

LAKELAND FAMILY MEDICINE
155 McDonald Drive SW
New Philadelphia, OH 44663
Phone: 330-308-8999 Fax: 330-308-8016
www.lakelandfamilymedicine.com

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PATIENT REGISTRATION FORM

Please Print Clearly

Patient Information

Legal Name _____	Patient Employer _____	Student _____
Mailing Address _____	Race _____	
City/State/Zip _____	Language Spoken _____	
Home Phone _____	Cell Phone _____	Work Phone _____
Social Security # _____	(Circle One) Sex: M F	
Birthdate _____	Marital Status: Married/Single/Divorced/Widowed	
Local Pharmacy of Choice _____	(Must list one local pharmacy including City)	
Email Address: _____	(Required for access to Patient Portal)-coming soon	

Parent/Guardian Information (Person who is legally responsible for above person)

_____ <i>Guardian Information same as above</i>	
<i>Initial</i>	
Guardian Name _____	Guardian Employer _____
First MI Last	
Address _____	Employer Address _____
City/State/Zip _____	City/State/Zip _____
Guardian Phone # _____	Employer Phone # _____
Guardian S.S. # _____	Guardian DOB _____ Sex: M F

Insurance Information

Primary Insurance	
Name of Ins. Co _____	Effective Date _____
Policy # _____	Group/Plan # _____
Insurance Address _____	
City/State/Zip _____	Insurance Phone # _____
Policy Holder's Name _____	
Policy Holder's SS# _____	Policy Holder's DOB _____
Policy Holder's Address _____	
Policy Holder's Relationship to Patient _____	
Policy Holder's Employer _____	

Secondary Insurance	
Name of Ins. Co _____	Effective Date _____
Policy # _____	Group/Plan # _____
Insurance Address _____	
City/State/Zip _____	Insurance Phone # _____
Policy Holder's Name _____	
Policy Holder's SS# _____	Policy Holder's DOB _____
Policy Holder's Address _____	
Policy Holder's Relationship to Patient _____	
Policy Holder's Employer _____	

Insurance Claim Filing

We will submit all charges to all insurance (primary, secondary, etc.) as a **courtesy** to you. However, we do require all office visits, deductibles and co-pays be paid at the time of service. We cannot bill your insurance unless you bring **all current** insurance information with you. Copies of your information will be made for our files. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some services provided may be “**non-covered**” under the terms of your contract and, therefore, not paid by insurance. You are responsible for the payment of your deductible and co-pay if there is no secondary insurance. We also participate in many Managed Care Organizations and will comply with those contractual obligations.

UCR (Usual and Customary Rates) and Managed Care Participation:

Our practice is committed to providing the best treatment possible for our patients and we feel that our fees are reasonable and fair for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.** Unfortunately, each insurance company determines its own schedule of fees and they often vary widely. We will provide any information to the insurance company to assist them in determining the proper payment. If your managed care company requires a referral from your primary care provider, it is **your** obligation to monitor the referral status. We will assist you in pre-certification, prior authorization and follow-up care, but it is best if we cooperatively monitor referral status.

Self Pay with No Insurance

We have multiple payment options available to those patients who do not have insurance, including monthly billing plans. It is very important that payment be made in a timely and consistent manner. Please ask to speak with a billing counselor for more details about these programs.

Adult Patients: Adult patients are responsible for full payment of their accounts.

Minor Patients: Patients under the age of 18 years will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment. The adult, parent or guardian accompanying a minor will be responsible for full payment of the account.

SIGNATURE OF FILE

I request payment of authorized Insurance/Medicare benefits be paid to Lakeland Family Medicine, Inc. on my behalf. I authorize any holder of medical information about me to release to the Healthcare Financing Administration, any information needed to determine these benefits. I understand my signature authorizes the physician to furnish information to insurance carrier concerning my illness/accident necessary to pay my medical claims and I hereby irrevocably assign payments to Lakeland Family Medicine, Inc. I understand I am financially responsible for all charges, whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

Signature of Patient or Responsible Party (state relationship)

Date

**LAKELAND FAMILY MEDICINE, INC
FINANCIAL AND PRACTICE POLICIES**

Please read the following carefully as these bullet points explain our major financial and practice policies. We are committed to providing you with the best possible health care and appreciate your understanding and cooperation. Thank you in advance.

- **Your co-payment is due at the time of service. This is mandated by your insurance company. There will be a \$10 fee for billing you when your co-payment is not made at the time of your service. We accept cash, check, money order or credit card.**
- It is your responsibility to inform us of any change in your insurance, name, address, telephone number or employment.
- If you do not have your insurance information at the time of service, you will be considered “self pay” and you will be expected to pay your office visit in full that day.
- If you do not have insurance coverage or we are not contracted with your insurance carrier, you are considered “self pay” and payment in full is expected at the time of service.
- It is important for you to keep your scheduled appointment. **If you must reschedule or cancel an appointment, please provide 4 hours notice so that we can use the appointment time for another patient. A fee of \$25.00 will be applied if you miss an appointment without notifying us. If there are 3 missed appointments for you or your family, you may be dismissed from the practice.**
- It is important that you ask for medication refills when you are in the office for your scheduled follow up appointments or call your pharmacist who will be in contact with us. You may pick up “mail away” prescriptions at the front desk within 2-3 business days of your call. Refills on prescriptions will not be called in during the weekend when these are not documented in your chart.
- Personal Injury Cases: This office does not bill for auto accident, liability or law suit related cases. You are responsible for payment at the time of service. **You** must report visit charges to your liability company for repayment of your accrued charges. If you have exceeded liability medical coverage, we will bill your health insurance policy.
- Our medical providers have chosen **not** to become certified by the Bureau of Workers Compensation, therefore, if you schedule an appointment for a “work related injury”, you will be expected to pay your office visit in full, otherwise, call the Occupational Medicine Center of Tuscarawas County.
- Patients who are seen for an annual preventive exam and who request treatment for an acute illness or problem will be charged separately for each service, even when both services are provided on the same day. Insurance companies require separate codes for billing. Sorry. You can choose to reschedule your preventive appointment to a later date or just undergo both on the same day.
- **Due to our increased costs and our time involved, there is a charge of \$15 for forms that we are asked to fill out (disability, insurance, letters to attorneys or employers, FMLA, etc). There will be a \$10 charge for School forms, unless these forms are completed on your visit date.**
- Medical records copied for transfer of care are subject to a fee as delineated by ORC 3701.74.
- All balances are due upon receipt of your statement. You may qualify for a “medical line of credit” with one of our credit agencies. Please ask us about this or we may contact you to apply for this service in order to pay your medical expenses.
- There is a **\$25 charge for all returned checks for non-sufficient funds.**

NOTICE OF PRIVACY PRACTICES

Lakeland Family Medicine, Inc.

155 McDonald Drive SW
New Philadelphia, OH 44663
330-308-8999

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the way we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change in Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use of disclosure will be listed. However, we have listed all of the different way we are permitted to use and disclose information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, mid-level providers, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with law relating to workers compensation or other similar programs.

NOTICE OF PRIVACY PRACTICES

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you \$ 0.10 cents for each page, and postage if you want the copies mailed to you. You may receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
2. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
3. Request that we communicate with you about your medical information by different means or to different location. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
4. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
5. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer, Shirley Charette, at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us by sending a letter outlining any concerns you may have to:

Shirley Charette, PA-C / Privacy Official
Lakeland Family Medicine, Inc.
155 McDonald Drive SW
New Philadelphia, OH 44663

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.