In the Sea Of Healthcare Choices, Let Us Be Your Anchor.

I CAME HERE TODAY TO SEE DR. ___________________.

DATE: ______________________

PARENT INFORMATION: (Please Print Complete Information)

MOTHER'S INFORMATION

NAME: ____________________________
STREET ADDRESS: ____________________________
Apt. or Unit #: ____________________________
CITY / STATE / ZIP: ____________________________
HOME PHONE # : ____________________________
CELL / BEEPER # : ____________________________
DATE OF BIRTH: ____________________________
MARITAL STATUS (Circle One): Single Married Other
SOCIAL SECURITY # : ____________________________
E-MAIL ADDRESS: ____________________________
EMPLOYER: ____________________________
EMPLOYER'S PHONE # : ____________________________
NEAREST RELATIVE / PHONE # / RELATIONSHIP:
____

FATHER'S INFORMATION

NAME: ____________________________
STREET ADDRESS: ____________________________
Apt. or Unit #: ____________________________
CITY / STATE / ZIP: ____________________________
HOME PHONE # : ____________________________
CELL / BEEPER # : ____________________________
DATE OF BIRTH: ____________________________
MARITAL STATUS (Circle One): Single Married Other
SOCIAL SECURITY # : ____________________________
E-MAIL ADDRESS: ____________________________
EMPLOYER: ____________________________
EMPLOYER'S PHONE # : ____________________________
NEAREST RELATIVE / PHONE # / RELATIONSHIP:
____

CHILD'S / CHILDREN'S INFORMATION

1) NAME: ____________________________ SEX (Circle One): Male Female
DATE OF BIRTH: ____________________________ SOCIAL SECURITY # : ____________________________

2) NAME: ____________________________ SEX (Circle One): Male Female
DATE OF BIRTH: ____________________________ SOCIAL SECURITY # : ____________________________

3) NAME: ____________________________ SEX (Circle One): Male Female
DATE OF BIRTH: ____________________________ SOCIAL SECURITY # : ____________________________

PHARMACY INFORMATION

NAME OF PHARMACY: ____________________________
STREET ADDRESS: ____________________________ CITY / STATE / ZIP: ____________________________
TELEPHONE # : ____________________________

INSURANCE INFORMATION

**NOTE: We will need to make a copy of your insurance card(s) for billing information. Please complete the following:
INSURANCE COMPANY: ____________________________ GROUP: __________________ POLICY / ID # : ________
CLAIM ADDRESS: ____________________________
CITY / STATE / ZIP: ____________________________
POLICY HOLDER'S NAME: ____________________________
DATE OF BIRTH: ____________________________
SOCIAL SECURITY #: ____________________________

By signing below, I acknowledge the following:

***A parent or guardian responsible for payment of the bill is accompanying the child at the time of service unless a separate permission form has been signed. Anchor Health Centers cannot be bound by any divorce or other family relationship contracts.
***I hereby authorize insurance benefits, including Medicare benefits, to be paid directly to the physician providing services and recognize it is my responsibility to pay for all non-covered services. I also authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid (CMS) and its agents, or any other third party liability or insurance carrier, any information needed to determine these benefits or the benefits payable for related services.
***I have reviewed and understand all the information on the second page of this document, including the HIPAA Notice of Privacy Practices Statement, as indicated with my signature and date below.

Parent / Guardian Signature ____________________________________ Date ________________________

In the Sea Of Healthcare Choices, Let Us Be Your Anchor.

Welcome to Anchor Health Centers!
Thank you for choosing us as your healthcare provider!

We believe it is important for our patients to fully understand our Financial Policy and acknowledge that they have read our **Notice of Privacy Practices**. Please review the Financial Policy below and the separate Notice of Privacy Practices document carefully. To avoid any misunderstanding regarding either policy, it is necessary for you to read both and sign on the first page of this document, **before** treatment is rendered. Please ask us any questions you may have regarding either document and take a copy of both policies home for future reference if necessary.

OUR FINANCIAL POLICY

This policy covers office visits, lab or radiology testing and therapy services performed at Anchor Health Centers' facilities. By signing on the first page of this document, I am agreeing to the terms of this Financial Policy.

Medicare Patients: We are participating physicians with Medicare. This means that you will be responsible for the 20% of the approved Medicare fee for covered services, the current yearly deductible and full payment of any non-covered services. Non-covered services include, but are not limited to, any and all annual physical exams following the "Welcome to Medicare" physical and most diagnostic tests performed for screening purposes.

Payment is at the time of service: Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate (please see insurance below). You will be charged a $25 service fee for any returned checks, no exceptions.

Insurance: Patients will be asked to present their insurance card to the receptionist for copying upon check-in at the office each time they are seen for medical services. Please make it a point to bring your insurance card with you each time that you visit our office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement.

For those patients covered by insurance plans with which we ARE participating providers, all co-payments, deductibles and non-covered services are due at the time of service. We will file the insurance claim to the insurance company. In the event that your insurance coverage changes to a plan with which we ARE NOT participating providers, we will require payment in full at the time of service and we will file with your insurance company as a courtesy. Any charges that are not paid by your insurance are your responsibility. Your insurance policy is a contract between YOU and your insurance company. Any pre-certifications of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.

Collections: Please note, if payment is not received from either you or your insurance company within 60 days from the date of the service(s), your account will be considered delinquent and subject to referral to an outside collection agency.

Surcharge for Missed Appointments: Patients may be subject to a surcharge for missed appointments if cancellation is not received at least 24 hours before the time of the appointment.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES STATEMENT

I have been given the opportunity to review Anchor Health Centers' (AHC) Notice of Privacy Practices (a separate document) prior to signing this acknowledgment. AHC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained from this office or by forwarding a written request to the Office of Clinical Compliance and Quality Improvement at 801 Anchor Rode Dr., Suite 300; Naples, FL 34103.

By signing on the first page of this document, I hereby acknowledge that AHC may use and disclose my protected health information to carry out treatment, payment and healthcare operations. AHC's Notice of Privacy Practices provides a complete description of such uses and disclosures. Uses and disclosures not listed in the Notice of Privacy Practices will require my prior written authorization. AHC is authorized to use my personal information to secure payment for services rendered and will comply with all reasonable measures to follow the FTC guidelines regarding identity theft.

I may make restrictions to the use and disclosure of my protected health information or revoke a previous request for restriction at any time except to the extent that the practice has already made disclosures in reliance upon my prior authorization to do so. Both Requests for Restriction and Revocations must be in writing. By signing on the first page of this document I am acknowledging that I have received AHC's Notice of Privacy Practices and understand my rights to modify how my information is used and disclosed. If AHC determines that my restrictions make it impossible for them to carry out my treatment, payment and healthcare operations, they may refuse to accept me as a patient.

Updated 8/13/09