PATIENT REGISTRATION 2022

(Updated Yearly)

PATIENT INFORMATION: (IF SEVERAL CHILDREN PLEASE LIST NAMES AND DATES OF BIRTH)

NAME: _____

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

DOB: _____ SS #:_____ SEX: M F HOME #:_____

E-MAIL ADDRESS: _____ Cell #: _____
(By providing your email address you are consenting to Liberty Medical Center staff to use it to send appointment reminders, etc)

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

PATIENT EMPLOYMENT INFORMATION:

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____ WORK #:_____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

HOME #:_____ WORK #:_____

INSURANCE POLICY HOLDER:

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP:_____
DOB: _____ S S #:_____ SEX: M F HOME #:_____

WORK #: _____ RELATIONSHIP TO PATIENT: _____

RESPONSIBLE PARTY EMPLOYER: _____

EMPLOYER PHONE #: _____

Insurance card/cards must be given at time of service and at any time it is requested by this office. If at any time your insurance changes, please let us know, so the proper insurance is filed in a timely manner. If incorrect information is given, you will be responsible for the entire bill.
ALL CO-PAYS, INSURANCE DEDUCTIBLES AND CO-INSURANCES ARE DUE AT THE TIME OF SERVICE.

I authorize payment of medical benefits to be made directly to Liberty Medical Center.

Signed: _____

(TURN OVER)

_____I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
Obtain payment from third-party payers.
Conduct normal healthcare operation, such as quality assessments and physician certifications.
Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

_____ I have been informed by you of your "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such "Notice of Privacy Practices" prior to signing this consent. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

_____ I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this account.

_____ We have adopted a policy that requires authorization from the patient to leave a detailed message for that patient. This is to protect the privacy of the patient and to protect the physician and staff of this practice from violating the patient's confidentiality. If there is not a signed consent on file, Dr. Malisos or the staff will only leave their name and telephone number on an answering machine, voicemail, or with a person answering the phone asking the patient to return the call.

By completing the consent below, you are allowing this medical office and its staff to leave a message on an answering machine, email, voicemail, or with a specified individual. You can specify what information is left and with whom. By signing, you are also consenting to the mailing, emailing or faxing of any results requested by you or another physician involved in your care.

I give my consent to Rodney Malisos, MD and the entire staff of Liberty Medical Center to leave a message regarding scheduling, treatment, surgery, lab, radiology results, or other information as necessary

____ on answering machine, email or voicemail at home or cell phone or work.
(please cross off any contact method you are not comfortable with being contacted at)

I give consent to share any and all medical history:

____ With _____ Relationship _____

____ With _____ Relationship _____

_____ **I DO NOT** consent to messages being left at home, work, or with any other person.
I wish to make an individual appointment each and every time I need to be notified by anyone from this office staff for any reason.

_____ _____
Patient's Name (Please Print) DOB

_____ _____
Patient's Signature Date

_____ _____
Witness Date

PATIENT FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES

Liberty Medical Center believes in communicating our office and financial policies to our patients and want you to have a full understanding of these policies.

1. **PAYMENT** is expected once the insurance claim has been processed and a self-pay balance is posted. Payment will include any deductible, co-insurance, co-payment amount, and charges not covered by your insurance company. If you do not carry insurance, or if your coverage is not accepted at our office, payment in full is expected at the time of your visit. All non-filed services are expected to be paid at the time of service.

2. **INSURANCE** We are participating providers with most commercial insurance plans. Please verify with our staff to insure we are in network with your plan. We will file all claims for these plans. Please remember that insurance is a contract between **the patient** and **the insurance company**. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. If you have a managed care plan that requires a prior authorization for a service or procedure, you must obtain the authorization in order for your visit in our office to be covered under your medical insurance. If this is not the case and you still wish to be seen, you will be asked to pay for the visit prior to your services. In order to bill your insurance and meet filing guidelines we ask for a copy of your insurance card and a photo ID.

3. **NON-COVERED SERVICES/SELF PAY** This office offers access to many innovative services and procedures at a self-pay rate. You will be responsible for payment in full at the time of service.

4. **BILLING AND COLLECTION FEES** Liberty Medical Center will submit a claim for payment to your insurance company. In the event your insurance carrier/company denies the services provided, you will be responsible for the full amount. We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay an additional $150.00 fee to cover the fees imposed to Liberty Medical Center by the collection agency in order to collect the outstanding balance.

5. **NO SHOW/LATE CANCELLATION** We understand that situations arise in which you must cancel your appointment. If you need to cancel your appointment, you must provide at least a 24-hour notice prior to your appointment time. Patients who do not show up or fail to provide a 24-hour notice are considered a NO SHOW and will be assessed a **$50.00 fee**. Patients who No-Show two (2) or more times in a 12-month period, may be dismissed from the practice.

I have read and understand the practice's office and financial policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

Signature of Patient/Guarantor _____ Date_____

CREDIT CARD ON FILE AGREEMENT

Liberty Medical Center has implemented a new credit card policy. We will be keeping a credit card on file for each patient account which will be used for payment of any self-pay balances due after insurance. This balance could include your co-pay, co-insurance, and/or deductible. This card will also be used for any account eligible for collections and any no show or late cancellation fees. At check in, your credit card information will be obtained and kept securely in your file.

If you have any questions about our policies, please ask.

By signing below, I authorize Liberty Medical Center to keep my signature and my credit card information securely on-file in my account. I authorize Liberty Medical Center to charge my credit card for any self-pay balances after insurance, no show or late cancellation fees when due. If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Liberty Medical Center a new, valid credit card which I will allow them to charge over the telephone. Even though Liberty Medical Center is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

* By verbally agreeing to these terms and/or by signing this form, I agree to allow Liberty Medical Center to charge my credit card for all expenses I owe and to write my signature for any credit card charges applied towards my account.

Visa □ MasterCard □ Discover □

Patient's Name (Print): _____ DOB: ___/___/_____
Name on Card (Print): _____
Credit Card Number: _____ CVV Number _____ Exp. Date: ___/___
☐ CARD WAS SCANNED INTO MY CHART

Please fill out information below for any other person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: ___/___/_____
Patient Full Name (Print): _____ DOB: ___/___/_____
Patient Full Name (Print): _____ DOB: ___/___/_____

By signing below, I agree with the above terms and give authorization for Liberty Medical Center to process any self-pay balance on my account that is due.

Credit Card Holder's Signature: _____ Date: _____

Our goal is to provide you with the best medical care possible. Annual physical exams give us a chance to address your overall physical and emotional health.

Regular office visits and sick visits differ from the preventative and wellness care that are provided in an annual physical exam visit. They differ because we address other new, ongoing, or medical issues of concern. These types of services need to be addressed separately from your annual wellness appointment. You can either discuss these concerns in your physical wellness appointment with the understanding that two separate visits will be billed to your insurance, and you will be responsible for any balance insurance has left over; or you can schedule a completely separate appointment.

Our goal is to address as much as we can in a quality manner during these visits. Please note and understand that the insurance companies do allow providers to address and discuss additional complaints not covered in a physical exam. If additional problems are discussed, an office visit will be billed in addition to your preventative physical exam code. We are required to submit billing in this manner. This could result in you owing a co-pay, co-insurance, or deductible for this date of service.

The coding rules set by the health care industry, specifically state, "If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventative medical evaluation service, then the appropriate visit code should also be reported."

Thank you for trusting your medical care to Liberty Medical Center. We look forward to helping you achieve the best health possible.

Sincerely,

Liberty Medical Center

I have read the physical exam and office visit letter and understand that I may be billed an additional charge from my insurance company. This charge may be a co-pay, co-insurance, or deductible that is not covered by my insurance under my annual preventative examination. I understand that I will be responsible for payment of this additional charge.

Patient name (PRINTED) _____ Date of birth _____

Patient signature _____ Today's date _____