

Liberty Doctors Patient Registration Form

PATIENT INFORMATION

Preferred Pharmacy	*Local pharmacy. This will be used to electronically send your prescriptions when possible.	In order to have access to your <u>Medication History</u> , Liberty Doctors needs your authorization. (PBM consent) Yes <input type="checkbox"/> No <input type="checkbox"/>			
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Cell Phone		Work Phone	
E-Mail		Date of Birth		Sex	M F
Marital Status	S M D W SEP	SSN		Race	
Preferred Language		Ethnicity			

RESPONSIBLE PARTY INFORMATION (if other than patient)

Relationship to Patient		*This area to be completed if responsible party is someone other than the patient (ie: minor child, legal guardian, etc...)			
Last Name		First Name		MI	
Address		City/State		Zip	
Home Phone		Cell Phone		Work Phone	
Date of Birth		SSN		Sex	M F

PRIMARY INSURANCE INFORMATION

Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer	
Policy Holder DOB		Policy Holder SSN			

SECONDARY INSURANCE INFORMATION

Insurance Name		Policy ID		Group ID	
Policy Holder Last Name		Policy Holder First Name		Employer	
Policy Holder DOB		Policy Holder SSN			

Emergency Contact Name		Phone #	
Patient/Legal Guardian Signature		Date	
Liberty Doctors Employee Witness Signature		Date	

Consent for Treatment, Assignment of Benefits, Release & Financial Policy

Thank you for choosing Liberty Doctors (LD) to meet your medical needs. We are dedicated to providing the best treatment available. **Carefully read and initial each section and sign and date the bottom.**

Patient Consent for Treatment

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by LD and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further stat that I understand that no guarantee has been or can be made as to the results of treatments or examinations at LD.

Initials _____

Assignment of Benefits & Release of Information

I hereby authorize treatment of myself or the minor described above. I hereby authorize LD to release my medical information to facilitate payment and coordination of care for rendered services. I authorize payment from my insurance company be assigned to LD. I understand that I am ultimately responsible for the balance of my account.

I authorize the release of all medical information necessary for LD to meet State and Federal reporting requirements. If receiving medical services for employment, I authorize the release of the results of my exam to my employer.

I authorize LD to obtain all of my medication/prescription history when using an electronic system to prescribe medications. I acknowledge that I retain the right to review LD Notice of Privacy Practices in the office upon request.

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Initials _____



LIBERTYDOCTORS
ASSURING HEALTHCARE FREEDOM

Financial Policy

Missed Appointments: A Missed Appointment fee may be charged if you do not show up for a scheduled appointment, or cancel with less than 24 hour notice. This fee must be paid before a new appointment is scheduled. You may be discharged from Liberty Doctors if you have more than 3 Missed Appointments.

Initials _____

Account Balances: Patient account balances are due within 30 days of the receipt of the billing statement. Balances must be paid prior to services being rendered. If you are unable to pay your balance in full, we will reschedule your appointment until payment arrangements have been established. If you have fail to make appropriate payment arrangements after 2 billing statements, your account may be turned over to an outside collection agency. If you have established a payment plan and fail to meet agreed upon terms, your account may be turned over to a collection agency. Accounts assigned to Collections may be charged a \$50 fee. Accounts turned over to an outside collection agency may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

Initials _____

Returned Checks: There is a \$35.00 fee for returned checks. This fee plus your balance is due when you are notified of the returned check.

Initials _____

Insurance: LD participates with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is in network with them. A **Valid Driver's License and Insurance Cards must be presented** at each visit. If you do not have your up to date insurance card, we will be happy to reschedule your appointment or classify your appointment as self-pay.

Initials _____

Self-Pay patients and patients who have not met their deductible are required to pay for services in full prior to leaving. It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. Please be aware there is a time limit on how long we have to file insurance claims. If we miss the deadline because you did not provide us with the correct information, you will be responsible for payment in full. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill. Please be aware that some and perhaps all of the services you receive may be non-covered by Medicare or other Insurers. You are responsible for any and all portions of the bill not covered by your insurance plan. You must pay for these services in full at the time of visit. **Co-pays must be paid Prior to services being rendered.** Your Insurance Company may deny the claim if co-pays are not collected and you may be responsible for the entire charge. To prevent this, if you are unable to pay your co-pay, we will have to reschedule your appointment. **Deductibles and co-insurance fees must be paid at check-out.** Patients who are unable to pay for the services as required by their insurance will be required to speak with an account representative to set up a payment plan.

Initials _____

Signature of Patient or Responsible Party: _____ **Date:** _____

Signature of LD Employee Witness: _____ **Date:** _____

Liberty Doctors, LLC

Communication Policy

- Patients must notify Liberty Doctors, LLC of any changes or updates to their demographic and/or TPP information.
- Patients will be informed by Liberty Doctors, LLC of their payment responsibility at the time of their visit. If a patient has an outstanding balance after a TPP adjudication, [the Office] will contact the patient with an invoice statement outlining the patient's payment responsibility. Liberty Doctors, LLC will also contact the Patient by phone call if a balance remains outstanding after 3 statements.
- Any charges denied by the TPP due to inaccurate and/or out-of-date information will automatically be dropped to patient's responsibility. The patient will be responsible to pay the balance or provide accurate/up-to-date information so that Liberty Doctors, LLC can file to the TPP.
- Patient accounts with outstanding balances will receive a statement every 30 days until the 2nd statement or payment in full. If the balance has not be resolved by the third statement, Liberty Doctors, LLC will contact the patient with a phone call and send notice on the third statement informing the patient that the balance will be sent to collections if not resolved in the next 14 days.



LIBERTYDOCTORS
ASSURING HEALTHCARE FREEDOM

Liberty Doctors, LLC

Designated Party Release

You may give Liberty Doctors, LLC written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information, such as results for labs, x-ray, prescription refills, and appointment reminders, on your home answering machine, voicemail at work, cell phone, email or with another party you designate.

Date: _____ Account/Chart# _____

Patient Name: _____
Date of Birth: _____

I authorize **Liberty Doctors, LLC** to disclose my Protected Health Information (PHI) to the following individuals:

Name: _____
Phone: _____

Name: _____
Phone: _____

Name: _____
Phone: _____

I authorize **Liberty Doctors, LLC** to communicate my Protected Health Information (PHI) to me via the following methods:

_____ Detailed message on my home phone answering machine
Phone: _____

_____ Detailed message on my voicemail at work
Phone: _____

_____ Detailed message on my cell phone voicemail
Phone: _____

_____ Email detailed Medical Information Email: _____

Authorized Signature: _____
Date: _____



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STOP – Cancellation Notice!

I understand that I may cancel this authorization at any time by signing the notice below. However, if I cancel this authorization, I also understand that the cancellation will not affect any actions taken by Liberty Doctors, LLC in accordance to this authorization prior to the receipt of written notice of cancellation.

Printed Patient Name: _____

Signature Authorizing Cancellation: _____
Date: _____



LIBERTYDOCTORS
ASSURING HEALTHCARE FREEDOM

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (please print)

Patient's Name: _____

Date of Birth: _____

Phone Number: _____

**PLEASE RELEASE ALL MEDICAL RECORDS FOR TRANSFER OF
PATIENT CARE**

FROM:

NAME OF PRACTICE: _____

PRACTICE FAX: _____

TO:

LIBERTY DOCTORS, LLC d/b/a

PHONE NUMBER:

FAX NUMBER:

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory / x-ray results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF ALL MEDICAL RECORDS

Patient Signature: _____ Date _____

Office Manager: _____ Date: _____

WE WELCOME YOU TO LIBERTY DOCTORS!

We look forward to many years of medical service to you and your family. Our offices are conveniently located and open Monday thru Friday. If you have an emergency after hours or on the weekend, the answering service will contact the physician on your behalf.

PRESCRIPTIONS

Please allow 24-48 hours for prescription refills. If your prescription needs to be picked up at the office during operating hours be sure to provide identification to receive your prescription.

REFERRALS

On certain occasions, Liberty Doctors, LLC will refer a patient to a specialist or a medical facility for a procedure. Liberty doctors, LLC will make every effort possible to obtain prior approval through your insurance company. It will be the patient's ultimate responsibility to make sure their insurance company has approved this visit or procedure, prior to the visit or procedure being performed.

PAYMENT OF SERVICES

Liberty Doctors, LLC accepts all major insurance companies. As a courtesy to our patients we will file with your insurance company. Please provide a valid insurance card and appropriate information so your claims may be files in a timely manner. Patients are responsible for copays and deductible at the time of service. We accept all major credit cards, personal checks, and cash. Uninsured patients are offered a 20% discount. Payment is due at the time services are rendered.

Liberty Doctors, LLC

Please fill out form completely. The following information will help us in providing you the best medical care and treatment possible. If you have questions, please ask the front desk clerk or the nurse. Thank you and we look forward to seeing you today!

Patient's Name: _____ Today's Date: _____
 Date of Birth: ___/___/___
 Who is your Primary Care Doctor? _____

Name Phone Number

List ALL medications you are currently taking (including over the counter and vitamins/supplements).

Medications	MGS	How Often

List any ALLERGIES

Medication Allergy	Reaction

LATEX ALLERGY Y N ADHESIVE ALLERGY Y N

Medical History of Patient

Heart Disease Y N	Asthma Y N
High Blood Pressure Y N	Depression Y N
High Cholesterol Y N	Stroke Y N
Diabetes Y N	Hypothyroidism Y N
Seizure Y N	Cancer Y N
Mental Y N	Type of Cancer: _____
Other: _____	

Social History

Do you smoke? Y N	How many cigarettes per day? _____
Any other forms of tobacco? Y N	List: _____
Do you drink alcohol? Y N	How often? _____
Do you use any illicit drugs? Y N	Marijuana ____ Cocaine ____ Other ____

Marital Status

Married Single (never married) Divorced Separated Widowed

What is your occupation? _____

What is your highest level of education? _____

Family History

Does anyone in your family (living or deceased) have the following: (please check all that apply)

- Mother Father Sibling Grandparents

High Blood Pressure: _____

High Cholesterol: _____

Cancer: _____

Stroke: _____

Heart Disease: _____

Diabetes: _____

Depression: _____

Mental (please be specific): _____

Hypothyroidism: _____

Other: _____

Surgical History

Please select /list all surgeries:

Surgery Dates:

Appendix Y N

Tonsils/Adenoids Y N

Hysterectomy Y N

Gallbladder Y N

C-Sections Y N

Heart Y N

_____ (type of surgery) _____

Other: _____

Females Only

Are you pregnant? Y N

Last Menstrual Cycle: _____

Last Pap Smear: _____

Abnormal Pap: Y N

How many times have you been pregnant? _____

How many live births: _____