BOZEMAN CREEK family health

# Patient Registration

Welcome to Bozeman Creek Family Health. We are committed to providing the best, most comprehensive care possible. Please assist us by providing the following information. All information is confidential and only released with your consent.

Thank you for allowing us this opportunity to care for you!

**Patient Information**

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Sex: M / F Social Security #: _____

Preferred Language: _____ Ethnicity (please circle): Hispanic Non-Hispanic

Race (please circle): White Black Asian Indian/Alask Pac Isle Other/Mult

Parent(s) / Guardian(s) Name (Minors Only): _____

Mailing/Billing Address: _____

City: _____ State: _____ Zip Code: _____

Primary #: _____ Secondary #: _____

Employer: _____ Work #: _____

Email: _____ Would you like to receive your billing statements via email? Yes___ No__

**How would you like to be contacted for your Appointment Reminders? [ ] Voicemail [ ] Email [ ] Text Message**

**May we leave clinical messages or healthcare information on the following:**

**Answering machine/Voicemail? [ ] yes [ ] no #: _____ Email: [ ] yes [ ] no _____**

How were you referred to our practice? (please ck) [ ] Doctors Office_____ [ ] Current Patient/ Friend _____

[ ] Insurance [ ] Phone Book [ ] Website [ ] Event_____ [ ] Internet Search_____ [ ] Other_____

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**In Case of An Emergency Please Contact**

Name: _____ Relationship: _____ Phone #: _____

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**Financial Information**

Insurance Company: _____ Policy #: _____ Group#: _____

**If you are NOT the policy holder on your insurance account, please fill out the following:**

**Subscriber: _____ Subscriber DOB: _____**

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**I hereby acknowledge that I have been presented with a copy of the Bozeman Creek Family Health notice of Privacy Practices.**

**Patient/Guardian Signature:** _____ **Date:** _____
**Print Patient Name:** _____
**Relationship to patient:** Self, Parent, Guardian, Responsible Party, Legal Representative, etc _____

## Authorization to Disclose Health Information

*As a patient of Bozeman Creek Family Health, you are protected under The Health Insurance Portability and Accountability Act of 1996 (HIPAA). We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.*

I authorize _____ to inquire about:
*(Print name of: parent, significant other, spouse, family member, etc.)*

**Please check all that apply:**

☐ Payments/Charges

☐ Health Information (prescriptions, test results)

☐ Consult with my Doctor regarding my healthcare

**Patient Signature:** _____ **Date:** _____

## Insurance Authorization

I hereby authorize Bozeman Creek Family Health to furnish information to my insurance carriers concerning my illness and treatments. I also authorize payments of insurance benefits to be made directly to Bozeman Creek Family Health. I understand that I am responsible for all charges incurred.

**Patient/Guardian Signature:** _____ **Date:** _____
**Print Patient Name:** _____
**Relationship to Patient:** Self, Parent, Guardian, Responsible Party, Legal Representative,etc _____

# No Show and Cancellation Policy for Medical Appointments

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement a no show/cancellation policy effective Jan 1st, 2008. The policy enables us to better utilize available appointments for our patients in need of medical care. We offer reminder call services as a courtesy, which does not void patient responsibility for keeping scheduled appointments.

## Cancellation:

As a patient in our clinic, it is your responsibility to keep scheduled appointments. Bozeman Creek Family Health requires notification of cancellation at least 24 hours prior to the scheduled appointment time. BCFH will consider it a "failed appointment" any time a patient has not given the advanced notice required above or fails to arrive within 10 minutes of their scheduled appointment time. If a patient has 3 failed appointments in a one year period, BCFH will no longer schedule appointments for that patient.

## No Show:

If a patient fails to arrive at the scheduled appointment time and does not call to cancel the appointment, the patient will receive a letter in regards to the missed appointment. If a patient has 2 "no show" appointments in a one year period, BCFH will no longer schedule appointments for that patient.

**All patients will be charged a $75.00 fee for every failed appointment or no show.**
**If you feel there has been an error in scheduling or believe you deserve special consideration, please let us know and you may speak with our Office Manager.**

Print Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

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# Credit Policy

It is the concern of our entire staff that financial matters do not become a burden, nor stand in the way of your receiving the best, most timely medical attention. It is for this purpose that we have formulated the following Credit Policy:

1. If you have insurance coverage, we will gladly file your insurance claim for you. We do request payment of any co-payment or deductible at the time the services are rendered. If you do not have insurance coverage, we request that you pay for all services when rendered.

If you are separated or divorced, the parent bringing the child in for treatment is responsible for payment at the time of service. Whatever financial agreement exists between you and your spouse is strictly your agreement and not part of our credit policy.

2. We currently are member physicians with MT Co-Op, United Health Care, Allegiance/Cigna, Blue Cross/Blue Shield of Montana, Pacific Source, First Health network, Interwest Network, Multi-plan Network, Medicare and Medicaid of Montana. However, we remind you that your insurance policy is a contract between you and your insurance company and does not affect our credit policy.

This practice is committed to providing the best medical treatment possible for our patients and charges what is usual and customary for our area. **You are responsible for payment in full regardless of your insurance company's determination of usual and customary allowances.**

3. We recognize the need to set up payment arrangements for patients who require extensive treatment. Any accounts with a balance of over $200 or more are asked to see our business office personnel to set up a payment plan.

4. Should circumstances arise where your account still has a balance one year from the date of service we ask that you seek alternative financial options and pay your account in full. Accounts that become greater than 90 days delinquent, with no attempt by the responsible party to make arrangements for payment, will be turned over to an independent collection agency.

5. Accounts returned to us as "undeliverable", i.e., moved without forwarding address, etc., will be held for one month, and if no contact is made, will be turned over to an independent collection agency.

6. In the event that an account must be turned over to a collection agency, we will request that you and your family seek medical care from another physician in the community. Failing to fulfill your payment obligation injures the mutual respect of the patient-doctor relationship set forth to ensure the highest quality of medical care; thus, we must insist the relationship be terminated. You understand that should you default on payment of your account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of your account.

The biggest single misunderstanding and possible source of problems for you and for us occurs when there is no communication about your financial matters. Please feel free to discuss fees and financial arrangements with us at any time. We are more than happy to work with you so that there is never a time that your medical care causes a financial burden. We will do our best to ensure that we fulfill our part of this agreement with you, and trust that you will do the same.

Patient/Guardian Signature: _____ Date: _____

Print Patient Name: _____