LSA FAMILY MEDICINE

Patient Demographic

First Name | Last Name | Last 4 #'s of SS# ____________

Date of Birth | Male or Female | Hispanic/Non Hispanic | English/Other | Race__________ | Marital Status: M S W D

Home Address | City | State | Zip

Cell Phone or Home Phone | Email

Contact Preference: (Please Circle) Home Cell Work Email

Emergency Contact

Name | Phone No. | Relationship

Patient Employer Information

Employer Name | Phone

Address | City | State | Zip

Guarantor/Policy Holder Information

First Name | Last Name

Date of Birth | Relation to Patient | Phone No.

Insurance Information

Name of Primary Insurance | ID/Policy No | Group No | Policy Holder

Name of Secondary Insurance | ID/Policy No | Group No | Policy Holder

List Other Household Members on Account

I agree to pay all copays, deductibles, co-insurances and non-covered services as determined by my insurance company. Payment for all services is the responsibility of the patient.
I understand verification of eligibility is not a guarantee of payment as stated by my insurance company. I authorize payment of my insurance benefits to Rural Family Medicine Associates.
I authorize payment of my insurance benefits to Rural Family Medicine Associates. I agree to pay an additional $5.00 fee a month for all accounts not paid in the time stated on the monthly statement.
Any additional charges related to the cost of collection (including, but not limited to collection agency fee, reasonable attorney fees and court costs) in the event that I would fail to pay my bill.
I understand there is a returned check fee applied to every returned check.
I hereby authorize Rural Family Medicine Associates to release any information acquired in the course of my treatment to my insurance company, any medical facility or physician involved in my care.
The insurance information furnished here represents a full disclosure of the insurance/third party to which I am entitled.
Failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of nonpayment by any carrier.

Signature | **Date**

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I, ________________________(*Patient Name or Authorized Agent*), hereby give my consent to Rural Family Medicine Associates to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ________________________________(*Patient Name).*

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at the office visit following the revision.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that

I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: ____Date: ______________________

If you are not the patient, please specify your relationship to the patient___________________________

CONSENT FORM DEFINITIONS

"Health care operations" refers to a. large number of activities, including: 1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; 2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities; 3. Underwriting, premium rating, and other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance); 4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including for development and administration, development or improvement of methods of payment or coverage policies; and 6. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is. not disclosed to such policy holder, plan sponsor, or customer, (c) resolution of internal grievances; (d) due diligence 1w connection with the sale or transfer of assets to a potential successor in interest, if the potential successor interest is a covered entity or, following completion of the sale or transfer, will become a covered entity and (e) creating de-identified health information, time raising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to: 1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;2. Billing, claims management; collection activities, obtaining payment under a contract for reinsurance, and related health care data processing3. Review of health care services with respect to medical necessity; coverage under a health plan, appropriateness of care, or justification of charges; 4. Review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number and name and address of the physician.

"Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

"Use" means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician's practice that maintains such information.

I, ____, (Date of Birth: ___/____/___)
(Print Name)

hereby give LSA FAMILY MEDICINE permission to discuss my personal medical information contained within my file with the following persons:

Name: ____

Relationship: _____________________ Phone #__________________________

Name: ____

Relationship: _____________________ Phone #__________________________

Name: ____

Relationship: _____________________ Phone #_________________________

___ No, I do not want any of my information discussed with ANYONE but myself.

SIGNATURE: ____ Date: ____________