Beckett Ridge
FAMILY MEDICINE

Financial Policies

Patient Name (print): _____ **Date of Birth**: _____

Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. If you have any questions, do not hesitate to ask a member of our staff.
Please read each section carefully and sign at the bottom.

Appointments:

- We value the time we have set aside to see and treat you. If you are not able to keep an appointment, we would appreciate a 24-hour notice. There is a charge of $50-$100, depending of the type of visit, for missed appointments (no show) that are not cancelled within 24 hours of the scheduled appointment time. NOTE: Multiple no shows may result in dismissal from the practice. **Please initial highlighted boxes below.**
- If you are late for your appointment, we will do our best to accommodate you. In order to avoid needing to reschedule, please make sure to arrive a few minutes before your scheduled appointment time. _____

Insurance Plans:

Please understand: It is **your** responsibility to keep our office updated with your correct insurance information and to notify us of any insurance changes prior to your scheduled appointment. ***Bring your insurance card to every office visit.*** _____

- If the insurance company you designate is incorrect or the policy is inactive, we will do our best to work with you to get the correct information. However, we **cannot** see you without valid insurance information. You may reschedule your appointment or self-pay for the visit.
- It is **your** responsibility to understand your insurance benefit plan. Only you and your member services can verify if our office or our laboratory (LabCorp) are in your plan network. We can't determine if services are covered prior to being seen, and we are not able to estimate what your charges will be prior to processing with your insurance company.

Co-pays and/or account balances are due at each visit:

- Co-pays **cannot** be billed. If you are unable to pay co-pay at the time of your visit it may be necessary to reschedule.
- If you have a balance on your account, regardless of whether you have received a statement, you will be asked to pay that balance prior to being seen. We make every effort to notify you prior to your appointment of any balances. If you need to set up payment arrangements please contact our billing department *prior* to coming in for your appointment.

Referrals:

- It is **your** responsibility to know if a written referral or authorization is required to see specialists, whether pre-authorization is required prior to a procedure, and what services are covered.
- Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember, we must approve referrals before they are issued.

Financial Responsibility:

- According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances.
- Self-pay patients are expected to pay for services ***in full*** at the time of the visit. Self-pay visits range from $130- $175 depending on the type of visit and if you are a current patient or a new patient. _____
- We ***do not*** bill medical insurance for auto accident-related claims. The cost of each appointment related to an auto accident must be paid ***in full*** at the time of the visit. The charge for such a visit is $130, payable by cash or credit only. _____
- We do not provide Work-Related Injury/Care Management ("Workers-Comp") services.
- A fee of $25 will be charged for the completion of FMLA, Disability, and other miscellaneous medical statements.
- Patient balances are due immediately upon receipt of your insurance plan's explanation of benefits (EOB). If a statement is issued, balances are due within 21 business days from the statement date. Unless previous arrangements have been made with our billing office, any account balance outstanding longer than 21 days will be charged a $25 late fee for EACH 21-day billing cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.

My signature below acknowledges that I have been made aware of the above policies.

Signature (patient or legal representative**): _____ **Today's Date:** _____

** Name/Relationship to Patient (if signed by legal representative): _____

4870 Wunnenberg Way, West Chester, OH 45069
Phone: 513.860.4600 Fax: 513.860.9059

Beckett Ridge Family Medicine

Patient Name: _____ DOB: _____ Today's Date: _____

APPOINTMENT POLICIES

Patient Name: **Date of Birth:**

As a family practice, Beckett Ridge Family Medicine sees patients for a wide variety of appointment types. Each appointment type is billed, coded, and scheduled differently. As a result, it is crucial that there is well-established communication regarding what type of appointment is needed. *Please read the following information and sign at the bottom.*

- Please be aware of the different types of appointments:
  - Pre-Op Physical: An appointment for surgical clearance ONLY. It is NOT a Preventative Annual Physical.
  - Preventative Annual Physical: An appointment for preventative care ONLY. No new issues or concerns will be discussed. It is not a follow-up appointment for medication refills. It is NOT a Well Woman visit for pap smears and breast exams.
  - Well Woman Visit: An annual visit for pap smears and breast exams. It is NOT a Preventative Annual Physical. It is not a follow-up appointment for medication refills.
  - Well Child Check: An annual visit for pediatric patients to assess growth and development. It is NOT a Sports Physical. It is not a follow-up appointment for medication refills.
  - Sports Physical: An annual visit for school-age patients for clearance to participate in school sports and activities. It is NOT a Well Child Check. It is not a follow-up appointment for medication refills.
  - Follow-Up: An appointment for medication refills and/or a previously-addressed issue/concern. No new issues or concerns will be discussed.
  - Sick Visit: An appointment for a new issue or concern. It is not a follow-up for medication refills.
  - ER/Hospital Follow-Up: An appointment to discuss a recent hospitalization or emergency room visit. It is not a follow-up appointment for medication refills.

- Only one appointment type can be scheduled per visit. Appointment types cannot be combined in one visit. (e.g., A Sick Visit for new onset back pain at a medication Follow-Up appointment.)

- Please be sure to let the office staff know exactly what appointment type you need upon scheduling. We cannot assume the appointment type that you are needing.

- Appointments and office notes cannot be changed or re-coded for past/completed appointments.

My signature below acknowledges that I have been made aware of the above appointment policies.

Signature (patient or legal representative*): _____

*Name/Relationship to Patient (if signed by legal representative):

Today's Date:

Beckett Ridge
FAMILY MEDICINE

HIPAA

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alterative means such as sending correspondence to the individual office instead of the individual's home.

Patient's Name (print): _____ **Date of Birth:** _____

I consent to all applicable means of communication by Beckett Ridge Family Medicine (BRFM) unless specified otherwise.

Check **ONLY** the ways in which you **DO NOT** wish to be contacted:

☐ Telephone:
- Specify restriction(s) [i.e. do not leave message with test results]: _____

☐ Written communication [not applicable for billing statements]:
- Specify restriction(s): _____

☐ Electronic Communication [i.e. patient portal, automated reminder calls/texts, etc.]:
- Specify restriction(s): _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and the request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Health care entities must keep record of PHI disclosures, Information provide below, if completed properly will constitute and adequate record.

NOTE: Uses and disclosures for reasons other than treatment, payment or operations may be permitted without prior consent in an emergency.

Beckett Ridge Family Medicine has permission to discuss/disclose my health information to the following individuals:
(** If leaving blank, please initial in the box below.)

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

** _____ **Initial here if your health information should not be disclosed to anyone but you.**

My signature acknowledges that I have been provided with a copy of the Notice of Privacy Practices (Version Effective 9/24/2013)

Signature (patient or legal representative*): _____ **Date:** _____

*Name/Relationship to Patient (if signed by legal representative): _____

4870 Wunnenberg Way, West Chester, OH 45069
Phone: 513.860.4600 Fax: 513.860.9059

Beckett Ridge
FAMILY MEDICINE

Patient Name:	First Name: MI:	Last Name:
Street Address:		
Mailing Address:		
Home	Work	Cell
Date of Birth:		
Social Security Number:		

Insurance Information

Primary Insurance:		
Phone Number:		
Insurance Address:		
Subscriber Name:		
Date of Birth :		
Subscriber ID:		
Group Number:		
Emergency Contact Name:		
Phone Number:		
Pharmacy Name:		
Pharmacy Number:		

I authorize Beckett Ridge Family Medicine to render treatments and/or medical advice for the betterment and well being of myself and or my dependant. I authorize the release of my independently identifiable health information including a photo copy of my signature for purposes of providing care and processing insurance claims. I authorize payments of benefits due to me to be made directly to the practice or physicians within the practice. In the event that I receive payment from my insurance company, carrier, or agent I acknowledge that the funds belong to the practice or physicians, of this medical practice. I, further, give permission for this office to release any medical information, dictation, lab results, or billing information about me to any medical specialist, physician healthcare giver or agency, or persons I authorize.

Signature of Patient or Legal Guardian: _____ Date: _____