ASPEN CREEK MEDICAL ASSOCIATES

Today's Date: ____/____/2011

PLEASE DO NOT ABBREVIATE ADDRESS INFORMATION
PLEASE PRINT CLEARLY

Section A: **Patient Information**

Primary Care Physician: Dr. Kent/ Dr. Kiley/ Dr. Ewer/ Dr. Henley/ Dr. Linsky/ Dr. Tibbs/ Dr. Zbylski/ NP-Lara Bouve/ PA-C Brenda Vanderwel

Last Name: **MI**: **First Name**: **DOB**: / / **SSN#**: - -

Race: White/Black/Asian/Indian Alaskan/Pacific Islander/Other/Multiple/Declined **Ethnicity:** Hispanic/Non-Hispanic/Declined

Preferred Language: English/Spanish/Other: **Marital Status**: S/M/D/W **Gender:** Male / Female

Email Address: **Name of Parents (if under 18)**:

Address: **City**: **State**: **ZIP**:

Home Phone: **Work Phone**: **Cell Phone**:

Employer Name: **Address**:

How did you hear about us (circle one): Friends and Family / Phone Book / Physician Referral / Internet/ Other:

Is the insurance policyholder the patient? **Yes / No**
If yes, skip section B & C and complete Section **D**

If no, is the policyholder's address and phone number the same as the patient? **Yes / No**
If yes, please complete section **B & D.**
If no, please complete section **B, C & D**.

Section B: **Policyholder's Information**

Last Name: **MI**: **First Name**: **DOB**: / / **SSN#**: - - **Gender:** M/ F

Address: **City**: **State**: **ZIP**:

Home Phone: **Work Phone**: **Cell Phone**:

Employer Name: **Address**:

Section C: **Policy Holder's address if different from the patient's**

Address: **City**: **State**: **Zip**:

Phone Number: (________)________________________

Section D: **Insurance Information**

Insurance Name:

Group#: **ID#**

DO YOU CURRENTLY HAVE MEDICAID/CHP? YES NO **IF YES, WHAT IS YOUR MEDICAID #**:

Pharmacy: *COSTCO / KINGSOOPERS / MEDICINE SHOPPE / SAFEWAY / SAMS CLUB / WALGREENS / WALMART* **Street Name:**

Emergency Contact (nearest relative not living with you)

Name: **Phone**: **Relationship to Patient**:

BY SIGNING BELOW I AM VERIFYING THAT I HAVE READ AND AGREE TO THE GUARANTORS BILLING AGREEMENT ON THE REVERSE SIDE OF THIS FORM.

GUARANTOR SIGNATURE: **DATE**:

PRINT NAME

1) I understand that if the insurance claim is denied due to incorrect information that I have provided, I will be billed, and payment in full will be due immediately.
2) I herby request and authorize Aspen Creek Medical Associates physicians & personnel to deliver medical care to the patient.
3) I verify that I have reviewed the information on the first page and that it is correct.
4) I verify that I have designated an Aspen Creek Medical Associates physician's within this office as the patient's primary care physician (PCP) with the patient's insurance company. I understand that if the insurance company denies paying the patient's claims because it is determined that one of these doctors WAS NOT the designated PCP in effect at the time of the visit that I may be responsible for paying in full for all services provided.
5) If Aspen Creek Medical Associates is contracted with the patient's insurance company, I authorize assignment of payment directly to the doctor for services provided to the patient. I understand that Aspen Creek Medical Associates will file the claim with the patient's insurance company and that I am responsible for following up with the insurance company to insure the patient's claim is paid within 60 days of the date of service.
6) I understand that if the patient has a PPO insurance plan, and the insurance has not paid the patient's claim within 60 days of the date of service, charges for that visit will become my responsibility to pay.
7) I understand that under the terms of the contract of the insurance company, co-payments must be paid at every visit.
8) If the patient has insurance that Aspen Creek Medical Associates is not contracted with, I agree to pay the bill in full at the time services are provided. I understand that Aspen Creek Medical Associates will file a claim with the patient's primary insurance company (except Tricare) as a courtesy but that is my responsibility to follow up with the patient's insurance company to insure personal reimbursement by them.
9) I understand that if I have no insurance coverage, I agree to pay the balance in full at the time services are provided to the patient.
10) I understand that medical records are the property of the physicians of Aspen Creek Medical Associates; however, the patient is entitled to photocopies, with sufficient advanced notice, upon the patient's written request. I understand that there may be a charge for these photocopies.
11) I hereby authorize the release of the patient's medical information to the insurance company concerning any illness and treatment associated with Aspen Creek Medical Associates.
12) I acknowledge that I can obtain a copy of the Aspen Creek Medical Associates Privacy Rights/HIPAA information from the front desk upon my request.
13) I understand that a **$35.00** fee will be charged for all appointments **except** physicals if missed or not canceled at least 2 hours in advance.
14) I understand that a **$70.00** fee will be charged for all Physical appointments if the physical appointment is missed or not canceled at least 24 hours in advance.
15) I understand that if the patient's account becomes past due, Aspen Creek Medical Associates will take the necessary steps to collect this debt. If Aspen Creek Medical Associates has to refer the patient's account to a collection agency, I agree to pay all of the collection fees. If Aspen Creek Medical Associates has to refer the patient's account balance to a lawyer, I agree to pay all legal fees incurred plus all court costs.
16) I understand that Aspen Creek Medical Associates may dismiss a patient from the practice if the patient and/or family have an outstanding balance.
17) I understand that if the patient is sent collections Aspen Creek Medical Associates will charge the patient up to $50 in interest for non-payment of an outstanding balance.
18) I understand that I am responsible for knowing the benefits of the patient's specific insurance company, and that Aspen Creek Medical Associates is not responsible for interpreting these benefits. Aspen Creek Medical Associates is also not responsible for how the patient's insurance company(s) processes the claims. I further understand that Aspen Creek Medical Associates **cannot** serve as an intermediary between the insurance company and the patient in claims processing or claims disputes; and that I must personally resolve these matters with the patient's insurance company.
19) I understand that it is the patient's responsibility to inform Aspen Creek Medical Associates if the patient chooses not have their insurance billed at the time of service.
20) I understand that Aspen Creek Medical Associates will not be responsible for claims sent to the insurance company that identify specific conditions that the patient is wanting to keep private if the patient does not inform Aspen Creek Medical Associates prior to checking out at the time of service.
21) I understand that if the patient chooses not to bill his/her insurance at the time of service payment is due in full at check out.
22) I understand that Aspen Creek Medical Associates cannot quote prices prior to treatment however prices may be quoted but not guaranteed at the time service

<u>I verify that the information on the reverse side of this form is current and unchanged. If this information is not current I will be billed for any denied claims.</u>