

FAMILY MEDICAL CENTER

Financial Policy

Thank you for choosing [Family Medical Center](#) as your primary healthcare provider. The following is our Financial Policy. If you have any question or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

We accept assignment from most major insurance companies and participating provider plans. 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.
2. All charges are your responsibility whether your insurance carrier pays or not.
3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. A \$10.00 service fee will be assessed if deductibles, co-insurance and/or co-payments are not paid at the time of service.
5. If your insurance carrier does not pay your balance in full within 30 days, we may ask that you contact your carrier to request prompt payment.
6. Any changes in insurance coverage, employment, address, and/or telephone number must be provided to the receptionist upon check-in. If the patient's insurance carrier fails to verify coverage, the patient/guarantor must pay for services in full at the time services are rendered. At all times, the office must maintain on file, a copy of the patient's insurance card and the patient/guarantor's driver's license.
7. Checks returned by the bank due to non-sufficient funds or account closures will incur a returned check fee of \$30.00 and may be represented electronically or by paper draft and your bank account will be debited or drafted for the check amount, service fees, and related expenses permitted by law. Any check not paid, along with the fees, within 10 business days, **WILL** be turned over to the Williamson County Attorney for prosecution. Additional checks will not be accepted.
8. If you are unable to keep your scheduled appointment, please call at least 24 hours in advance so that we may offer that appointment to another patient in need and reschedule your appointment for another time. If you fail to cancel your appointment, you will be charged a \$25.00 missed appointment fee. ***Patients who arrive more than 15 minutes late for a scheduled appointment will be asked to reschedule their appointment***
9. Unpaid balances over 60 days may be assessed a \$20.00/month billing fee.
10. Unpaid balances over 90 days may be subject to collections via small claims court, attorney and/or collection agency with applicable collection fees (33% of account balance). All collection fees are the sole responsibility of the patient.
11. Completion of forms such as FMLA, Disability, and Disabled Placard are subject to a \$25.00 charge if not completed during an office visit.
12. A patient may request a copy of their medical record. Requests must be submitted in writing and signed by the patient or parent/guardian if the patient is a minor child. Patients must allow 10 working days for medical records requests to be processed. In most cases, there is no charge to the patient if medical records are forwarded to another physician/clinic for continued care. If a patient requests a copy of the medical record for personal use, a charge of \$25.00 will be assessed for 1-50 pages. An additional charge of \$.50/page will be assessed for medical records of greater than 50 pages. The patient must pay the duplication fees prior to release of the copies. The clinic and staff recognize the importance of maintaining the confidentiality of each patient's private health information and are therefore trained in appropriate medical records and confidentiality laws and procedures.

We understand that unforeseen circumstances and temporary hardships may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I agree that I have read and understand this document in its entirety. I have had the opportunity to ask and have my questions answered to my satisfaction. I certify that I am the patient or am duly authorized by the patient or by law to execute the following agreement and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I authorize the release of any medical records or demographic information necessary to process my insurance claims. I hereby assign to Family Medical Center, the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid.

Printed Name of Guarantor

Printed Name of Patient

Guarantor Signature

Date

Signature of Patient

Date



FAMILY MEDICAL CENTER

Agreement to Treatment

Thank you for choosing **Family Medical Center** as your primary medical care provider. If you have any questions or concerns about the following information, please do not hesitate to ask your provider, nursing staff or business office staff. We ask that all patients read and sign this notice prior to seeing a medical care provider.

Medicine is a unique practice. Every individual and every medical problem is different. We practice medicine one patient at a time, which is good news for you! In this practice, it is not uncommon for patients to be inconvenienced by a wait. Although we make every effort to ensure that patients are seen in a timely manner, emergent or unexpected needs of other patients may cause delays. We respect your schedule and apologize for any inconvenience. Our staff will keep you informed so that you may choose to wait or to reschedule. We value our staff and are committed to providing exceptional medical care and customer service. We expect that our patients give our staff and us the same respect and professionalism they receive.

Test Results – The clinic receives the results of laboratory tests and diagnostic imaging within 48 business hours to one business week depending upon the particular test or procedure and the laboratory vendor. Upon receipt of the laboratory or imaging report, the *provider* must review and interpret the results and provide instruction or other feedback for the patient. **This process may take up to an additional week.** Patients receive the results of their laboratory tests or diagnostic imaging by mail, email or telephone, whichever the patient prefers. At the patient's request an alternate format may be used. *Patients are asked to allow 10-14 days for results to be available, prior to inquiring at the clinic.* The providers or nursing staff will address any laboratory or imaging results requiring immediate patient follow up personally.

Medication Refills – *Medication refills must be requested at the patient's pharmacy 3 – 4 days before they are needed.* The pharmacy will fax/transmit a Medication Refill Request that provides all the information necessary for the providers to consider a prescription refill. Refill requests may be denied if the patient has failed to follow up, is in need of laboratory or imaging studies, is requesting a refill too soon, or for various other reasons. *Patients must allow our office 24 – 48 hours to process medication refill requests.*

- Patients requiring triplicate prescriptions must call our office to request a refill at least 72 hours in advance.
- We do not refill antibiotics, narcotic pain medications or cough medications without an office visit.
- Medications will not be refilled outside of regular office hours.

After Hours – Office hours are from 8:00 am – 12:00 pm and 1:30 pm – 5:00 pm, Monday through Friday. Should a patient need to contact a provider outside regular office hours, the clinic's after hours recording provides instructions for after hours callers. Emergencies must dial 911 immediately.

I am voluntarily seeking healthcare and hereby consent to medical treatment, procedures, laboratory tests and other healthcare services. I have the right to refuse specific treatments or procedures. I agree that I have read and understand this document in its entirety. I certify that I am the patient or am duly authorized by the patient or by law to execute the following agreement. I authorize the release of any medical records or demographic information necessary to consulting physicians, clinics, hospitals, therapists, or testing facilities for my continued care.

Printed Name of Guarantor

Printed Name of Patient

Guarantor Signature

Date

Signature of Patient

Date

FAMILY MEDICAL CENTER

Health History

Name : _____ Date of Birth : _____

Have you ever been diagnosed with any of the following?

<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Immune Disorder
<input type="checkbox"/> Neurological Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Peptic Ulcers	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Mental Health Issues
<input type="checkbox"/> COPD	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Asthma	<input type="checkbox"/> Musculoskeletal Issue	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Enlarged Prostate	<input type="checkbox"/> Gout	<input type="checkbox"/> Seizures
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other

Preventative History

Date of Last Colonoscopy	
Date of Last Influenza Vaccine	
Date of Last Pneumonia Vaccine	
Date of Last Tetanus Booster (TDaP)	
Date of Last Bone Density Screening	
Date of Last Mammogram	
Date of Last Pap Smear	

Drug Allergies

Current Medications

Prior Surgeries/Hospitalizations

Women Only

Age menstruation began ____ # of Pregnancies ____ # of Live Births ____
 Pregnant? Yes No Planning Pregnancy? Yes No

Men Only

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? Yes No
 How often does this occur? Frequently Sometimes Rarely

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Social History	
How would you rate your general health?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Fair <input type="checkbox"/> Poor
What is your marital status?	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
How would you describe your occupation?	
What is your employment status?	<input type="checkbox"/> Fulltime <input type="checkbox"/> Parttime <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Self <input type="checkbox"/> Student
What is your living situation?	<input type="checkbox"/> Alone <input type="checkbox"/> With family members <input type="checkbox"/> With caregiver <input type="checkbox"/> Assisted living
Do you use alcohol?	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily
Do you use tobacco products?	<input type="checkbox"/> No <input type="checkbox"/> Quit (When) <input type="checkbox"/> Yes (# packs/day # years)
Do you use drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes Type/Frequency
Do you drink caffeinated beverages?	<input type="checkbox"/> No <input type="checkbox"/> Yes Amount/day
Do you exercise outside of normal daily activities?	<input type="checkbox"/> 5+ days/wk <input type="checkbox"/> 3-4 days/wk <input type="checkbox"/> 1-2 days/wk <input type="checkbox"/> occasionally <input type="checkbox"/> zero Exercise consists of
What is your stress level?	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High

Family History	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						
Arthritis						