St.Vincent's HEALTH SYSTEM

Pt Name: ____________________________ DOB: ________

Acknowledgement of Receipt of Joint Notice of Health Information Privacy Practices

By signing below, I acknowledge that I have received St. Vincent's Joint Notice of Health Information Privacy Practices.

____ ____________________________

Signature of Patient or Legal Representative Date

The privacy, security and confidentiality of your health information are important to us. Please let us know how you prefer us to contact you with results, questions, or appointment reminders.

Please select and number in the order we should attempt: **Phone Number:**

_____ Home phone - Can we leave a message? ☐ Yes ☐ No _________________________

_____ Cell phone - Can we leave a message? ☐ Yes ☐ No _________________________

_____ Work phone - Can we leave a message? ☐ Yes ☐ No _________________________

_____ Mail to home address

_____ Telephone and message to another person
(Please name______________________) _________________________

_____ Other _________________________

Please list any other persons to whom we may discuss your healthcare treatment and/or payment information. Many patients take this opportunity to list a spouse and/or an adult child or caregiver who often participate in their healthcare decisions and payment.

Name: ________________________________ Relationship: __________________

Name: ________________________________ Relationship: __________________

Name: ________________________________ Relationship: __________________

Name: ________________________________ Relationship: __________________

Vincentian Physician Services

Account Number: **PATIENT INFORMATION**

Name:	**Date of Birth:**	
Address One:	**Social Security #:**	
Address Two:	**Sex:** ☐ **Female** ☐ **Male**	**Marital Status:**
City:	**Language:**	**Ethnicity:** **Race:**
State: **Zip:**	**Employer:**	
Home Phone#:	**Employer Address:**	
Work Phone#	**Employer City:** **Employer State:** **Employer Zip:**	
Cell Phone#:	**Emergency Contact:**	
Emergency Home Phone #: **Cell #:** **Work #:**	**Emergency Relationship:**	

GUARANTOR INFORMATION

Name:	**Date of Birth:**
Address One:	**Social Security#:**
Address Two:	**Usual Provider:**
City:	**Employer:**
State: **Zip:**	**Employer Address:**
Home Phone#:	**Employer City:**
Work Phone#:	**Employer State:** **Zip:**
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Certificate#:	**Certificate#:**
Group Number:	**Group Number:**
Group Name:	**Group Name:**
Subscriber Name:	**Subscriber Name:**

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, to release any information necessary for my course of treatment.

______________________________________ ____________________
Signed (patient or parent if minor) Date

ST. VINCENT'S FAMILY CARE
FINANCIAL POLICY

Thank you for selecting St. Vincent's Family Care, as your health provider. We are committed to providing you the best possible care. Your clear understanding of this financial policy is important to our professional relationship. Our staff will be pleased to discuss our fees and this policy with you at any time. Please read and sign this policy prior to seeing the physician.

1. Payment for services is due at the time services are rendered. For any of your portion that is not covered by insurance, or for our private pay patients, we accept cash, check, MasterCard and VISA.
2. Federal guidelines (Red Flag Rules) require us to have proof of identification of the patient prior to treatment.
3. We are contracted with most managed care plans. Please present your insurance card at the front desk so that we can accurately file a claim on your behalf. We will follow their guidelines for submission of claims, co-pay amounts, and reimbursements. Any contractual differences will be deducted from your balance.
4. A $75.00 deposit is due on all self pay accounts prior to being seen and the balance will be due at the time of discharge.
5. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Insurance companies and employers decide what procedures are covered benefits and which are not. Please check your insurance plan documents for any questions. Fees for uncovered services and unmet deductibles and copayments are due at the time of treatment.
6. Your insurance policy is a contract among you, your employer, and the insurance company. We are not party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, copayments, covered charges, secondary insurance and “usual and customary charges”.
7. Returned checks and balances older than 90 days are subject to placement with a collection agency.
8. If a refund is due to you, we will process the check through our accounting department.
9. Due to varied contractual arrangements between laboratories and health insurance plans, please verify that you are directing our office to a lab that is a participating provider with your insurance plan. Please remember that your lab billing is separate from our physician’s billing and you may receive a separate itemized bill from the laboratory. If you a private pay patient, we can provide an estimated cost of the lab charges.
10. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to our staff so that we can assist you in the management of your account.

Again, thank you for choosing St. Vincent's Family Care. We appreciate the opportunity to serve you.

____

Patient Signature Date

____

Witness Date

ASSIGNMENT OF INSURANCE AND MEDICARE BENEFITS

I hereby assign any and all insurance benefits providing coverage for medical and/or surgical treatment to which I am entitled to St. Vincent's Family Care.

MEDICARE ASSIGNMENT: Statement to permit payment of Medicare Benefits to Provider, Physician and Patient. I request that payment of authorized Medicare benefits be made either to me or my behalf for any services furnished to me by St. Vincent's Family Care including physician services, radiological services, and consulting services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine their benefits or the benefits for related services.

We are willing to assist you by supplying information for your insurance carrier and/or managed care organization to help in getting your claim for medical payments processed. You may not rely upon our doing so in every instance and the responsibility remains yours to make certain that we are paid for our services to you. Providers, insurance carriers, or managed care organization have various procedures and regulations and varying opinions as to who is primarily responsible for the payment of treatment.

A photocopy of the authorization shall be considered as effective and valid as the original.

Parent/Guardian______________________________________ Date____________________

Printed Name ____

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of medical records for_______________________ to the referring and family physician(s), as well as any/all records necessary to process insurance claims. (If there are any exceptions to this, please list here.)

____

Parent/Guardian______________________________________ Date____________________

Printed Name ____

FINANCIAL AGREEMENT

This information is given for the purpose of establishing or updating records with St. Vincent's Family Care. It is my understanding that any and all records here concerning my personal and medical history are the confidential property of St. Vincent's Family Care.

I understand that I am responsible for any and all charges incurred by me or us, and that I agree to pay any collection costs incurred, including reasonable attorney's fees, payment is due at the time medical services are rendered. I hereby waive to the extent allowed by laws, all personal property rights of exemption under the constitution and laws of the State of Alabama, in connection with or related to the collection of any amounts due for services rendered. Itemized charge tickets are provided to you for each visit for reimbursement by your insurance carrier. Patients requiring special arrangement will be considered on an individual basis. Patients covered by any type of insurance plan should remember that they are responsible for all charges incurred, regardless of their plan coverage.

My signature below indicates my consent to Assignment of Benefits, Release of Medical Information and Agreement of the above Financial Policy.

Parent/Guardian______________________________________ Date____________________

Printed Name ____