PATIENT INFORMATION FORM **PLEASE COMPLETE ENTIRE FORM**

Name: ____ Date of Birth:______________SS#:_______________
Last First MI
Address:______________________________________ City/State:_______________________ Zip:_______________
Home Phone:_____________________ Cell: ____________________________ Work:___________________________
Email Address: ____Age:________________ Sex: M / F

May we leave a message on an answering machine or voice mail for any of the numbers above?___________

Spouses Name:____ Spouses Date of Birth_____________________
Parents Name if Minor:_______________________________________ Parents Phone:__________________________
**Person Responsible for this Account:_________________________________ Phone:___________________________

EMERGENCY CONTACT INFORMATION

Emergency Contact Person:____________________________________ Phone Number:_________________________

AUTHORIZED FAMILY/FRIEND: Whom may we speak to regarding your medical treatment/condition/billing?

____ ______________________________________
Print Name and Relation to Patient Print Name and Relation to Patient

PHYSICIAN INFORMATION

Referring Dr.____ Primary Care Dr.________________________________

PHARMACY INFORMATION

Name:_________________________________ Address:___________________________ Phone:____________________

EMPLOYMENT INFORMATION

Patients Employer:_____________________________________ Occupation: __________________________________
Employers Address:____________________________________ Employers Phone:_____________________________

Is this visit related to a work related injury? YES/NO (please see receptionist for additional form)
Is this visit related to a Motor Vehicle Accident? YES/NO (if yes, **STOP** immediately we DO NOT bill to NF)

PRIMARY INSURANCE ***It is your responsibility to check with your Insurance Company to see if a referral is needed***

Name of Insured:___________________________ Relationship to Patient:_____________ Birth date:_________________
Insurance Company:________________________ Subscriber/Member ID #:______________________________________

SECONDARY INSURANCE

Name of Insured:___________________________ Relationship to Patient:_____________ Birth Date:_________________
Insurance Company:________________________ Subscriber/Member ID#:_______________________________________

IMPORTANT INSURANCE INFORMATION: If your Insurance Carrier requires a REFERRAL PRIOR to your appointment, it is up to you and your Primary Care Physician to obtain the authorization. If your claim is denied due to not having this prior authorization, you will be responsible to pay the bill in full. I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any neglect on my party for failure to update insurance information. **INITIAL** _________

PRIVACY NOTICE ACKNOWLEDGEMENT: I acknowledge that I am aware Notice of Privacy at Dr. Medved's. I understand that I may request a copy of these privacy practices at any time: **INTIAL**________

I acknowledge that I have received and understand our office **Financial Policy & Procedures and Patient Disclosure Requirement.**

____ ____________________________
Patient/Responsibility Party's Signature Today's Date

Please keep for your records

Louis H. Medved, MD
Neurology
Electromyography & Infusion

FINANCIAL POLICY & PROCEDURES

Welcome to our Practice!

It is our desire to provide quality medical care to all our patients in an efficient manner, as well as complying to all generally acceptable standards of care and Federal/State laws!

INSURANCE BILLING: If you have medical insurance that we participate with, we will gladly submit the claim for you. It is your responsibility to update the office with changes in your insurance, failure to do so will result in a financial burden on you for any uncovered or unauthorized services. If we do not participate with your insurance then you are responsible for all charges at the time of service.

CO-PAYMENTS: Insurance companies usually require their members to pay a "Co-Pay" for their office visit. All co-pays are due at check in prior to your visit with the physician. Failure to pay your required co-pay will result in a billing fee of $25.00.

DEDUCTIBLES: Your deductible is considered to be your "Out of Pocket Expense" (OOP), this is to be paid by you before your insurance carrier will cover your medical expenses. We will require an upfront payment before your visit with the physician. If you are not able to pay the required down payment, we may ask you to reschedule appointment when you able to pay the required deposit.

****You should call your Insurance Carrier if you have any questions regarding your Co-Pay, Deductible, Referrals and Physician's Participation.**

APPOINTMENT CANCELLATION: When we make an appointment for you, we reserve time on Dr. Medved's schedule just for you. If you cannot make your appointment we ask that you give us the courtesy of a 24 Business Hour (Monday-Friday 8:30-4:30) call. Leaving appointments on the schedule that you not going to show for is both a financial burden to the practice and denies care to other patients. Failure to cancel appointment within the appropriate time frame will result in a $50.00 "No Show" or same day cancellation fee.

EMERGENCIES: Emergencies are those medical conditions that require immediate attention. We are a Specialist, we do not have same day "urgent" appointments available. If you feel you are experiencing an emergency or life threatening condition, call 911 immediately.

PRESCRIPTION REFILLS: Please allow at least 48 Business Hours for your prescription refill request to process, Controlled Medications may take up to 72 Business Hours, so please allow ample time when requesting refills. Our office utilizes the Surescript e-prescribing system for sending all prescription requests to your pharmacy. In order to process a refill request on your medication, contact your pharmacy. Your pharmacy will then send our office an electronic refill request. ALL requests are done electronically! **PLEASE NOTE**: We can only refill prescriptions that our healthcare provider has originally prescribed. If you have not been seen in our office with the last year, you will need to make an appointment before we can refill the prescription.

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PAPER WORK REQUEST: All paper work requests are subject to a $25.00 fee, prior to filling out any forms, this is including but not limited to, FMLA, disability and DMV forms. **We will not fill out any paper work if you have an outstanding balance until its Paid in FULL.** Please allow 5-7 Business days for completion. We will be more than happy to fax/mail your forms for you, however please be sure that you have completed your portion of the form.

MEDICAL RECORDS: Your medical record is strictly confidential. No information will be released to anyone or place without your written consent to do so. If you wish to have your medical records released to another party for any reason you will need to complete an authorization form requesting where you would like your records sent. We cannot accept authorization over the phone. We have forms available in our office that you may come in and complete. Please allow 7-10 Business days to process your request.

BILLING CHARGES: A $25.00 service charge will be added to an unpaid balance after 30 days. If your bill remains unpaid after 90 days you will be sent to a Collection Agency/Attorney. Any additional collection fees are the patients responsibility. In addition, the office reserves the right to terminate the doctor/patient relationship if your account is sent to collections. The office will follow all Federal/State requirements as to continuity of care upon dismissal from the practice and you will receive a letter of notification of termination.

PAYMENTS: We gladly accept VISA, Master Card, Discover, American Express, Cash and personal checks NOTE: there will be a $25.00 fee for any returned checks.

DISCLOSURE REQUIREMENTS

HOSPITAL AFFILIATIONS: Dr. Medved is affiliated with Rochester Regional Health and Strong Memorial Hospital, however he does not provide inpatient coverage at any hospitals.

SURPRISE BILL MANDATE: Dr. Medved participates in **most** Commercial and Workers Compensation Insurance plans; however, we do not participate in Department of Labor Workers Comp, No Fault and straight Medicaid.

OUTPATIENT FACILITY SERVICES: If you are referred for further testing outside of our office, we will provide you with the facility name, address and phone number. You, the patient are ultimately responsible to verify with the facility that your insurance is accepted before having any tests performed.

Dr. Medved and his staff work hard to provide you with high quality care. Any time service is rendered, whether it is for an appointment, form completion, referral, prescription refill or some other service, it generates a cost to the practice. It takes time, equipment and supplies to respond to your needs and provide you with outstanding medical care. Payment of your bill ensures the availability of our services to you and others.