MICHELLE COOPER NP, LLC

Certified Registered Nurse Practitioner
176 Thomas Johnson Dr. Ste103
Frederick, MD 21702
P: (301) 644-3305 F: (301) 644-3308
Website: www.adultprimarycareservices.com

2019 Patient Information Update Form

NAME(LAST, FIRST, MI):_____DATE OF BIRTH:_____

HOME PHONE:_____ CELL PHONE:_____

EMAIL ADDRESS:_____ (for portal communication)

HOME ADDRESS:_____

_____

EMERGENCY CONTACT:_____ PHONE:_____

RELATONSHIP TO PATIENT:_____

INSURANCE INFORMATION:

PATIENTS MUST HAVE INSURANCE CARD(S) AND PHOTO ID PRESENT AT EACH VISIT.
COPAYS AND PAYMENT TOWARDS BALANCE ARE DUE AT TIME OF VISIT.

PRIMARY INSURANCE:_____POLICY HOLDER/SUBCRIBER:_____

ID NUMBER:_____GROUP NUMBER:_____

SUBCRIBER DATE OF BIRTH:_____ SUBSCRIBER RELATION TO PATIENT:_____

SECONDARY INSURANCE:_____POLICY HOLDER/SUBCRIBER:_____

ID NUMBER:_____GROUP NUMBER:_____

SUBCRIBER DATE OF BIRTH:_____ SUBSCRIBER RELATION TO PATIENT:_____

CANCELLATION/NO SHOW OF APPOINTMENTS AND LATE ARRIVALS:

We reserve the right to charge a $35 cancellation fee for visits that cancelled less than 24 hours and NO SHOW. We will also discharge any patient with 3 or more NO SHOW or repeated cancellations.

Patients arriving more than 10 minutes late will be rescheduled.

_____ _____

PRINT PATIENT NAME PATIENT SIGNATURE

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HIPAA RELEASE:

Patient Name:_____ Date of Birth:_____

I do _____ I do not _____ want a copy of HIPAA form.

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

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

Name:_____ Relationship:_____Phone:_____

_____ I DO NOT want any information released to anyone. (I do understand that I will have to give a verbal/written permission for release of information to outside providers)

I understand that I may change my HIPAA release information at any time – in writing or in person.

The office is to contact me at _____ with all messages.

_____ The office can leave a detailed message.

_____ The office is to leave a message to contact the office ONLY.

FORM COMPLETION:

Our office requires a visit for the completion of all forms (MVA, disability, durable medical supplies, etc). This will insure all information is current and records are updated. Turn around for form completion is 72 hours.

REFERRALS:

It is the responsibility of the patient to request a referral no less than 72 hours before an appointment with a specialist.

Patient Initials:_____

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Financial Disclosure Policy:

The following are the financial police for Adult Primary Care Services. If you have any questions, please contact our office for further assistance. We are committed to provide the best care to you and your understanding of the following protocols is essential to that goal.

- Patients are to have a photo id and insurance card with them at each visit – this will help to assure proper billing and thus payment from your insurance company(ies).
- An insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand your policy. You need to be aware of co-pays, co-insurance, and deductibles. You will be responsible for any balance after insurance payment or denials.
- It is your responsibility to update the office with any changes to your insurance. Failure to do so may result in patient payment in full for services.
- Benefits are verified before each visit – per insurance companies "this is not a guarantee of payment or coverage".
- Balances are due within 30 days of statement date. We do except payments for balances. Accounts not paid upon are subject to collections and will be subject to fees and interest charges. (Our office is currently using an outside billing service.)
- Outside laboratory and imaging is billed through the provider of the service. (example: FMH or CRA)
- Medical Records: $20 fee for your records to be given to you, attorney, or other agency. We will gladly transfer records to other providers at no charge. All record transfers require a completed request form – from our office or the transferring entity.

_____	_____	_____
Patient Name PRINTED	Patient SIGNATURE	DATE