Frenchtown Family Medical and Wellness

New Patient Packet

Today's Date:	

PATIENT INFORMATION

Patient's legal last name:	Legal First:	MI:	Marital status:

Nickname / Preferred Name:	Birth date:	Gender:	Sex:		

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security No. :	Home phone: Cell Phone:	Email Address:
Occupation:	Employer:	Employer phone:

Chose clinic because or referred to clinic by:

INSURANCE INFORMATION

Please give your insurance card to the front desk

Person responsible for bill: Relationship to patient:	Birth date of Responsible Party:	Address (if different than yours):	Primary phone:
<u>Medicaid Patients Only:</u>	Is Frenchtown Family Medical and Wellness your Passport Provider?	Would you like to change your passport provider?	

Primary insurance:

Subscriber's name:	Birth Date of Subscriber:	Group #:	Policy # :	CoPay:	

Patient's relationship to subscriber: ____ Spouse _____ Child _____Other: Please List: _____

Name of secondary insurance (if applicable):	Subscriber's name:	Policy #	Group #

Patient's relationship to subscriber: ____ Spouse _____ Child _____Other: Please List: _____

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone:	Mobile phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Frenchtown Family Medical and Wellness or my insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Release of Records

I hereby authorize _____

(Name of Provider and Health Care center where records are located, please list their fax and phone number)

To release the records of:

Name:_____ DOB: _____

To: Frenchtown Family Medical and Wellness | PO Box 535 Frenchtown, MT 59834

Phone: (406) 541-4700 | Fax: (406) 541-4701

If my records are with CMC or a Providence location I authorize my medical records to be accessed electronically.

Reason: Sharing with other health care providers as needed

The type of information to be used or disclosed is as follows (check appropriate box)

_____ Discharge Summary

_____ Imaging

_____ Immunization Records

_____ History and Physical

_____ EKG

_____ Lab Results

_____ Entire Record

_____ Other (please specify) _____

I understand that the record release may contain the following information which is protected by state and federal law and I authorize you to release this information (initial all that apply)

_____ Mental Health Treatment

_____ Drug and Alcohol Abuse

_____ AIDS / HIV related information

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke authorization, I must do so in writing and present my written revocation to the clinic. I understand that the revocation will not apply to information that has already been released. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations.I understand that the use and disclosure of the information identified above is voluntary. I need not sign this form to ensure health treatment. I acknowledge that I might be charged a reasonable, cost based fee for making copies. I acknowledge that third party payers and other parties requesting health information on behalf of myself will be charged as state law allows.

Signature of patient or legal guardian: _____ Date: _____

Relationship to Patient:_____

Date: 09-08-2021

Welcome to Frenchtown Medical!

PATIENT FINANCIAL POLICY

Thank you for choosing Frenchtown Family Medical & Wellness, P.C. as your healthcare provider. We are committed to building a successful physician-patient relationship with you and your family. Our goal is to provide you with the best medical care. As a small local business, we strive to be patient centered and cost effective.

Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

· Most insurances are accepted at Frenchtown Medical, you may need to check with your insurance to ensure that we are in network.

· When you arrive at the clinic, bring your insurance card, driver's license, and a form of payment with you. We will make a copy of your license, insurance cards; and for your convenience put your credit or debit card on file for payment.

· *Payment is expected at time of service.*

Co-pays
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in. We accept cash, check or credit cards.

Insurance Claims
Insurance is a contract between you and your insurance company. In most cases, we are NOT a party to this contract. We will bill your insurance company one time as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Electronic billing and payment. Historically we have billed by mail, but in an effort to be more efficient, we are asking every patient to provide us with a credit card at the time of service. Your card will not be charged until the Explanation of Benefits (EOB) returns from your insurance.
The only amount charged will be the "patient responsibility" portion as defined by your insurance. We will contact you before submitting charges over $200. You will receive an Email notification or mailed statement with the amount charged to your credit card

Participating Insurance. If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.

Workers' Compensation
It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which our practice does not participate, or patients without an insurance card on file with us. Liability and workers' comp cases will also be considered self-pay accounts. It is always the patients' responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

Self-pay patients will be required to pay full amount at time of service. If you pay in full at time of service we offer a 10% discount from our customary fee schedule. Payment arrangements are available if needed. Please ask to speak with a collection coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

COMPLETION OF FORMS POLICY

In order for us to better serve you, we request that you are aware of the following:Your insurance company will not be billed as insurance companies do not reimburse for the time and judgment that are required to complete these forms.

Please allow 7 business days for completion of forms.

Payment is required prior to completion of all form(s)
The fee for completion of forms is $35.00.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent an e-statement or a paper statement dependent on preference. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency and possible discharge from the practice.In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs.

Returned Checks
The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Cancellation Policy/No Show Policy For Appointments

- **Cancellation/ No Show Policy for Appointments. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.**
- **If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.**
- **Scheduled Appointments We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.**

Frenchtown Family Medical & Wellness, P.C.
406-541-4700

HIPAA / Notice of Privacy Practices / Consent for Diagnosis and Treatment

Patient Name: _____
Date of Birth:_____
Primary Care Provider: _____

I agree that medical information may be left on my answering machine or voicemail:
Yes ❒ No ❒
I agree that this person can call on my behalf and medical information may be given to:

Name: _____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Name:_____ Phone: _____ Relationship: _____

Initials: _____

As a courtesy to our patients we will file a claim with the primary insurance on your behalf. All charges regardless of the insurance coverage are the patient's responsibility. We ask that if your insurance company has not paid within 45 days that you contact them. Any questions regarding your benefit coverage should be directed to your insurance company prior to coming in for your appointment. We will make a copy of the insurance card for billing purposes and we will collect your copay at every visit.

I hereby authorize Frenchtown Medical and Wellness to supply information to the insurance carrier(s) regarding my illness and treatment with respect to the services rendered and I assign all payments for such services to Frenchtown Family Medical and Wellness. I understand that I am financially responsible for all charges.

I have read and understand the contents of this disclosure and certify that this information is true and accurate and I agree to the terms of this disclosure.

Signature: _____
Date: _____/_____/_____

This document is valid for 3 Years

Phone Consent; I consent to and authorize Frenchtown Family Medical and Wellness to contact me via phone or text in relation to any services received or planned to be received including billing items and appointment reminders.
PHI: I authorize Frenchtown Family Medical and Wellness to use and disclose my protected health information to perform, treatment, payment and health care operations. The practice may call or mail to my home or alternative location and leave voicemail or email referencing any items to perform treatment, payment and health care operations such as insurance items, laboratory tests or items pertaining to clinical care. I may revoke consent in writing except to the extent the practice has already made disclosures with my prior consent. If I do not sign this consent or later revoke it the practice may decline to provide me treatment.
Initial Here: _____

Medication History: A variety of sources including pharmacies and health insurers contribute to the collection of your medication history. It is stored in the clinic's electronic medical record system and becomes part of your personal record. Medication history is important in helping providers treat symptoms properly to avoid dangerous drug interactions. It is important that you and your provider discuss all your medications in order to ensure your medication history is 100% accurate. I give permission to allow my healthcare provider to obtain my medication
history from pharmacies, health plans and providers.
Initial Here: _____

I give permission to Frenchtown Medical and Wellness to give me medical treatment and to bill my insurance to pay for the care I receive. I understand the practice will have to send my medical information to the insurance company and I must pay my share of the costs. I must pay for services if my insurance company does not pay. I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my provider. I am financially responsible for all charges incurred regardless of insurance coverage or third-party liability and all proceeds of insurance are assigned to this office. I authorize the practice to release medical information necessary to process claims. There will be a finance charge of 10% for any unpaid balance over 90 days and I will be charged an additional fee (50% of unpaid balance) if my debt is assigned to a collection agency. This amount shall be in addition to any other costs incurred directly or indirectly to collect the amount owed.
I also acknowledge that I have received a copy of the Patient Financial Policy
Initial Here: _____

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this serves as a basis for planning care and treatment, communicating with health professionals who may contribute to my care, a source of information for applying for diagnosis and surgical information to my bill, a means by which a third party can verify services billed were services rendered and a tool for routing health care operations such as assessing quality and reviewing the competence of health care professionals. I understand as part of my care and treatment it may be necessary to provide my protected health information as specified below for the purpose and to the parties designated to me:

This practice reserves the right to change the notices and practices and that prior to implementation, will mail a copy of any notice to the address I provided if requested. I have the right to to reject the use of my health information for directory purposes.

I may Revoke this consent in writing at any time except to the extent that this practice has already taken action in reliance thereon.

I have a right to request restrictions as to how my PHI may be used or disclosed and this practice is not required by law to agree to the restrictions requested.

Initial Here:_____ Printed Patient Name:_____

Signature:_____ Date:____/____/____

Valid For Three Years