JOHN R HARTMAN MD & ASSOCIATES

PATIENT INFORMATION FORM

Name _____
(DO NOT USE NICKNAMES)

Date of Birth_____ Marital Status_____ Sex_____

Social Security_____ Home # (_____)_____

Cell # (_____)_____ Work # (_____)_____

Home Address_____

City_____ State_____ Zip Code_____

Employer_____ Occupation_____

Address_____

City_____ State_____ Zip Code_____

Spouse's name:_____

Nearest Relative / Friend, ***Not Living With You***_____

Relationship_____ Phone_____

RESPONSIBLE BILLING PARTY:

Name_____ Date of Birth_____

Relationship to Patient_____ Social Security_____

Home # (_____)_____ Work # (_____)_____

Address_____

City_____ State_____ Zip Code_____

Employer_____ Occupation_____

Address_____

City_____ State_____ Zip Code_____

_____

Whom may we thank for referring you to us ?_____

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY.(See Reverse Side)

_____ _____

SIGNATURE DATE PLEASE PRINT NAME

Rev 071911

JOHN R. HARTMAN, MD & ASSOCIATES
Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carriers. We accept cash, personal checks, Visa and MasterCard.

2. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept assignment of benefits. If you are required to pay a co-payment it is due at the time of service. **If a co-pay is not paid at the time of service, we reserve the right to charge a statement fee.**

4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

5. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you as a courtesy of unassigned benefits. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

6. We will bill your insurance for all the services provided in the hospital. You are responsible for any balance due.

7. **FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with an outside medical record company to make copies for which the charge may be passed on to the patient**.

8. The practice reserves the right to charge the patient for any form completion or letters which are requested.

9. **The practice reserves the right to bill you for any appointment which is not cancelled 24 hours in advance, when allowed for by insurance contract.**

10. The practice reserves the right to bill you for any collection or attorney fees necessary to collect any unpaid debt.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of patient (or responsible party, if minor) Date

_____

Please print the name of the patient

Patient Insurance Authorization

Patient's Name (Please print) _____ Date _____

I authorize the release of any medical information necessary to process medical claims on my behalf. I also request payment of benefits to myself or John R. Hartman, M.D. & Associates; John R. Hartman, M.D., Pearl S.Huang-Ramirez, M.D. or Lori White, A.R.N.P.

Patient's or Authorized Person's Signature _____ Date _____

I authorize the release of my medical records to consulting specialists or facilities for the continuation of care as deemed necessary by my provider.

Patient's or Authorized Person's Signature _____ Date _____

I authorize the release of my financial records to my spouse or authorized parent or guardian for the purpose of reconciliation of my account.

Patient's or Authorized Person's Signature _____ Date _____

Patient's Relationship to Insured: _____

Insured's Name: _____

Insured's Date of Birth: _____

Insured's Social Security: _____

How did you hear about our practice? _____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____ , understand that as part of my health care, JOHN R. HARTMAN MD & ASSOCIATES originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that JOHN R HARTMAN MD & ASSOCIATES is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that JOHN R HARTMAN MD & ASSOCIATES reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

The patient agrees that the Practice may NOT disclose the following types of information contained in the Patients medical records (please initial the appropriate categories listed below):

_____ HIV/AIDS Information _____ Mental Health Information
_____ Substance Abuse Information _____ Sexually Transmitted Disease Information
_____ If Patient is under the age of eighteen (18), Pregnancy Information

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept the terms of this consent.

_____ _____
Patient's Signature Date