VINEYARD MEDICAL CARE

VINEYARD HAVEN, MA 02568
508-693-4400

Patient's Legal Name: _____ **Date of Birth:** _____

Social Security No: _____ Marital **Status:** _____ **Sex:** M F Other: _____

Landline Phone: ☐ _____ Cell **Phone:** ☐ _____
(Please check preferred number)

Permanent Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Summer Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Race: White African American Asian American Indian Other_____ Decline to Answer

Language(s) Spoken: _____

Insurance Information

WALK-IN PATIENTS MUST CALL THEIR **PRIMARY CARE PROVIDER** FOR A **REFERRAL** IF REQUIRED

PLEASE NOTE THAT ALL LABORATORY FEES ARE SEPARATE CHARGES FROM YOUR OFFICE VISIT

Primary Care Provider: _____

Primary Insurance Company: _____

AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND REFERRAL MEDICAL RELEASE

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance utilization management, and complaint resolution. I authorize payment directly to VMC for all medical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductible and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original. I agree to pay all collection charges including reasonable attorney fees if it is necessary to pursue payment of the account. I have read this information and I understand it.

Patient Signature: _____ Date: _____

Signature of Patient/Parent, Guardian or Authorized Representative (Guardian or Authorized Representative must have documentation)

Print Name: _____ Relationship: _____

HIPAA CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal healthcare information is protected. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information only to those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

DOB: _____ Print Name: _____

Date: _____ Signature: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that our employees undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalty or retaliation if they feel that an event in any way compromises our policy of integrity. In addition, we welcome your input regarding any service problem so that we may remedy the situation properly.

Thank you for being one of our highly-valued patients.

Vineyard Medical Care Financial Policy

Your Responsibility – You are financially responsible for any services rendered by Vineyard Medical Care. Many patients have obtained insurance coverage to assist with their medical costs. Your insurance plan is specific and does not guarantee coverage. You should review your plan coverage to determine what you are obligated to pay. It is the patient's responsibility to know their coverage. Vineyard Medical Care will assist you through the process of insurance coverage when possible, but it is impossible to know the specifics of each individual plan. The patient is responsible for the bill should the insurance company decline payment. As a courtesy, we will file a claim to your primary and secondary insurance plans. Co-payments and charges for non-covered services are due at the time of service. Any balance remaining after insurance has paid their portion of covered services will be due upon receipt of the bill. VMC does not bill for specialists' services including but not limited to diagnostic lab tests performed at another facility or specimens forwarded to another facility.

Cancellation/No-Show Policy- We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance you may be charged a $75 fee; this would not be covered by your insurance company.

Medicare Patients - Vineyard Medical Care accepts Medicare assignment. You are responsible for coinsurance, deductibles, and any charges for non-covered services. If no response is received from your secondary insurance, you will be responsible for any remaining balance.

Mass Health Patients - Vineyard Medical Care accepts assignment for Medicaid patients. A current Medicaid card must be presented at each visit.

Private Insurance Patients-

- Vineyard Medical Care accepts assignment for many major insurances. You will be required to pay applicable co-payments at the time of service and you are responsible for any coinsurance, deductibles, and payments for non-covered services.
- Vineyard Medical Care is pleased to be able to provide services to patients that do not have an accepted assignment. However, if you have insurance that it is not accepted by VMC, you will be expected to pay a fee of $170 at the time services are provided. We will be glad to provide you with a claim summary to file a claim with your insurance plan in order for you to request reimbursement.

Patients Without Insurance - Vineyard Medical Care is pleased to be able to provide services to patients that do not have insurance. However, if you do not have insurance, you will be expected to pay an adjusted fee at the time services are provided.

HMO Patients - If Vineyard Medical Care participates with your insurance, you will be required to pay the applicable co-pay at the time of service. When required, you are responsible for obtaining a referral for Vineyard Medical Care allowing us 48 hours to process the referral. If you do not have a proper referral, you may be required to reschedule your appointment

Liability Insurance – We do provide treatment for Worker's Compensation, motor vehicle or personal injuries. In order to have these billed properly, we ask that you provide any claim number associated with the incident and the billing address.

Methods of Payment - We accept cash, check, VISA, MasterCard and Discover. We do not accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made as necessary.

Returned Checks -There will be a $20.00 fee assessed for any and all checks returned from the bank for any reason.

Prior Balance - If you have a prior balance at the time services are requested, you will be asked to pay the prior balance in full before being seen. If the balance cannot be paid in full, then we may consider monthly payment arrangements.

Collection Procedures - Members of our billing department are available to help you with questions and or payment arrangements. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/physician relationship. Prompt payment for services rendered is expected and failure to comply or respond to repeated communications from our office may result in immediate discharge from the practice with 30-day emergency coverage and/or involvement of an outside collection agency. Once an account has been referred to an outside agency, prior balances must be resolved before being seen by a physician. Any expense incurred as a result of VMC's attempts to collect past due balances will become the responsibility of the patient or guarantor, including all collection agency fees.

For questions or concerns regarding your statements you may contact the Billing Office at 800-787-1596

I have read and understand the terms of this contract.

Patient/Responsible Party:_____ Date_____

Vineyard Medical Care

Patient Authorization to Release Protected Health Information to Family, Caregivers or other designee(s)

I, _____, ____/____/____ authorize my health care
(Print Full Name) (Date of Birth)

providers/advocates of Vineyard Medical Care to release all medical and billing information; including mental health, laboratory and diagnostic testing including HIV, to the individual(s) named below. This authorization will become part of my medical record and will remain in effect until the date of my death.

I understand that my personal medical information may further be released by the designee(s) I have listed below, if those designee(s) are not required by law under the Health Insurance Portability and Accountability Act (HIPAA) to protect the privacy of the information, or in the event the information is no longer protected by federal regulations governing privacy regulations.

I understand I am authorizing release of my protected health information to my designee(s) as provided below, and that I may revoke this authorization, except to the extent that my health care providers have already taken action based on this authorization, at any time by notifying Vineyard Medical Care in writing.

*****Please advise us in writing if there is any exception to this release*****

I understand I am under no obligation to sign this authorization, however it is not valid unless signed.

Please enter information of friends and/or family members:

Name: **Address:**

Relationship to Patient: **Home #:** **Cell#:**

Name: **Address:**

Relationship to Patient: **Home #:** **Cell#:**

Name: **Address:**

Relationship to Patient: **Home #:** **Cell#:**

_____ _____

(Patient Signature) **(Date)**