Joshua Z. Steiner, D.O., P.A.

PATIENT INFORMATION SHEET

Date Completed: _____/_____/_____

NAME: _____ SEX: _____ MARITAL STATUS: S M W D

BIRTHDATE: _____/_____/_____RELIGION: _____PRIMARY LANGUAGE:_____

REFERRED BY: _____

ADDRESS: _____

CITY_____ STATE _____ ZIP _____

HOME PHONE:_____ CELL PHONE: _____

EMAIL: _____

EMPLOYER/SCHOOL: _____

TITLE:_____WORK PHONE: _____

ADDRESS:_____

CITY/STATE/ZIP: _____

SPOUSE/PARTNER: _____ BIRTHDATE:_____

SPOUSE EMPLOYER/SCHOOL: _____ CITY/STATE: _____

SPOUSE PHONE:_____

RACE/ETHNICITY: Caucasian African American Native American Asian Hispanic Latino Other_____ Refuse to Answer

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SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY *OTHER THAN SOMEONE LIVING WITH YOU:*

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE: _____ ID #:_____

SECONDARY INSURANCE:_____ID #:_____

Joshua Z. Steiner, D.O., P.A.

PATIENT INSURANCE RESPONSIBILITY

I hereby authorize my insurance company to make payments directly to my physician and further permit a copy of this authorization to be used in place of the original. This authorization applies to all claims submitted by my physician. I hereby authorize my physician to release any information required in the course of examination and treatment. I further authorize my physician to release any of medical records to any insurance company that may request them. This includes all information of HIV, drug use, psychiatric treatment, or other problems. I understand that my physician will comply with all applicable HIPAA regulations. There is no time limit on this record release.

I understand that a physical exam, school exam, or pre-operative exam including lab and diagnostic testing may not be a covered benefit under my insurance. I will be held responsible for any payment due. I understand that I should check before any lab work, diagnostic tests, or specialist visit that the provider is still affiliated with my insurance company as these can and do change frequently. My physician will not be held responsible for the fees of any lab, diagnostic facility, or specialist that is not covered by my insurance for any reason. If I find that a service will not be covered. I should call the office for a new referral.

A 1.5% late payment charge may be added to all unpaid balances not paid within 30 days of request. In addition, if this account is delinquent and is forwarded to a collection agency or attorney, I agree to pay any and all costs.

I understand the following message from my physician: To avoid any misunderstanding regarding medical insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. As a courtesy, we will prepare the necessary forms to help you obtain your benefits from your insurance company. We do not render our services on the basis that insurance companies will pay our fee, except in instances such as with specific PPO/HMO groups. If the insurance company does not cover our fee in full, the balance is due and payable by you.

Please sign below to indicate that you have reviewed the above information and give Joshua Z. Steiner, D.O.. P.A. permission to treat you.

_____ _____

Patient Signature Date

_____

Patient Name (printed)

MEDICARE BENEFICIARIES ONLY

I request that payment of authorized Medicare benefits be made to my treating physician for any services rendered. I authorize any holder of medical information about me to release to the Center for Medicare Services and its agents any information needed to determine these benefits or benefits payable for related services.

_____ _____

Patient Signature Date

Joshua Z. Steiner, D.O., P.A.

OFFICE FINANCIAL POLICIES

In order to better serve your needs and clarify any questions that you may have regarding your insurance, we have adopted the following financial policies. If you have any questions, please speak with one of our billing or managerial staff, and she will gladly assist you.

We will gladly file your insurance claim. Copayments, deductibles, and co-insurance amounts are collected at the time of service. We will verify your insurance coverage at each visit. All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified, you will be responsible for all charges.

As a courtesy to you, insurance forms for services rendered will be completed by our office and submitted to your primary insurance carrier. We will not file the secondary insurance – unless it is secondary to Medicare.

In the event that your health insurance plan determines a service to be "not covered", you will be responsible for the uncovered charge.

All forms and letters that we are asked to complete, including Disability forms, FMLA forms, Leave of Absence forms, jury duty excusals, letters regarding travel, and/or any requested correspondence that is not associated with reimbursement of a claim will incur a $25.00 fee to the patient.

NON-CANCELLATION OF APPOINTMENTS

There is a $25.00 charge to patients for a missed appointment without prior notice. Please call us no later than 9:00 AM on the day of your appointment to notify us of your cancellation.

RETURNED CHECK FEE

There is a charge of $50.00 in the event a check is returned for insufficient funds.

STATEMENT PROCEDURE

We will mail a statement to the address you have provided once we receive payment from your insurance carrier. If we do not have payment from you within 90 days, we will make every effort to notify you that the account is being turned over to our collection agency and may impact your credit rating.

MEDICAL RECORDS REQUEST

Any patient requesting records must submit a signed records release form and there will be a clerical fee of $1.00 per page to process.

I AGREE TO MY FINANCIAL RESPONSIBILITIES. I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICIES

_____ _____

Patient Signature Date

_____

Patient Name (printed)

Joshua Z. Steiner, D.O., P.A.

ALTERNATIVE COMMUNICATION RELEASE FORM

Patient Name: _____ Date of Birth_____

I authorize Joshua Z. Steiner, D.O., P. A. in regards to my protected health information (PHI):

(check as many as you wish)

[ ] To call me at work

[ ] To call me at home

[ ] To call my cell phone

[ ] To speak with anyone on the Right To Share Information list below

[ ] To speak only with me

[ ] To fax information to me at this secured number _____

[ ] Other_____

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Joshua Z. Steiner, D.O., P.A. reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy. In order to have your PHI shared in other circumstances with members of your family or friends, please list below those individuals to whom we are authorized to release information.

_____

_____

_____

_____

Signature of Patient_____ Date_____