CHALLIE A. MINTON, MD PC / SURRY RURAL HEALTH CENTER

Financial Policy

The Financial Policy is to help us provide the most efficient and reasonable health care services to all patients.

Therefore, it is necessary for us to have a Financial Policy stating our requirements for payment for services provided to patients. Patients are responsible for the payment of all services provided.

Self-Pay Policy

- If you are a self-pay patient, you will be required to pay for the office visit before services are rendered.
- In addition, any remaining balance on your account will be collected at checkout.

Insurance Policy

- If you are an insurance patient, it is our policy to file to your insurance as a courtesy to you. It is your responsibility to make sure we have the accurate and complete insurance information so your claim can be filed in a timely manner. If we do not have the correct information, you will be the responsible party for the services.
- If a service is provided that is not covered by your insurance company, you will be the responsible party at the time of service.
- You will be the responsible party for deductibles, co-payments, coinsurance, and out of network cost.
- You will be the responsible party for out of network services.

Explanation of Deductible, Co-Payment, Coinsurance, and Out of Network

What is a deductible?

A Deductible is the dollar amount you must pay for covered services in a benefit period before benefits are payable under a health plan. The deductible does not include coinsurance, charges over the allowed amount, amounts exceeding any maximum or expenses for non-covered services.

In other words:

A Deductible is the set dollar amount you pay toward covered medical services each benefit period (typically one year) before your health insurance starts paying toward those services. For example, if you have a $2,500 yearly deductible, you'll need to pay the first $2,500 of your total eligible medical costs before your plan helps to pay.

What is a co-pay?

A co-pay (or copayment) is a flat fee that you pay on the spot each time you go to your doctor when you check in.

Your co-pay does not go toward your deductible amount.

What is coinsurance?

Coinsurance is a percentage of a medical charge that you pay, with the rest paid by your health insurance plan, that typically applies after your deductible has been met. For example, if you have a 20% coinsurance, you pay 20% of each medical bill, and your health insurance will cover 80%.

What does Out-of-network mean?

A provider your insurance plan has not negotiated a discounted rate with. If you get care from an out-of-network provider, you may have to pay the entire bill yourself, or just a portion, as indicated in your insurance policy summary.

Continue on back.

Workers Compensation Policy

- If you are a workers compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If you are covered under worker's compensation, we will accept the payments from the worker's compensation carrier.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within thirty (30) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

24 Hour Cancelation & "No Show" Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Challie Minton MD PC reserves the right to charge a fee of $40.00 for all missed appointments ("no shows") that are not canceled with a 24-hour notice. "No show" fees will be billed to the patient. This fee is not covered by your health insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12-month period may result in termination from our practice.

Overdue and Credit Balances Policy

- Over-due balances are to be paid on with agreed amount before you may schedule appointments.
- Over-due patient balances will be sent to collections.

To help in this policy, we ask that you assist us by:

- Providing us with current and updated information on yourself, your insurance company, and understanding your insurance policy. Please familiarize yourself with your co-pay, deductible, and coinsurance amounts.
- Presenting an updated insurance card.
- Making the appropriate payment at the time of service, whether it is a deductible, copay, coinsurance, or for the full amount if you are a self-pay patient.
- To provide the best medical care. We ask that you do not discuss your account balance or financial aspects with the providers or clinical staff. Please discuss any account information with the front office manager, front staff, or practice administrator.

I have received, read, and agree to the Financial Policy.

Patient Information

_____ _____ _____ _____

Patient's First name **MI** **Patient's Last Name** **Date of Birth**

Responsible Party

_____ _____ _____

First name **MI** **Last Name**

_____ _____

Patient / Responsible Party Signature **Date**

New Patient Form

Demographics

Full Name (first, middle, last)_____
Date of Birth_____ Gender ☐Male ☐Female
Social Security #_____ Preferred Language_____
Race(optional)_____ Ethnicity(optional) _____
Address_____
City_____ State_____ Zip_____
Home #_____ Cell#_____
Which phone number is your primary? ☐Home ☐Cell
Email_____
Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Employer Information

Employment status ☐Employed ☐Unemployed ☐Retired ☐Semi-retired ☐Student
Employer_____
Occupation_____
Employer Address_____
City_____ State_____ Zip_____

Emergency Contact Information

Full Name_____
Relationship to patient_____
Home #_____ Cell #_____

I acknowledge that providing my phone number(s) gives Challie Minton, MD PC permission to call that number.
I designate and authorize Medicare payments directly to Challie Minton, MD PC for any benefits payable for services rendered.
I hereby authorize Challie Minton, MD PC to release any medical information to the insurance company(s) that I designate, and to the agents, to determine benefits or benefit related services. I authorize payment directly to Challie Minton, MD PC for any benefits payable for services rendered. I understand that regardless of whether any insurance is applicable, I am responsible for this account in full, including any copayments or deductibles due at the time of my visit.
I acknowledge that I have received a copy of Challie Minton, MD PC Notice of Privacy Practices.
I authorize Challie Minton, MD PC to treat me as a patient. I authorize such care, treatments, and/or diagnostic studies to be performed as are deemed necessary by my healthcare provider.

By signing below, I am agreeing that I have read and understand the above statements.

Signature _____ Date_____

If signed by a representative, state relationship to patient._____

Continue on back.

HIPAA Compliance Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If the terms change, you will be notified at your next visit to update your signature.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that my protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we call, email, or send text to you to confirm appointments? ☐yes ☐no
May we leave a message on your answering machine or voicemail? ☐yes ☐no
May we discuss your medical condition with anyone other than yourself? ☐yes ☐no
If yes, please list the people we are given permission to talk to.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Print name_____

Signature_____ Date_____

Witness_____ Date_____

Patient Medical History Form

Name_____ Date of Birth_____

Preferred Pharmacy_____

Complete the form the best you can. If you need additional space for any section, please let a staff member know.

Current Medications

Name	Dosage	How Often

Please list any allergies below ▢ No known Allergies

Allergy to	Reaction

Family History- indicate any diseases that your family members have been diagnosed with
*Example: Diabetes, High Blood Pressure, Cancer, Lung diseases, Strokes

Family Member	Disease(s) or Problem(s)

Continue on back.

Menstrual History (if applicable)

Number of Pregnancies _____ Number of Miscarriages_____ Last Menstrual Cycle_____

Social History

Do you smoke? ☐yes ☐no If no, are you a former smoker? ☐yes ☐no

If yes to either question, how long?_____ How much per day?_____

Do you drink alcoholic beverages? ☐yes ☐no If yes, how often?_____

Surgical History

Type of Surgery	Name of facility	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Specific Problems

Headaches	☐Yes	☐No	Approximate Date_____
Trouble with vision	☐Yes	☐No	Approximate Date_____
Trouble with hearing	☐Yes	☐No	Approximate Date_____
Allergies: Hay fever? Asthma?	☐Yes	☐No	Approximate Date_____
Thyroid	☐Yes	☐No	Approximate Date_____
Diabetes	☐Yes	☐No	Approximate Date_____
Skin problems	☐Yes	☐No	Approximate Date_____
Anemia/ abnormal bleeding	☐Yes	☐No	Approximate Date_____
Heart problems	☐Yes	☐No	Approximate Date_____
Circulation problems	☐Yes	☐No	Approximate Date_____
High/low blood pressure	☐Yes	☐No	Approximate Date_____
Chest pain	☐Yes	☐No	Approximate Date_____
Lung problems	☐Yes	☐No	Approximate Date_____
Shortness of breath or coughing	☐Yes	☐No	Approximate Date_____
Wheezing	☐Yes	☐No	Approximate Date_____
Liver Disease or Jaundice	☐Yes	☐No	Approximate Date_____
Gallbladder disease	☐Yes	☐No	Approximate Date_____
Stomach problems	☐Yes	☐No	Approximate Date_____
Change in Bowels	☐Yes	☐No	Approximate Date_____
Abdominal pain	☐Yes	☐No	Approximate Date_____
Kidney disease or stones	☐Yes	☐No	Approximate Date_____
Urinary problems	☐Yes	☐No	Approximate Date_____
Female/male issues	☐Yes	☐No	Approximate Date_____
Joint pain or stiffness	☐Yes	☐No	Approximate Date_____
Depression	☐Yes	☐No	Approximate Date_____
Anxiety/nerves or trouble sleeping	☐Yes	☐No	Approximate Date_____
Psychiatric	☐Yes	☐No	Approximate Date_____
Fainting spells	☐Yes	☐No	Approximate Date_____
Stroke	☐Yes	☐No	Approximate Date_____
Weight loss/gain	☐Yes	☐No	Approximate Date_____

Other_____

Patient Preventative Questionnaire

Name_____ Date of Birth _____

Please fill in this information below as accurately as you can. If you know you have had the test and you do not know the exact date, put an approximate month and year. If it does not apply to you, check N/A.

Test	yes	no	n/a	Date
Colonoscopy	☐	☐	☐	_____
Bone Density	☐	☐	☐	_____
Dilated Eye Exam	☐	☐	☐	_____
Mammogram	☐	☐	☐	_____
Pap Smear	☐	☐	☐	_____
Tetanus Vaccine	☐	☐	☐	_____
Flu Vaccine	☐	☐	☐	_____
Pneumonia Vaccine	☐	☐	☐	_____
Shingles Vaccines	☐	☐	☐	_____
PSA (for men)				

Drug Abuse Screening Test (DAST-10)

The following questions concern information about your possible involvement with drugs (not including alcoholic beverages) during the past 12 months. “Drug abuse refers to the use of prescribed or over-the-counter drugs in excess of the directions and any nonmedical use of drugs. The various classes may include cannabis, marijuana, hashish, solvents (ex, paint thinner), tranquilizers (ex. valium), barbiturates, cocaine, stimulants (ex. speed), hallucinogens (ex. LSD) or narcotics (ex. heroin).

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly correct or if you feel it does not apply to you, write N/A beside the question.

In the past 12 months…	yes	no
Have you used drugs other than those required for medical reasons?	☐	☐
Do you abuse more than one drug at a time?	☐	☐
Is it difficult to stop using drugs when you want to?	☐	☐
Have you ever had blackouts or flashbacks as a result of drug use?	☐	☐
Do you ever feel bad or guilty about your drug use?	☐	☐
Does your spouse (or parents) ever complain about your involvement with drugs?	☐	☐
Have you neglected your family because of your drug use?	☐	☐
Have you engaged in illegal activities in order to obtain drugs?	☐	☐
Have you ever experienced withdrawal symptoms when you stopped taking drugs?	☐	☐
Have you had medical problems as a result of drug use (ex. memory loss, hepatitis)?	☐	☐

Scoring: scoring 1 point for each question answered “yes”. **Score:**

Interpretation of score

Score	Degree of problems related to drug abuse	Suggested action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess later
3-5	Moderate Level	Further investigation
6-8	Substantial Level	Intensive Assessment
9-10	Severe Level	Intensive Assessment