PALM MEDICAL GROUP PATIENT INFORMATION

PATIENT INFORMATION

Last First M.I.		D.O.B.	Social Security Number	Sex M F / Marital Status S M D W
Maiden Name Ethnicity/Race Primary Language		EMERGENCY CONTACT		Relationship
Address Street		Home Phone ( )		Cell Phone ( )
City State Zip		Employer		
Home Phone ( )	Cell Phone ( )	Name of your Primary Care Physician		Phone
E-Mail Address		Name of physician who referred you to our office		Phone

PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION)

Last First M.I.		Relationship	Social Security Number
Street		Employer	Occupation
City State		Street	
Home Phone ( )	Cell Phone ( )	City State Zip	

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Insurance Company	Phone	Insurance Company	Phone
Insured's Name	Date of Birth	Insured's Name	Date of Birth
Policy Number	Group Number	Policy Number	Group Number

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that there is a new health care act (HIPAA – The Health Insurance Portability and Accountability Act) that serves to protect my personal health information. I have been given the opportunity to review Palm Medical Group's privacy practices and to take a copy of it home with me if I would like. I understand that my personal health information is important to the associates of Palm Medical Group, and that they will not misuse my personal health information in any way.

CONSENT FOR TREATMENT

I hereby authorize and consent to diagnostic testing and treatment as ordered by my physician. I authorize Palm Medical Group's physicians, nurses, medical assistants, employees and others as necessary, to carry out the instructions of my doctor with respect to the procedures and treatment he has ordered.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the physician or group indicated on the claim. I understand that I am responsible for any deductibles, co-payments or amounts for services not covered by my insurance plan. All professional services rendered are charged to the patient, or guarantor, if a minor. In the event of collection proceedings due to lack of payment, there may be additional charges for any and all collection fees. A copy of the signature is as valid as the original.

Signature of Patient (or legal representative) Relationship Date

PALM MEDICAL GROUP

9280 W. Sunset, Suite 306
Las Vegas, NV 89148
(702) 696-7256
FAX (702) 796-7256

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We ask that all patients take a few moments and review our financial policy, initialing each item. Our practice accepts cash, debit cards, checks, Visa and MasterCard. Should you have any questions, please do not hesitate to request to speak with our staff.

_____ ***Cash Patients:*** Payment is due at the time services are rendered.

- We offer a 30% discount off our fee schedule if payment is made in full at the time of service.
- A minimum of 40% of your charges are due at the time of service. Full payment of the balance due is required before your next visit.

_____ ***Co-payments and deductibles:*** All co-payments, co-insurances, and deductibles are due at the time of service unless you have secondary insurance or an HRA account. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances, and deductibles from patients can be considered fraud. Please help us in upholding our contractual obligations by paying your co-payment or deductible at each visit.

_____ ***Insurance:*** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

_____ ***Proof of insurance and coverage changes:*** All patients must complete our patient information form before seeing the doctor. We will obtain a copy of your driver's license (or other valid identification card) and current valid insurance card to provide proof of insurance. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

_____ ***Returned checks*** are subject to a $25.00 returned check fee. If a check is returned, unpaid, it is the patient's or guarantor's responsibility to pay the balance, including the returned check fee, within 10 business days of notification to avoid further collection activity.

_____ ***Missed Appointments –Arriving Late:*** Our physician's schedules are booked out weeks or months in advance. If you fail to show, or arrive late for an appointment we are unable to offer that appointment slot to another patient who needs it. Please help us to serve you better by keeping your regularly scheduled appointments. **Cancellations are required at least 24 hours prior to the appointment. Any patient who do not show up on time for an appointment or cancel with less than 24 hours' notice may be charged a $50.00 missed appointment fee. This fee is your responsibility and must be paid before a new appointment will be scheduled. Patients with three missed or late arrival appointments will be asked to the transfer their care to another providers office.**

_____ ***Late Fee***: You acknowledge and agree that we will necessarily incur direct and indirect costs and expenses as a result of any failure by you to make prompt and timely payment for services provided. Accordingly, and to the extent the law allows, in the event your account remains unresolved after 120 days from the date of service, you agree we may add a late fee of $25.00 to the unpaid amount of your account to offset the additional direct and indirect costs we will have to incur to recover your outstanding medical bill.

I have read and understand this Financial Policy

_____ _____

Signature of Insured/Guarantor/Patient Date