Kettering Family Practice

Patient Registration Information

NAME (Last, First, MI): DATE:

SEX: M F RACE: ETHNICITY: Hispanic / Latino Y / N BIRTH-DATE: / / AGE S.S. NO.: – – MARITAL STATUS:

ADDRESS:

CITY: STATE: ZIP: EMAIL:

HOME PHONE: ( ) WORK PHONE: ( ) CELL PHONE: ( )

EMPLOYER: EMPLOYER PHONE:

ADDRESS:

CITY: STATE: ZIP:

SPOUSE NAME: SPOUSE S.S. NO.: — —

SPOUSE EMPLOYER: EMPLOYER PHONE:

NAME AND TELEPHONE # OF EMERGENCY CONTACT:

PREFERRED PHARMACY: ADDRESS: PHONE:

IF PATIENT IS NOT RESPONSIBLE FOR THE BILL, PLEASE INDICATE WHO IS:

NAME: RELATIONSHIP TO PATIENT:

ADDRESS:

CITY: STATE: ZIP:

S.S. NO.: PHONE NO: ( )

EMPLOYER: EMPLOYER PHONE:

ADDRESS:

IF MINOR: MOTHER'S NAME: FATHERS NAME:

INSURANCE INFORMATION

(Please present your insurance card to the receptionist)

PRIMARY INSURANCE

INSURANCE CO.

CITY STATE

ID # GROUP/PLAN#

EFFECTIVE DATE RELATION TO PATIENT

INSURED'S NAME DOB

SS#

INSURED'S EMPLOYER

ADDRESS

SECONDARY INSURANCE

INSURANCE CO.

CITY STATE

ID # GROUP/PLAN#

EFFECTIVE DATE RELATION TO PATIENT

INSURED'S NAME DOB

SS#

INSURED'S EMPLOYER

ADDRESS

CONSENT TO TREAT AND AUTHORIZATION FOR RELEASE OF BILLING INFORMATION

I recognize the need for health care and consent to services as ordered by the physician(s). I hereby authorize the release of any medical information necessary from Kettering Family Practice for insurance claim submission and/or payment for services. I authorize payment of medical benefits to Kettering Family Practice for services described herein. Regardless of my insurance benefits, if any, I understand that I am financially responsible for the fees for the services rendered.

DATE: / /	X SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF MINOR):	RELATION TO PATIENT:

KETTERING
FAMILY PRACTICE

FINANCIAL POLICY

In order for us to deliver quality care, we have established our financial policies.

PLEASE READ ALL INFORMATION AND SIGN BELOW.

1. We may ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance. If you have a change of address, phone number, or employer, please notify the receptionist and we will give you a form to update.
   ***INITIALS _________**

2. We will collect your deductible, copay, charges for non-covered services and any **outstanding balance AT THE TIME OF YOUR VISIT**. *NO EXCEPTIONS* Patients with no insurance will be expected to pay in full at each visit.
   ***INITIALS _________**

3. We will file your insurance to your plan. You are to make sure payment is made by your insurance company. Your insurance may not cover all your visit. It is the patient's responsibility to know their policy. After you receive a billing statement from us payment is expected **within 30 days**.
   ***INITIALS _________**

4. If your plan requires you to choose a primary care physician, it is your responsibility to make sure our physicians are listed as your PCP. If your plan requires you to have an authorization to see a specialist, or for testing, you will need to obtain that from our office prior to seeing the specialist/facility. It is the patient's responsibility to notify us each time an authorization is needed. No retroactive referrals will be given.
   ***INITIALS _________**

5. When an appointment is scheduled with the doctor/nurse, time is specifically allocated for you. When an appointment is not cancelled in advance, another patient that needed to be seen could have been scheduled. "No show" appointments will be charged a $25.00 fee. Multiple "no show" appointments can lead to dismissal from the practice.
   ***INITIALS _________**

6. Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you ever have any questions concerning your billing, call our billing department at (937) 298-1439.

By signing this document I confirm to have read and that I understand the financial policy of Kettering Family Practice.

SIGNATURE ________________________________ **DATE _____________**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

☐ I consent to Kettering Family Practice using and disclosing my protected personal health information to carry out treatment, payment, or health care operations.

☐ I understand and have been provided with a NOTICE OF PRIVACY PRACTICES, which provides a more complete description of how my protected personal health information may be used or disclosed. These can be found in the binders of the lobby.

You have the right to request that we restrict disclosure of your Protected Health Information only to certain individuals involved in your care, such as family members and friends.

☐ I do not wish any information given to anyone.

OR

☐ Information may be shared with only the following persons:

Name ______________________________ Relationship ________________

Name ______________________________ Relationship ________________

Name ______________________________ Relationship ________________

Name ______________________________ Relationship ________________

PRINTED PATIENT'S NAME _____________________________________

SIGNATURE (PATIENT/LEGAL GUARDIAN) ________________________

DATE ________________________

This notice will stay in effect until revoked by the patient.