CLINE FAMILY PRACTICE

Mark A. Cline, M.D.
4604 NE Stallings Drive
Nacogdoches, Texas 75965
(936)559-8770 Fax(936)559-8773

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell: _____

Marital Status: S M D W SS#: _____ Email: _____

Employer: _____ Full Time / Part Time

Employer Address: _____ City, State, Zip: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Mailing Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext. _____ Cell: _____

Marital Status: S M D W SS#: _____ Email: _____

Employer: _____ Full Time / Part Time

Employer Address: _____ City, State, Zip: _____

SIGNATURE: _____ DATE: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

******You May Refuse to Sign This Acknowledgment******

I, _____, have reviewed a copy of this office's Notice of Privacy Practices. Upon my request, I may obtain my personal copy from the business office.

_____ _____

SIGNATURE (Parent or Guardian must sign if patient is under 18.)

DATE

_____

RELATION TO PATIENT (if patient is under 18)

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ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to Cline Family Practice for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Cline Family Practice to: 1) release any information necessary to insurance carriers regarding my illness and treatments; 2) to process insurance claims generated in the course of examination or treatment; and 3) to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Cline Family Practice on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

SIGNATURE (Parent or Guardian must sign if patient is under 18.) DATE

_____

RELATION TO PATIENT (if patient is under 18)

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HIPAA NOTICE OF PRIVACY PRACTICES

The following people have my permission to pick up my medical records:

_____ _____

_____ _____

The following people have my permission to pick up my prescriptions:

_____ _____

_____ _____

The following people are authorized to talk with you regarding my medical information:

_____ _____

_____ _____

If the patient is a MINOR, the following people are authorized to bring my child for medical care:

_____ _____

_____ _____

******These authorizations are good until I change them in writing.******

_____ _____

SIGNATURE (Parent or Guardian must sign if patient is under 18.) DATE

_____

RELATION TO PATIENT (if patient is under 18)

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PATIENT FINANCIAL POLICY SHEET

In order to reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment (for the patient due portion of the service) is due at the time of service. For your convenience we accept VISA and MasterCard. Payment for co-pays will be taken at the time of check-in.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized deductible and co-payment at the time of service. It is the policy of our office to collect this deductible and co-payment when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim. However, each insurance company has its own version of "usual and customary" and the patient will be responsible for payment of this amount.

- In the event that your health 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.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

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

_____ _____

SIGNATURE (Parent or Guardian must sign if patient is under 18.) DATE

_____

RELATION TO PATIENT (if patient is under 18)