

PLEASE PRINT

Date _____

Name _____
First Middle Last A.K.A

Social Security Number _____ Date of Birth _____

Mailing Address _____
Street City State Zip Code

Primary Phone _____ Secondary Phone _____

Work Phone _____ Email Address _____

Contact Preference: Mail Phone E-Mail Phone Text

Race: American-Indian or Alaska Native Asian Black / African-American
 Pacific Islander/Native Hawaiian White Hispanic or Latino

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Primary Language: English Spanish German Other _____

Marital Status _____ Spouse's name _____

Emergency Contact Name _____ Tele. Number _____

Family Physician _____ Referred by _____

Insurance Information

Please give your insurance cards to the receptionist to copy at every visit.

Name of Insurance Company _____

Policy Holder's Name _____ Date of Birth _____

Policy ID Number _____ Group Number _____

Policy Holder's Social Security Number _____

Address to Mail Claims _____

Name of Secondary Insurance _____

Policy Holder's Name _____ Date of Birth _____

Policy ID Number _____ Group Number _____

Policy Holder's Social Security Number _____

Address to Mail Claims _____

Patient Signature _____ Date _____



We appreciate the opportunity to provide gynecological/obstetrical services to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. To help minimize fee increases, to be as fair as possible to all patients and to our practice, and to reduce confusion and misunderstandings between our patients and the practice we have adopted the following financial policy. If you have any questions about this policy, please discuss them in advance with our front office personnel.

Full payment is due and expected at the time of service.

For your convenience, we will accept cash, check, money order, and all major credit cards.

If you pay by check and it is returned to our office for any reason, the amount of the check will be reinstated to your existing balance, along with a service charge of \$30.00 plus any bank fee charged to Smoky Mountain OB-GYN. Payment of these amounts must be made immediately in the form of cash or money order.

Your insurance policy is a contract between you and your insurance company; the physician is not involved. If your insurance company does not pay the practice within a reasonable length of time, we will look to you for payment. If for any reason you do not pay for services and your account goes to collection status, you will incur a \$10.00 late fee per month to your account balance.

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment when you arrive for your appointment. Most insurance plans will not allow us to see you without you paying the required copayment.

Medicaid Patients

We accept Medicaid insurance. It is the patient's responsibility to bring a signed valid card and a Carolina Access referral number, if necessary, to **ALL** visits. If you do not have a valid card with you at each visit, we may reschedule your appointment to a time when you can bring it. For non-pregnant adults (21 and over) on Medicaid, a \$3.00 copayment is expected at the time of the visit.

Medicare Patients

We currently accept assignment on Medicare. This means we have agreed to accept Medicare approved amounts and we will file your Medicare claim for you, however, Medicare only pays 80% of the approved amount leaving a 20% copayment to be paid by the patient. A yearly deductible may also be due if you have not met this at the time of service. We will file secondary insurance as a courtesy to you.

Medicare will not pay for a list of services they have deemed not medically necessary. For those services, Medicare requires Smoky Mountain OB-GYN to have you sign a waiver acknowledging that you have been informed that Medicare will not pay, and that you will be solely responsible for payment of that service. Payment is expected at the time of service for these noncovered services. If you are a Medicare recipient and did not receive this form, please check with our front office personnel.

Managed Care Plans

If we are a participating provider, we will file your insurance. Your copayment is expected before being seen by the provider and if your yearly deductible has not been met then it may be collected as well. For services not covered by your plan, payment in full is expected at the time of service.

Others

We will provide you with the necessary paperwork to file your insurance so that you will be reimbursed as soon as possible. If we file the claim for you, it is a courtesy and payment is still the responsibility of the patient.

Laboratory testing may receive a separate billing statement from Pathology.

Failure of any insurance company to pay does not excuse the patient's responsibility. It is the patient's responsibility to know what is covered by their policy, and what is not covered. There are many different insurance companies with many plans to choose from. It is impossible for us to keep up with each patient's individual policy.

Medical Forms

We will be happy to complete health forms including those related to Family Medical Leave (FMLA) and disability; however, because of the time involved in completing these documents, there is a \$25.00 service charge. An appointment is needed with one of our nurses to complete these forms. Payment is due at the time of the appointment.

Missed Appointments

In order to provide the best possible service and availability, we do maintain a "wait list". Please call us as early as possible if you know you will need to reschedule your appointment so that one of the patients on the wait list can be scheduled. We do reserve the right to charge our office visit fee for any appointment not cancelled at least 24 hours prior to the appointment time.

After 2 missed scheduled appointments and no advance notice, you will only be scheduled for the last appointment in the morning or the last appointment of the day. After 3 missed appointments you will be discharged from the practice.

I have read and understand the Financial Policy of Smoky Mountain OB/GYN, my Patient's Rights and Responsibilities and I agree to be bound by its terms. I also understand and agree that such terms may be amended at any time by the practice without prior notification.

(Signature of Patient or Responsible Party)

(Date)

(Please Print the Full Name of the Parent/Legal Guardian)

(Please Print the Full Name of the Patient)

Privacy Authorization

I have read the NOTICE OF PRIVACY PRACTICES and have been given the opportunity to ask questions. I hereby authorize the use of this signature for release of information for treatment, payment and daily health care operations. This authorization will remain in effect until revoked in writing.

Listed below are individuals with whom Smoky Mountain OB/GYN is authorized to disclose protected health information:

___ Spouse Name: _____ Relationship: _____

___ Significant Other Name: _____ Relationship: _____

___ Any Other Person Name: _____ Relationship: _____

___ Leave MESSAGE on Answering Machine (please check if OK)

(Signature of Patient or Responsible Party)

(Date)

(Please Print the Full Name of the Parent/Legal Guardian)

(Please Print the Full Name of the Patient)