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 Child Demographic Form

Child's Full Name____ Date of Birth_____________
Social Security # (optional)______________________________ Gender ◯Male ◯Female
Race(optional)_____________________ Email____
Child's Physical Address____
State________ City____ Zip Code________________
Does the child live with one or more parent(s)? ◯ Yes ◯ No
If not, who is the legal guardian? ____

Mother's Information

Name____ Date of Birth__________________
Phone #________________________________ Social Security #__________________________
Address____ State____ Zip Code_____________

Father's Information

Name ____Date of Birth__________________
Phone#________________________________ Social Security # __________________________
Address ____ State____ Zip Code____________

Legal Guardian Information (If Not Mother or Father)

Name ____ Date of Birth__________________
Phone #______________________________ Social Security #____________________________
Address ____ State____ Zip Code_____________

Person Responsible for child's account (No Absent Parent Billing)

Please note Just because a parent carries the child under their insurance plan, does not mean they are responsible for the balance due after insurance is processed.

Please indicate who will be responsible for the account. ▢Mother ▢Father ▢Guardian

Authorization to allow others to bring my child for treatment (optional)

I give permission to the following people to be allowed to bring my child to his/her appointments and sign documents or consent forms on my behalf.

Name____Relationship_______________________
Name____Relationship_______________________
Name____Relationship_______________________
Name____Relationship_______________________

Authorization to Release Information and Benefits: I hereby authorize Challie Minton M.D. to release any medical information to the insurance company(s) that I designate and to the agents to determine benefits of benefit related services rendered.
Acknowledgement of Notice of Privacy Practices: I acknowledge that I have received a copy of Challie Minton M.D. Notice of Privacy Practices.
Consent to treatment: I authorize Challie Minton M.D. to treat my child as a patient. I authorize Challie Minton M.D. to send forms, shot records or discuss general medical information with my child's school, daycare, or headstart.

By signing below, you acknowledge that you have read this notice and understand this policy

Legal Guardian Signature_____________________________________Date___________________
Witness____Date______________________

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 guardian name____

Guardian Signature____ Date___________

Relationship to Patient ____

Witness____ Date___________

Patient Medical History

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

Name______________________________________ Date of Birth____________________

Preferred Pharmacy____

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)

Surgical History

Type of Surgery	Name of facility	Date

Other medical conditions the provider should know about

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