Muskogee Family Medicine

Brad McIntosh, M.D.
Jason Dansby, M.D.
Justin Roberts, APRN-CNP

PATIENT INFORMATION

Patient **Last** Name

First Middle

Mailing Address

City State Zip

Birthdate SSN

Marital Status Gender

Indicate if we may leave a voice message with medical information at the numbers below by marking yes or no.

Primary Phone

Secondary Phone

Employer:

Work Phone:

Parent/Guardian or Spouse name:

Birthdate: Phone #

Address if different from patient:

City State Zip

Please indicate your preferred method(s) of receiving appointment confirmations below

☐ Text Message: Phone #

☐ Email:

☐ Voice: Phone#

Insurance Company Name

Cardholder's Name

Cardholder's Date of Birth SSN

Cardholder's Employer:

Cardholder's Relationship to Patient:

PRIVACY NOTICE

I have been provided a copy of Muskogee Family Medicine HIPPA notice of privacy practices

I authorize the physicians of Muskogee Family Medicine to provide medical care to the patient. Also, to release any medical information necessary to process claims and request payment of benefits from Medicare or other insurance to myself or to this clinic.

RELEASE OF MEDICAL RECORDS

In addition to the above statements, I also authorize realease of my protected health information to the following persons:

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Name Relationship to Patient

Note: If no individuals are listed above, the patient and/or legal guardian(s) are the ONLY persons who will have access to ANY health information. If you would like your spouse to have access to your health information, you MUST list them here

I agree to all of the above and attest that the information provided is complete and accurate to the best of my ability.

Patient Signature: Date

(Parent/Guardian signature if patient is a minor)

Printed Name of Signer:

Office use only:

Initial of staff:

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PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in many insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit and you will be provided information to submit your own claim. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service unless you have documentation that your deductible has been met. Failure to collect co-pay and deductibles from our patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit if we notify you that a service is not covered by your insurance. If we are not aware the service is not a covered benefit until we receive notification from your insurance company, you will then be asked to pay in full as soon as we notify you.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims if you are insured with a company with which we are currently contracted and we will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will be asked to sign a payment agreement. If you do not meet the obligations of your agreement, the total balance of your account will become due immediately. You will not be allowed to increase your balance during the period of your payment agreement. If you continue to have a delinquent account you will be referred to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physicians will only be able to treat you on an emergency basis.

8. Missed appointments. There is a $25 charge for missed appointments. Kindly call us 24 hours in advance to cancel or reschedule your appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

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Patient Consent for E-Mail Transmission of Protected Health Information

1. RISK OF USING E-MAIL

Transmitting patient results by e-mail has a number of risks that patients should consider before authorizing receipt of e-mail transmissions. These include but are not limited to the following risks:

a. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) recommends that e-mail that contains protected health information be encrypted. All transmissions from Muskogee Family Medicine will be encrypted and will require the patient to establish an account with a password to view.

b. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.

c. E-mail senders can easily misaddress an e-mail.

d. Back-up copies of e-mail may exist even after sender has deleted his copy.

e. Employers and on-line services have a right to inspect e-mail transmitted through their systems.

f. E-mail can be used to introduce viruses into computer systems.

g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

2. CONDITIONS FOR USE OF E-MAIL

Muskogee Family Medicine cannot guarantee the security and confidentiality of e-mail but will use reasonable means, including e-mail encryption, to maintain security and confidentiality. The facility and physicians are not liable for improper disclosure of confidential information that is not caused by practice or physician intentional misconduct. Patients must acknowledge and comply with the following:

a. All e-mails sent from the facility will be one way. Patients will not be allowed to respond since the e-mail address will not be monitored. The e-mails will be sent from donotreply@muskogeefamilymedicine.com

b. Provide a valid e-mail address and inform the facility of any future address change.

c. Establish an account to open encrypted e-mails upon receipt of first encrypted e-mail.

d. Protect his/her password to the encrypted e-mail.

3. PATIENT ACKNOWLEDGE AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail from Muskogee Family Medicine, and I consent to the conditions outlined as well as any other instructions that the practice may impose to communicate with patient by e-mail. If I have questions, I may inquire with the manager.

E-mail address (please print)_____

Patient Name Printed_____ DOB_____

Patient signature_____ Date_____