The Family Health Center

PHYSICIAN NOTICE

Your insurance will only pay for services that it determines to be reasonable and necessary. If your insurance determines that a particular service is “not reasonable or necessary” under their program standards, your insurance may deny payment for that service.

We do not accept assignments from your insurance carrier for any Medications or Injections.

All Medications and Injections are the Patient’s Responsibility, which includes, Pyridoxine, Vitamin B12 and B Complex, Terramycin, Penicillin, Cephazolin, Demerol, Talwin, Phenergan, Testosterone, Cortisone, Hepatitis B, Flu, Pneumonia, PPD, and Allergy injections.

BENEFICIARY AGREEMENT

I have been notified that I am financially responsible for any procedure and/or balance not covered by my insurance as long as I am a patient of Dr. Tomas Friedrich.

Signed: _____ **Date:** _____ /_____ / _____

Patient Name: _____

Special Procedure (S): _____

PHYSICIAN NOTICE

The Family Health Center

PATIENT INFORMATION

Name: _____ **S.S#:** _____-___-_____

Address: _____ **City/State/Zip:** _____

Home Phone: (____)____-_____ **Other Contact #:** (____)____-_____ **Date of Birth** ___ /___ / _____

Gender: Male / Female ****Marital Status:** Single / Married / Widowed / Divorced / Separated

Employer: _____ **Employer Phone:** (____)____-_____

Employment Status: Full Time / Part Time / Retired

POLICY HOLDERS INFORMATION

Guarantor's Name: _____ **Relationship to Patient:** Self / Spouse / Parent / Other

Guarantor's S.S#: _____-____-_____ **Guarantor's Date of Birth:** ___ /___ / _____

Employer: _____ **Employer Phone#:** (____)____-_____

Employer Address: _____ **Status:** Full Time / Part Time / Retired

PRIMARY INSURANCE INFORMATION

****Please Provide Copy of Card**

Insurance Company Name: _____ **Phone:** (____)____-_____

Insurance Identification #: _____ **Group #:** _____

SECONDARY INSURANCE INFORMATION (MEDICARE PATIENTS ONLY)

****Please Provide Copy of Card**

Policy Holders Name: _____ **Relationship to Patient:** Self / Spouse / Parent / Other

Insurance Company Name: _____ **Phone:** (____)____-_____

Insurance Identification #: _____ **Group #:** _____

Please Note:
It is not the practice of this office to submit secondary insurance claims, except for Medicare cross over. Please retain today's walkout receipt (along with your Primary insurance's explanation of benefits) to mail to your secondary insurance, to get reimbursed any co-insurance or co-pay.

**I hereby authorize direct payment of surgical/medical benefits to Dr. Tomas Friedrich for services rendered by him-In person or under his supervision. I understand that I am financially responsible for any balance not covered by the insurance.

Patient Signature: _____ **Date:** ___ /___ / _____

** I herby authorize Dr. Tomas Friedrich to release any medical information that may be necessary for medical care or processing Insurance claims.

Patient Signature: _____ **Date:** ___ /___ / _____

****Medicare Patients Only**
I certify that the information given by me in applying for payment is correct. I authorize the release of all records on request. I request the payment of authorized benefits be made on my behalf.

Patient Signature: _____ **Date:** ___ /___ / _____

PATIENT INFORMATION

The Family Health Center

CANCELLATION POLICY

In order to provide EVERY patient with the most optimal treatment schedule, we have a formal “same day” cancellation and “no show” policy. A $10 charge will be billed for same day cancellation and a $25 charge will be billed for failure to show up for a scheduled appointment without prior notice.

We request that anyone wishing to cancel a scheduled appointment do so before 5:00pm the day prior to the appointment. Cancellations made after 5:00pm on the day prior to treatment will necessitate a $10 fee. Failure to show up to an appointment without ANY prior notice will necessitate a $25 fee.

Patient Signature: _____ **Date:** _____ /_____ / _____

PRESCRIPTION REFILL POLICY

Due to the increase in number, complexity, and time required to write, call, or fax prescriptions or prior authorizations to pharmacies or prescription service companies it has become necessary for us to charge for these services.

In addition a charge will be assessed for replacement of lost or misplaced lab slips, referrals, diagnostic slips, and prescriptions.

We reserve the right to charge for all forms completed for prior authorization, medical supplies, and insurance inquiries. An additional charge will be assessed to fax these requests.

Copies of the above mention fees are available upon request.

Patient Signature: _____ **Date:** _____ /_____ / _____

Please note that these policies will affect ALL patients. These fees are not billable to insurance. **Our staff is not at liberty to exempt anyone from a billed fee.**

We feel these policies are necessary in order to best serve all patients scheduling needs as well as our productivity and time management demands. Thank you for your understanding and cooperation.

CANCELLATION POLICY

The Family Health Center

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

If you do not have insurance, we expect payment in full for all treatments at the time of service unless other arrangements have been made. We accept cash, checks, VISA, MasterCard, and Discover. New patients will be required to pay by cash or credit card only, for the first six months.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. Your insurance claim will ONLY be completed and submitted if we are provided with all pertinent insurance company information. It is your responsibility to verify that your policy is in force on your date of service. Otherwise, you are responsible for payment at the time of service.

Insurance is an agreement between you and your insurance company. We file insurance claims as a courtesy to you, our patient. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurances, "usual and customary" charges, etc., other than to supply necessary factual information. Deductibles and/or co-payments/co-insurances are required at the time of service. You are responsible for the prompt payment of your account. If payment is not received from your insurance company within ninety (90) days, the balance on the account becomes your responsibility.

By signing the form below, you hereby authorize The Family Health Center to bill your insurance company for the services rendered. You further authorize payment of all medical benefits for these services to be paid to The Family Health Center directly.

AGREEMENT

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance(s). I understand and agree that my account may be turned over the Credit Bureau for collection after ninety (90) days and that a 33% collection fee will be added to my account

Patient Signature: _____ **Date:** _____ /_____ / _____

Responsible Party (Please Print): _____

Responsible Party Signature: _____