Patient Information Record

Account Number : _____ Date : _____

Patient Name : _____

Address : _____

City, State, Zip : _____

Home Phone Number : _____

Cell Phone Number : _____

Email Address: _____

Preferred method of contact:_____Home _____Cell _____Email _____Text

Date of Birth : _____

Social Security Number: _____ - _____ - _____

Allergy Information: __ IODINE __ LATEX

Parent/Guardian/Responsible Party *(Only if patient is a minor)

Name _____ D.O.B ___/___/___ Relation/SSN _____

Employers Name Employers Address Phone #

_____

Emergency Contact Required

Name:_____ Phone Number:_____

Relationship:_____

Primary Insurance:

Insurance: ID#: Group#:
Insured:

Secondary Insurance:

Insurance: ID#: Group#:
Insured:

Is this visit related to an Auto Accident or a Work Injury? ___ Yes ___ No If yes, date of injury? ___/___/____
What physicians do you want to receive a copy of today's report? _____

_____ _____
Signature Date

Diagnostic Imaging Acknowledgement

Patient Name: _____ Referring Physician:_____ Exam/Procedure: _____

Due to the complex requirements of most third party payors, including Medicare and Medicaid, as a Diagnostic Company we must obtain your previous history regarding any similar diagnostic procedure within the last year. Please check the following box that applies to you.

I have had this same diagnostic procedure within the past (1) year.

___ **YES**, If you have had this same study in the time period mentioned, we will need to contact your insurance company for special authorization. Without that approval, we will not be able to provide this study unless you are willing to pay the procedure in advance.

___ **NO**, I have not had this same diagnostic procedure within the past (1) year. If you are unsure, we will contact your insurance company to verify; however, this may cause a delay in providing your procedure.

By checking NO, we are able to perform this study without delay. If it is later determined that you have had this study within the past year, and the third party payor refuses payment, then you will be responsible for the entire balance not to exceed Medicare allowable.

Signature _____ Date _____

Consent to Perform Exam

I hereby give consent to Emery Medical Solutions to provide the testing that the assigned physician may deem necessary to the patient named above.

Signature _____ Date _____

Medical Release

This section of the encounter form authorizes all physicians, hospitals and medical attendants to furnish to:
Full and complete medical reports, films and other information that are requested by this facility, affording them to examine a copy of medical records to obtain evaluations and options concerning prior subsequent medical care. The patient has the right to revoke this authorization at any time. This authorization will expire 1 year from the date of completion.

Signature _____ Date _____

Assignment of Benefits

Signature of this document authorizes medical benefits to Emery Medical Solutions, Inc for services rendered, release of results to physicians, release of medical information to insure (including Medicare, its agents, and third party payers) necessary to process and request payment for services rendered, and acceptance of responsibility for payment of said charges if Emery Medical Solutions, Inc is denied payment from insurance or providers for services rendered. I hereby designate assignment and release to **Emery Medical Solutions, Inc at 2151 E. Semoran Blvd, Apopka, Fl. 32703, Phone (407) 628-9100 Fax (407) 628-0748**.

Signature _____ Date _____

Patient Financial Policy

Name: _____ Date of Birth: _____

Thank you for choosing **Emery Medical Solutions** as your health care provider. Our practice is committed to providing our patients with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

The following is a statement of our financial policy, which we require you to read and sign before any Medical treatment.

*** All patients must complete our information and insurance form.**
*** Full payment (deductibles) and/or co-payments are due at the time of service.**
*** We accept cash, checks, CareCredit, Visa/MasterCard, and American Express.**
*** Returned checks are subject to a $30.00 service charge.**

HEALTHCARE INSURANCE PLAN OBLIGATION
Our office maintains a list of healthcare service plans, which are to be contracted to provide professional medical services. We will agree to bill those insurance carriers for all services rendered. Authorization from your insurance does not always guarantee payment. The undersigned and/or patient shall remain responsible for all charges, applicable co-payments and deductibles.

PPO/HMO/MANAGED CARE/MEDICARE/MEDICAID/TRADITIONAL/INSURANCE WAIVER REGARDING NON COVERED PATIENTS
Medicare under section 1862 (A) (1) of the Medicare law and some health insurance carrier determines that a particular service or services were unauthorized, or not a covered benefit under your plan, Medicare and/or other insurance plans will deny payment for these services. We believe that according to your Insurance/Medicare plan, payment is often denied for the following services:

*** Routine/Screening testing.**
*** Certain diagnostic testing (Mammograms and/or Dexa Scans) IF THEY ARE TOO FREQUENT.**
*** Medical Necessity (even though ordered by your Physician the reason for the testing may NOT be payable by your Health Insurance Company)**
*** Auto Accidents-PIP insurance has been exhausted. We do not take LOPS from your attorney**

The undersigned and/or patient understand and agree to be personally and fully responsible for all non-covered services. Should collections become necessary, the patient will be responsible for all collection costs and attorneys fees. Please let us know if you have any questions or concerns.

I authorize Emery Medical Solutions to be my personal representative, which allows Emery Medical Solutions to: (1) submit any and all appeals when my insurance company denies me benefits to which Im entitled, (2) submit any an all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand that I am responsible for full payment of my medical debt if my insurance company has not paid 100% of my benefits, within (90) days of any and all appeals or requested information.

Although we receive verification and/or authorization from your insurance, it is not a guarantee of payment.

If for any reason your Insurance is terminated on any date of service patient/member becomes fully financially responsible for payment of their test.

I authorize Emery Medical Solutions to release my information to collection services should that be necessary for services rendered.

I have read the financial policy of Emery Medical Solutions and I understand and agree to the above statements.

_____ _____ _____
Patients Name (Print) **Patients Signature** **Date**

_____ _____
Witness/Emery Medical Staff **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations

I understand that as a part of my health care, Emery Medical Solutions, Inc. receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination, and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that Emery Medical Solutions, Inc. and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my medical condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel).

I have received a Notice of Information Practices that fully explains the uses and disclosures the Emery Medical Solutions, Inc. will make with respect to my individually identifiable health information. I understand that I have the right to review the Notice before signing this consent. Emery Medical Solutions, Inc. has afforded me sufficient time to review this Notice and has answered any questions that I have to my satisfaction.

I acknowledge and agree that the practice may disclose my protected health information and medical record information to the following individuals who are my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

Please list the individuals with whom we may discuss details of your medical care. Please give full name and relationship, and list any information you do not want shared:

_____

_____

_____

_____

Patient Name: _____

Patient or Guardian Signature: _____

Witness: _____

Date 12/6/2017