Premier Independent Physicians™

Demographic Information

Patient Name	**Date of Birth**	**Sex** Male / Female
Social Security Number / **Email**		**Marital Status** Single / Married / Widowed / Divorced / Other
Mailing Address	**City/State**	**Zip Code**
Primary Phone	**Secondary Phone**	**Work Phone**

I authorize detailed messages containing pertinent medical information to be left in a voicemail at the following numbers:
□Primary Phone □ Secondary Phone □ Work Phone □ Emergency Primary □ Emergency Secondary

Responsible Party □ Self □ Other – Information Below

Name	**Mailing Address** [☐ **Check if Same as Above**]
Date of Birth / **Primary Phone**	**Social Security Number**
Employer's Name	**Relationship to Patient**

Emergency Contact	**Emergency's Primary Phone**	**Emergency's Secondary Phone**
Pharmacy Name and Address		**Pharmacy Phone Number**
Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown		**Language** □ English □Other_____
Race □ American Indian or Alaska Native □ Asian □ White □Other □ Black or African American □ Native Hawaiian or Other Pacific Islander		**Appointment Confirmation Preference** □Email □Primary Phone □Text □None □Other Contact_____

Protected Health Information Authorization

Name	Relationship	Type of Information Authorized
1.		□All □Scheduling □Medical □Billing
2.		□All □Scheduling □Medical □Billing

I have reviewed the above information and authorize my protected health information to be released to the individuals listed, as specified. I understand that this authorization applies to both written and verbal communications. I also understand that I may request to revoke this authorization, in writing, at any time.

_____ _____

Signature of Patient/Legal Representative **Date**

Insurance Information

Primary	Secondary	Tertiary
Insurance Company	**Insurance Company**	**Insurance Company**
Insured Date of Birth	**Insured Date of Birth**	**Insured Date of Birth**
Member ID/ Policy #	**Member ID/ Policy #**	**Member ID/ Policy #**
Group #	**Group #**	**Group #**

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our Patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check, cash, debit card, Visa or Mastercard.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This offices' policy is to collect this co-payment when you arrive for your appointment.

Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary care physician (PCP), or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the Patients' share of the medical fees owed when using non-contracted physicians will usually be more than when using contracted physicians.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of the balance that is designated as the Patients' responsibility is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office or from your insurance.

Keep in touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. You will be held responsible for services not paid by your health plan.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, or the parent or guardian with custody, for payments.

I have read and understand the financial policy of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

_____	_____
Printed Name of Patient	**Date of Birth**
_____	_____
Signature of Patient/Legal Representative	**Date**

Premier Independent Physicians™

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed, or have been given the opportunity to review this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

** If you would like to receive a copy of our Notice of Privacy Practice, please ask an associate.*

_____	_____
Printed Name of Patient	**Date of Birth**
_____	_____
Signature of Patient/Legal Representative	**Date**

Premier Independent Physicians™

Prescription Policy

Our practice is a medical office that treats many types of ailments and conditions. On occasion we may prescribe medications for you to help relieve pain. These medications, when used properly, can help patients feel better and lead productive lives. These medications can also be misused, causing harm to patients and to others. For this reason, the State of Oklahoma and the Federal Drug Enforcement Administration regulates use of these medications. Our practice follows those laws:

Our Policy:

1. Written prescriptions will not be replaced if lost, stolen, destroyed, or misplaced.
2. Prescriptions are to be taken as directed. In other words, DO NOT change the frequency of the dose unless otherwise directed by your physician. If a change does occur, this will be documents in your chart.
3. By law, controlled substances cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office in the past three months, prescriptions for the following cannot be refilled. Exceptions to this must be discussed with the physician during an office visit. Exceptions will not be granted over the phone.
    a. Sleep Aids such as Ambien or Lunesta
    b. Anti-inflammatories such as Celebrex, Ibuprofen, or Naproxen
    c. Narcotics such as Lortab, Vicodin, Darvocet, or Hydrocodone
    d. Muscle Relaxers such as Soma, Flexeril, or Robaxin.
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will NOT be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough medication.
7. Before you visit our practice, please check your supply of medication. If you need refills, please ask for them during your appointment.
8. Refill request for hormone replacement and birth control pills can only be refilled if you have a routine gynecology appointment scheduled.
9. Refill request for prescriptions not prescribed by you physician will not be authorized.
10. At least 2 business days are needed for prescription request. Call before Friday.
11. Do not call more than once about a medication, refills, or any issue. When you call our office, a message is sent to your physician. Nothing can be done until you physician has a change to review the message. The physician is the only one who can approve for your medication to be refilled. Everyone who answers the phone are able to take refill request, so it is not necessary to ask for a nurse/MA.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescriptions refilled. I agree to abide by this policy and understand that this signed policy will be scanned into my chart.

_____ _____

Printed Name of Patient **Date of Birth**

_____ _____

Signature of Patient/Legal Representative **Date**

Premier Independent Physicians™

Authorization to Release Healthcare Information

This is a release form for authorization of your medical information to be used/and or disclosed between **health care providers, health insurance companies and any other party involved in your medical care.**

I, _____, hereby authorize the following facilities/hospitals and doctor(s) to release all medical information to our practice to better manage my health.

This request includes: hospital summaries, laboratory reports, physician progress notes, and any other healthcare information relating to my condition.

**List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:*

*1*_____

*2*_____

*3*_____

*4*_____

*5*_____

_____ _____

Printed Name of Patient **Date of Birth**

_____ _____

Signature of Patient/Legal Representative **Date**

Premier Independent Physicians™

Cancellation and No-Show Policy Acknowledgement

In an effort to minimize waiting periods and improve appointment availability we have found it necessary to enact a Patient Cancellation Policy. Any patient that cancels an appointment **with less than 24-hour notice** and/or does not show up for their appointment will have their credit card on file automatically charged a fee of $50 for missed appointment. **If there is no credit card on file, patient will have to make the late charge payment prior to being given another appointment.** Additionally, after 2 cancelled appointments, we will be unable to accommodate schedule requests. We hope this policy will ultimately benefit all patients by improving the quality of your treatment experience.

I understand Premier Independent Physicians cancellation policy.

_____

Signature and Date

CREDIT CARD ON FILE: BILLING AUTHORIZATION

The undersigned agrees and authorizes Premier Independent Physicians to charge the credit card indicated below for collection of patient responsibility for late cancellations and no-show fees.

Name as it appears on card: _____

Type of Card:

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Card Number:

Expiration Date: _____(month/year) Security Code: _____ (last 3 digits on back)

I authorize Premier Independent Physicians to process credit card as "signature on file" for late cancellations and no-show fees. I understand this authorization will expire upon conclusion of care.

_____

Cardholder's Signature and Date