SOUTH MOUNTAIN FAMILY PRACTICE

WILLIAM BODENHEIMER, M.D.

PATIENT REGISTRATION

Last Name: _____ First Name: _____MI __ Date of Birth: _____

Home Phone__ _____ Work Phone: _____ Cell Phone: _____

Mailing Address: _____ City _____ Zip Code: _____

Email Address: _____ Employer: _____

Patient Social Security #: _____ Patient Sex: _____ Marital Status: S_ M_ W_ D_

I authorize South Mountain Family Practice to release my information during my examination and or treatment to the following designated person(s):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Whom may we contact in case of Emergency? _____ Phone: _____

May we leave a message for you via the phone number(s) provided? Yes_____ No_____

INSURANCE AND RESPONSIBLE PARTY INFORMATION

Primary Insurance Carrier: _____ Member ID #: _____

Policyholder's Name: _____ Policyholder's date of birth _____

Secondary Insurance Carrier: _____ Member ID #_____

Policyholder's Name: _____ Policyholder's date of birth _____

I have received services from a provider (SMFP) for the condition for which I seek treatment today and I will promptly disclose any necessary information to my Insurance Carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I am responsible for notifying this office of any changes in my status, (Insurance, Address, Phone, etc).

Signature: _____ Date: _____

South Mountain Family Practice

Consent for Treatment

This section is to obtain patient signature to authorize or consent treatment, assignment of benefits, and release of information. The above information is true to the best of my knowledge.

- I authorize the physicians of South Mountain Family Practice to provide myself (or dependent) with reasonable and proper care.
- I authorize my health insurance company or third party payer to pay my insurance benefits directly to South Mountain Family Practice.
- I authorize South Mountain Family Practice to release any information required to process my insurance claim.
- I understand that I am ultimately financially responsible for any balance remaining on the account after insurance has paid or total charges even if the insurance is pending or has denied.

Patient or Guardian Signature _____ Date: _____

Patient or Guardian Name _____ Date of birth: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information/ Please review it carefully. A copy will be provided upon request.

Your Health Information Rights

- Although your health record is the physical property of the Medical Practice that compiled it, the information belongs to you.
- You have the right to inspect or obtain a copy of your health record (except where restricted by law) upon your written request.
- You have the right to request an amendment of the information in your health record that you believe is incorrect or incomplete. Any request for amendments to health information must provide the reason for the amendment.
- You have the right to requests restriction on certain uses and disclosures of your information; however, we are not required to agree to a requested restriction.
- You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can request that we only contact you at work or by mail.
- You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken. Any request must be made in writing.

Signature of patient or legal representative _____ Date _____

Patient name _____ Date of birth _____

SOUTH MOUNTAIN FAMILY PRACTICE FINANCIAL POLICY

South Mountain Family Practice believes that communicating our financial policy is a good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and SMFP. Secondary insurance does not necessarily mean that your services are covered at 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

You are financially responsible for all copays, coinsurance, deductibles, and non-covered services/items. We are obligated to collect any copay at the time of service per your insurance company. We accept cash, check, MasterCard, and Visa. Statements are mailed out monthly, and we ask that payment for outstanding balances be rendered when you receive your statement or at your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances; they are applied to the current date of service. There is a $30.00 returned check service charge. Payment will then need to be made by cash, money order or credit card for the balance due and the service charge.

When you receive healthcare services from us and we bill your insurance, it is the same as us extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursement by many insurers, including Medicare, we cannot carry large balances. Balances not paid within 90 days will be turned over to an outside collection agency unless prior payment arrangements have been made. You will be fully responsible for care not authorized by your HMO, PPO plan. You are responsible for all insurance denials regarding "incorrect insurance information" provided to us.

Some patients may accrue large balances for services provided. We will work with these patients to set up a mutually feasible payment plan. In some cases, if the minimum payment due cannot be paid; we will need proof of financial hardship. Please understand that we cannot waive deductibles, coinsurances or co pays that are required by your insurance. This is a violation of our contracts with the insurance plans. Appointments not cancelled within one business day of the scheduled appointment will be charged a "No Show" fee of $35.00 due at your next visit .Our office requires 48 hours to process all Insurance referrals.

Completing disability forms, FMLA forms, and other requested supplemental forms requires time away from patient care and day to day business operations. There will be a charge applied depending on information requested. Please understand that in order to complete forms your medical record must be reviewed, forms completed, signed by the physician and scanned into your medical record. We request that you allow 5 business days for this process.

I understand and agree to South Mountain's Family Practice Financial Policy.

Print Name_____ Date_____

Signature_____

South Mountain Family Practice, 9 Saint Paul Street, Boonsboro, Maryland 21713

Phone 301-432-0623 Fax 301-432-0765

SOUTH MOUNTAIN FAMILY PRACTICE

NO SHOW/MISSED APPOINTMENT POLICY

We, at South Mountain Family Practice, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 301-432-0623

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least twenty-four (24) hours' notice.
2. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment. A $35 no-show appointment fee will be applied to your account when applicable.
3. **Any** "No-Show" may result in discharge from our care at provider's discretion. A letter will be mailed advising you of dismissal of care. **A thirty-day discharge of care notice will be given to find a new provider of care.**

I have read and understand the South Mountain Family Practice No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify South Mountain Family Practice appropriately if I have difficulty keeping my scheduled appointments.

Patient Name	Date of Birth	Date
Patient Signature or Parent/Guardian if minor		Relationship to Patient
Staff Signature	Date	