CLINE FAMILY MEDICINE

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell: _____

Marital Status: S M D W Social Security#: _____

Race: (circle one) American Indian, Alaskan Native, Asian, African American, Native Hawaiian or other Pacific Island, White, Other

Ethnic Group: (circle one) Hispanic or Latino, Not Hispanic or Latino

Spouse Name:_____Cell#_____

PATIENT PORTAL ACCOUNT

A portal account will be created for you at your first visit. This is the primary method of communication with the office staff regarding lab results, prescription refill requests, and basic questions regarding your health. **YOUR STATEMENTS/BALANCES OWED WILL SHOW UP ON YOUR PORTAL!** You may also request prescription refills and review your medical record. You may also download the HEALOW app for your Android or I-phone.

EMAIL ADDRESS:_____

CURRENT INSURANCE INFORMATION

INSURANCE POLICY HOLDER

Name: _____ Sex: M/F Date of Birth: _____

Relationship to Patient: _____

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

I hereby authorize the insurance carrier listed above to make payments directly to Mark Cline, M.D. and understand that I am financially responsible for all charges incurred that are not covered by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify Mark Cline, M.D. otherwise I will be responsible for payment for services rendered.

Signature: _____ Printed Name: _____ Date: _____

EMERGENCY CONTACTS: (MUST LIST 2 CONTACTS)

Name:_____Relationship:_____

Home#_____Work#_____Cell#_____

Name:_____Relationship:_____

Home#_____Work#_____Cell#_____

FINANCIAL POLICY

This is an agreement between Cline Family Medicine and the Patient/Debtor named on these forms.

I, voluntarily consent to receive medical and healthcare services provided by Cline Family Medicine that they deem necessary in my diagnosis and treatment. I understand that such services may include diagnostic procedures, examinations, and treatment. The services will be provided by Dr. Cline, or a supervised licensed board certified clinician employed with Cline Family Medicine.
Initial:_____Date:_____

In this agreement the words "you", "your", and "yours" mean the patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words, "we", "us", and "our" refer to any Cline Family Medicine providers. By executing this agreement, you are agreeing to pay for all services that are received.

Payment Options: You may choose to pay by Cash, Check, or Credit Card on the day that treatment is rendered. Any copayments required by an insurance company must be paid at the time of service. This is an insurance requirement, we cannot bill you for these.

Monthly Statements: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid in full by the end of the month. If you have a balance on your account you will be notified by email and it will be on your portal to view. It will show any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Insurance: Cline Family Medicine is a preferred provider on many insurances. Each insurance has its own contracts, copays, and deductibles. Please note that it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. This includes, but is not limited to, labs, procedures, injections, or any other medical service. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and increase the amount you owe.

Late Fee/Collections: A LATE FEE of $25 will be imposed on each item of your account which has not been paid within 60 days of the time the item was added. A collections service fee will be added to your account not to exceed 50% of your past due balance.

Waiver of Confidentiality: You understand if this account is submitted to a collections agency, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In the event of divorce or separation, the party named responsible for the account prior to the divorce or separation will remain responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to pay for services up front then collect from the other parent**.**

Signature:_____Name:_____Date:_____

OFFICE POLICIES

1. Office hours are from 7:30am-5pm Monday through Thursday, 7:30am-12 noon Fridays (Nac) and 7:30am-5pm Fridays (Center) Closed for lunch 12-1pm daily
2. If you arrive later than 10 minutes after your scheduled appointment time, you may be asked to reschedule.
3. Twenty-four hour notice is expected for appointment cancellations. If two (2) or more no-shows occur, our office reserves the right to not schedule any future appointments for that particular patient.
4. Copayment, coinsurance, deductible payments, and cash pay patients are due at time of service. NO BALANCES WILL BE KEPT ON PATIENT ACCOUNTS. Payment forms accepted are: Cash, Check, Credit Cards. No checks will be held or postdated without prior approval before you are seen. NSF checks are assessed a $35 NSF fee. A second NSF check will result in us not being able to accept checks in the future.
5. All insurance claims will be filed electronically. Our office will make every effort to file your claim in a manner that is acceptable to your insurance company. If your insurance does not cover a certain procedure, the claim balance will become your responsibility and payment is expected promptly.
6. All insurances cover prescriptions differently. It is your responsibility to work with your insurance to find an acceptable drug for us to prescribe. If your pharmacy is out of a prescribed drug it is your responsibility to find a pharmacy that has the medication on hand***. Please allow 48 hours for prescription refills.***
7. Insured patients with balance over $200.00 will not be scheduled for any future appointments until substantial payments are made towards their accounts. All family balances must be maintained current and not past due or your account may be placed on hold for appointments/refills. (family is considered husband/wife/minor children.)
8. Occasionally medical emergencies arise at our office or the hospital that require the staff's immediate attention. We appreciate your patience in triaging and assisting those patient with urgent medical needs.
9. Once a nurse or physician has begun treatment (vitals taken, note started, etc,) no refund will be made.
10. Patients that fail to cancel scheduled appointments will be charged a $25 no show fee.
11. If we cannot get in touch with patients via patient portal and/or phone number, a $5 admin fee will be charged to the patient's account. It is imperative that we are able to get in contact with our patient's regarding labs, x-rays, scans etc.
12. **PATIENT FORMS/FMLA/DISABILITY ETC:** ANY FORMS THAT YOU REQUIRE TO BE FILLED OUT WILL BE ASSESSED A $40 CHARGE THAT MUST BE PAID BEFORE THE FORMS ARE FILLED OUT.

****PLEASE ALLOW UP TO 7 BUSINESS DAYS FOR THE FORMS TO BE COMPLETED.****

This office reserves the right to make updates to this policy at any time. A current copy of this policy will be posted in the waiting room. By signing below you acknowledge and understand the office policies as printed above and agree to abide by them.

Signature:_____ Printed Name:_____ Date:_____

THANK YOU FOR ALLOWING US TO TAKE CARE OF YOU!!!

PRIVACY POLICY

IMPORTANT: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, initial evaluations and daily treatment received will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to see payment from all sources of coverage such as private insurance carriers. For example, your insurance carrier may request and receive information on dates of service, services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-today activities and management of Cline Family Medicine. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Prescription History: By signing this document, you authorize for staff members to view your prescription history from external sources. This is a requirement by law to check prescription history for certain prescribed medications.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. All vaccinations received in this office will be uploaded to ImmTrac (Texas Immunization Registry).

Disclosures Requiring your Authorization: Disclosure of your health information (medical records, insurance information, individual pictures, etc) or its use for any purposes other than those listed above require your specific written authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Appointment reminders: Your health information may be used by our staff to call for appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Marketing: Your name will not be used for marketing efforts without your written permission.

Signature: _____Printed Name: _____Date:_____

HIPPA RELEASE

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of Cline Family Medicine to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I DO NOT authorize Cline Family Medicine to release any or all information concerning my medical care to any individual except as set for above.

_____ I DO authorize Cline Family Medicine to verbally release any or all information concerning my medical care to the following individuals: **(This may involve billing/accounts past due and or prescription pick-ups by the authorized individuals as well.)**

Name:_____Relationship:_____

Name:_____Relationship:_____

Signature:_____ Printed Name:_____ Date:_____

WORKERS COMPENSATION/PERSONAL INJURY/AUTO ACCIDENTS

Workers Compensation: We do file with some workers compensation insurances. We will need all required information from your adjustor and/or employer. We do not accept injuries that are older than 30 days old.

Personal Injury/Auto Accidents: Payment of the bill remains the patient's responsibility and must be paid in full at the time of service by the patient. We cannot bill third parties for charges incurred due to a personal injury.

Signature:_____ Printed Name:_____ Date:_____

YOUR PATIENT RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice. (This is our printed notice).

You have the right to choose which provider you see. At the time of scheduling please be sure your appointment is scheduled with whom you want to see for that visit.

Duties of Cline Family Medicine

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in this
notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

I have been offered a copy of my patient packet. I have read all policies and consents.

_____	_____	_____
Signature	**Printed Name**	**Date**

PATIENT PORTAL INFORMATION SHEET AND SIGNED CONSENT

How Secure Patient Portal Works:

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass –phrase to log in to the portal site. It is your explicit responsibility to maintain the security of your login and password.

How to participate in our Patient Portal:

Once this form is agreed to and signed, we will send you an email notification that tells you how to register for the first time. This notification will give you the URL (internet address) of the web site where you can log in.

We need you to make sure we have your correct email address and you MUST inform us if it ever changes. You will also need to keep track of who has access to your email account: so that only you, or someone you authorize can see the messages you receive from us. If you think someone has learned your password, you should promptly go to the Patient Portal and change it. It is our intent to offer this as a free service but we reserve the right to change this policy. We will provide adequate notice of any changes. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible. We will never sell or give away any private information, including email addresses, without your written consent.

PRESCRIPTION REFILLS: All refills are to be requested through your patient portal. Please allow 48 hours after submitting the request for it to be processed and submitted to your pharmacy.

Conditions of Participating in the Patient Portal:

Access to this secure Patient Portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate this service we will notify you as promptly as we reasonably can. You agree to not hold Cline Family Medicine or any of its staff liable for network infractions beyond its control.

If you agree to abide by the conditions set forth on this letter and wish to have a Patient Portal account created for you, please sign and date.

_____	_____	_____
Signature	Printed Name	Date