Westwood Primary Care PLLC.
Confidential Patient Information

Today's Date:

Patient Information			
PATIENT'S NAME:		SS#	
Address		City, State	Zip Code
Home Phone	Cell Phone	Work Phone	
Birth date	Age/Marital Status	M ☐	☐ Female
Employer/School/Occupation		E-MAIL	
Emergency Contact		Relationship	Phone
Race/Ethnicity		Pharmacy Preferred:	Location

IS TODAY'S VISIT RELATED TO A WORK INJURY? _____YES_____NO / CAR ACCIDENT: ____YES_____NO

Primary Financial Responsibility		
Primary Holder	Relationship to Patient	
Home Phone	Cell Phone	Work Phone
Birth date	**SS#**	

Primary Insurance	
Insurance Company	Phone #
ID#	Group#

Secondary Insurance	
Insurance Company	Phone #
ID#	Group#

Consent to Treatment

☐ I am the patient ☐ I am the parent/guardian of the patient ☐ Other Relationship

I herby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing. I understand that medical students, under supervision, may be involved in my care.

Signature of Patient/Parent/Guardian : **Date:**

Acknowledgement of Receipt of Office & Financial Policy

☐ I am the patient ☐ I am the parent/guardian of the patient ☐ Other Relationship

I acknowledge that I have received the Office and Financial Policy of Westwood Primary Care PLLC and agree to its terms.

Signature of Patient/Parent/Guardian: **Date:**

Confidential Patient Information

Acknowledgement of Receipt of Joint Notice of Privacy Practices
This Joint Notice of Privacy Practices applies to the privacy practices of the Affiliated Entities and the Entities participating in the Organized Health Care Arrangement. These Entities include: Westwood Primary Care PLLC. This form is used to document (a) an individual's acknowledgement of receipt of our Joint Notice of Privacy Practices of (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.
Section A: Individual
Section B: Acknowledgement of Receipt of Joint Notice Of Privacy Practices I acknowledge that I have a Joint Notice of Privacy Practice from Westwood Primary Care PLLC. **Signature:**_______________ **Date:**_______________ Personal Representative's Name: Relationship to Individual:
Section C: Good Faith Effort to Obtain Acknowledgement of Receipt Describe your good faith effort obtain the individual's signature:_______________ _______________ Describe the reason why the individual would not/could not sign this form: _______________ _______________ Signature: _______________ Date:_______________ Print Name:_______________ Title:_______________ Include this Acknowledgement of Receipts in the individuals Medical Records

Assignment of Benefits
☐ I am the patient ☐ I am the parent/guardian of the patient ☐ Other Relationship I acknowledge full responsibility for the payment of services received and agreed to pay them in full at the time of service unless other arrangements have been made. I understand that insurance coverage is an arrangement between the insurance carrier and the patient. Westwood Primary Care PLLC will assist in billing my insurance company, but I am ultimately responsible for payment should my insurance fail to pay within a reasonable amount of time. I authorize Westwood Primary Care PLLC to bill my insurance or third-party payer and receive payment directly from them for services rendered. I also authorize Westwood Primary Care PLLC to release information as required to my insurance or third-party payer (including my employer's worker's compensation carrier), for the purpose of determining benefits. I understand that such records may include information regarding HIV/AIDS testing, substance abuse and /or mental health issues. A photocopy of a faxed copy of this authorization shall be deemed as valid as the original. My signature signifies acceptance of all terms in this Assignment of Benefits. **Signature of Patient/Parent/Guardian:** **Date:**

Staff Witness to signatures: Date Witnessed:

Westwood Primary Care, PLLC
Magnolia Family Medicine
FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

MAGNOLIA FAMILY MEDICINE/WESTWOOD PRIMARY CARE PLLC
FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE: Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable copayments, coinsurance and deductible payments for participating insurance companies. We accept cash, personal checks (in-state only), Visa, MasterCard, Discover and American Express.

THERE IS A SERVICE CHARGE FEE OF $30.00 FOR ALL RETURNED CHECKS

LATE FEES: Patients with an outstanding balance of 30 days overdue must make arrangements for payment prior to scheduling appointments. ***There will be a $30.00 MONTHLY LATE FEE CHARGE on any balance after 30 days.*** *All accounts more than 120 days past due will be transferred to a collections agency and you will be responsible for all agency fees and would adversely affect your credit rating with the credit bureaus.*

INSURANCE: We bill participating insurance companies as a courtesy to you. You must present your most recent insurance card at the time of service. You are expected to pay your deductible/copayments at the time of service in full. *VERIFICATION OF BENEFITS IS NEVER A GUARANTEE OF PAYMENT: ALL CLAIMS ARE SUBJECT TO THE TERMS OF YOUR PLAN AFTER FILING YOUR CLAIM*. If we have NOT received payment from your insurance company within 45 days from the date of service, you will be expected to pay the balance in full. You are responsible for all charges and all late fees. Your time of service receipt includes all information necessary for submitting claims to your insurance company. We do bill secondary insurance companies if applicable.

MANAGED CARE: If you are enrolled in a managed care insurance plan (i.e. HMO) you must present your most recent insurance card with our Primary Care Physician’s name on it. If you do not have it at the time of service we will reschedule your appointment for a later date. Referrals will be given only after consultation with one of our doctors. You must receive a referral from our office before seeing a specialist. NO retroactive referrals will be given.

OUT OF NETWORK: We accept a variety of insurance plans, and due to the complexity of managed care contracts, we suggest patients to verify our doctors participation of IN NETWORK STATUS with their insurance company prior to making the appointment AT MAGNOLIA FAMILY MEDICINE.

REFUNDS: Overpayments will be refunded upon written request within 30 days to the responsible party.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed/late-canceled appointments. Excessive abuse of scheduled appointments may result in the discharge from the practice.

I have read and understand WESTWOOD PRIMARY CARE PLLC FINANCIAL POLICY. I agree to assign insurance benefits to Westwood Primary Care PLLC whenever necessary. I also agree that if it becomes necessary to forward my accounts to a collections agency I will be responsible for all collection fees.

Signature of patient/authorized representative___________________________________Date:____________