COMPREHENSIVE PRIMARY CARE
FAMILY MEDICINE CLINIC

Documents to be Presented by Patient:
- One form of picture ID
- Primary Insurance Card
- Secondary Insurance Card (if applicable)

Patient Information *- Please present one form of picture ID at the time of the visit*

Patient's First Name		Middle Name		Last Name (as it appears on insurance card)	
Sex	Marital Status	Date of Birth	Age	Social Security Number	
Patient's Address			City	State	Zip
Home Phone		Mobile Phone		Email Address	
Referred by			Preferred Lab:		

Patient Employer/School Information

Employer/School	Occupation		Employer/School Phone	
Employer/School Address		City	State	Zip

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance *- Please present your Insurance Card(s).*

Primary Health Insurance *If Insurance Card presented, skip this section. Fill only the underlined fields if Primary Insured is different than Patient.*

Insurance Company	Plan	Insured's Employer/School		
Plan/ID Number	Group Number	Relation to Patient	Insured's Phone Number	
Insured's Name (as it appears on insurance card)		Insured's Birthdate	Insured's Social Security Number	
Insured's Address		City	State	Zip

Secondary Health Insurance *If Insurance Card presented, skip this section. Fill only the underlined fields if Secondary Insured is different than Patient.*

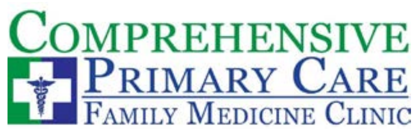
Insurance Company	Plan	Insured's Employer/School		
Plan/ID Number	Group Number	Relation to Patient	Insured's Phone Number	
Insured's Name (as it appears on insurance card)			Insured's Social Security Number	
Insured's Address		City	State	Zip

Responsible Party *Fill only if different than Patient.*

Billing Name (if other than patient)	Phone	Relation to Patient	
Date of Birth	Social Security Number		
Address	City	State	Zip

Signature of Patient or Authorized Guardian ______________________ Date ______________

Check-In by:



Consent for Treatment

I hereby authorize the health care providers affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, EKG, x-rays, labs, and/or medical/surgical procedures.

____ ____________________________
Signature of Patient/ Patient's Parent/Guardian/Representative Relationship to Patient

Acknowledgement of Privacy Practices

Our "Notice of Privacy Practices and Patient Rights" provides information about how we may use and disclose protected health information about you. The notice includes your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have a right to review the Notice before signing this consent. The terms of the Notice may change. A current copy is available by contacting our office.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing. However, such revocation shall not affect any disclosures we have already made in reliance of your prior consent.

Patient's Printed Name: ____________________________ Date: ______________________

____ ____________________________
Signature of Patient/ Patient's Parent/Guardian/Representative Relationship to Patient

Consent to Release Medical Information

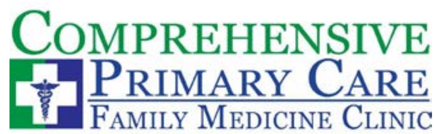
'We will not share your medical information unless you wish to grant permission for us. To disclose information to others, please indicate below. You have the right to revoke this consent at any time.

☐ *Do not disclose my information to anyone else but myself.*

☐ *You may disclose information to the following:*

Name(s)____________________________________Relation:__________________

Name(s)____________________________________Relation:__________________



FINANCIAL POLICY

Thank you for choosing Comprehensive Primary Care Group as your health care provider. We are committed to providing you the best available medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time.

We ask that all patients read and sign our financial policy as well as our Patient Information form prior to seeing the physician. Payment for services are due at the time service is rendered. We accept cash, checks, and all major credit/debit card. We will be happy to help you process your insurance claims for your reimbursement.

In special instances, we may accept assignment of insurance benefits, however you must understand that:

1. **Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract.** Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductible, co-payments, covered charges, secondary insurance, and "usual and customary" charges. We are however, contracted with certain managed care, and preferred provider plans; we will follow the guidelines for patient care, reimbursement, and submission of claims for services rendered. Any contractual provider discounts will be deducted from your balance.
2. **All charges are your responsibility whether your insurance company pays or does not pay.** Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. **Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.**
4. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurer to expedite payment. If your insurance company does not pay in full within 45 days, **you will be responsible for any unpaid claims.**
5. Returned checks and balances older than 45 days will be subject to collection placement and collection fees.
6. A charge of $10.00 will be collected when requesting itemized patient account information.
7. FMLA/Disability forms charge of $35.00-$50.00 will be due at time of request.
8. A charge of $20.00 will be collected when requesting to replace a lost general prescription.

Please note that if you must cancel or reschedule your appointment all cancellations must be made 24 hours in advance. If you **fail to cancel your appointment/no show you will be charged a $25.00 fee.** We encourage you to communicate with our business office concerning any payment problems, so that we may assist you in the management of your account.

Again, thank you for choosing Comprehensive Primary Care Group as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

ACKNOWLEDGEMENT OF PATIENT FINANCIAL RESPONSIBILITY

I acknowledge that I am responsible for payment of any services rendered to me or my dependent. I understand that financial policies of the practice and have read or been offered a copy of the practice policies. I authorize the practice to release information necessary to process my insurance claims (to both primary and secondary insurance).

____ _______________________

Signature of Patient/ Patient's Parent/Guardian/Representative Date

COMPREHENSIVE PRIMARY CARE FAMILY MEDICINE CLINIC

PATIENT PORTAL CONSENT FORM

Comprehensive Primary Care Group Family Medicine offers secure viewing and communication as a service to patients who wish to view part of their records and communication with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How does the Secure Patient Portal Work

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorized can see the messages you received from us. If you pick up a secure message from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent from and the Policies and Procedures Regarding the Patient Portal that appears at Log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

I HAVE READ AND UNDERSTAND THE USE OF THE PATIENT PORTAL:

- I understand that the Patient Portal will allow me the opportunity to:
    1. Update my demographic/medical information
    2. Review my labs, diagnostic tests and Office Visit Summary
    3. Request appointments, referrals and refills
- I understand that this site **will not** be used to ask medical advice or questions regarding my care.
- I understand that it is **my responsibility** to make a follow-up appointment 7-10 following my test, with my medical provider to discuss results.
- I understand that the Patient Portal **may not** publish all labs and diagnostic tests pertaining to my care.

Print Name:____ DOB: _____ /____ / ____

Print Email: ____

Signature: ____