____