**** CONFIDENTIAL PATIENT ADMISSION**

2017

**ADMISION DEL PACIENTE**

**PATIENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male € Female**

Nombre Y ApellidosFecha de NacimientoSexo: **€ M  F**

**Marital Status:  Single € Married  Divorced €Widowed Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Estado Civil:  Soltero € Casado  Divorciado €Viudo (Required. If presenting Insurance-Medicare- Medicaid)

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dirección Postal:

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Make it legible)**

**Mobile #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day Time Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person to notify in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nombre de Persona para notificar por emergencias**

**Relationship/parentesco con el paciente:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your prefer language is /Lenguaje De Preferencia es : □ English □ Spanish □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Select your prefer communication method: **□Mobile □ E mail □ US Mail □ Home/Work** [**Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**](Tel:__________________)

**INSURANCE INFORMATION *IT IS MANDATORY TO PRESENT INSURANCE ID CARD AND PHOTO ID***

**Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEMBER ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Nombre de Seguro Primario **Group # IF ANY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Principal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Nombre del Asegurado Principal **Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Relación o Parentesco con el paciente:

**Date of Birth of Policyholder/Fecha de Nacimiento:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance: □ Yes □ No**

**Secondary Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_**

**RELEASE OF INFORMATION FOR PATIENTS WITH INSURANCE**

**Lifetime Medicare Part B and Commercial Insurance Signature Authorization for services starting on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Today’s Date) Spanish: Autorizacion para los servicios de Medicare Parte B y Seguros.**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of The Medical Centre of Lehigh Acres, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of all medical insurance benefits either to myself or to the party who accepts assignment.

I authorize the release of medical information necessary to process this claim. I authorize payment of medical benefits to The Medical Centre of Lehigh Acres for services rendered.

**Signature of Patient or Legal representative: x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Firma de Paciente o de Tutor o Representante Legal**

2017

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**CONSENT TO DISCLOSE MEDICAL INFORMATION**

**Consentimiento para divulgar su información de salud**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please CHECK one of the following:**

**Seleccione una de las siguientes opciones. Desea otorgar permiso a los familiares que su nombre aparece en este**

**Documento. Si marca la segunda opción, no ofreceremos información a ninguna otra persona.**

**€ I give my permission to the employees of The Medical Centre of Lehigh Acres to disclose my Protected Health Information to me AND the following friends or family:**

**Yo autorizo a los empleados de este centro médico a brindar información sobre mi estado de salud además de**

**a mi los siguientes miembros de mi familia.**

**NAME: RELATION:**

**NAME: RELATION:**

**OR**

** I request that all my Protected Health Information be disclosed ONLY to me and no other friends or family.** **No quiero que le brinden mi información a ninguna otra persona. Solamente a mi.**

**WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?**

In an effort to serve you better The Medical Centre of Lehigh Acres would like to know what type of message we may leave on your voice mail when contacting you. It is the policy of The Medical Centre of Lehigh Acres to call you at any phone number you provide to us. When we contact you by calling you at any phone number you have provided us:

May we leave a detailed message on your answering machine/voicemail? € Yes  No

If no, we will leave a message with just enough information for you to call us back.

**\*\*\*\*Please Note: For appointment reminders, we will ALWAYS leave a detailed message on your answering machine/voicemail or with anyone who answers your phone.**

I understand that I may revoke or change this authorization at anytime by filling out another Consent to Disclose Medical Information” form. I understand that I will not be denied or refused treatment if I refuse to sign this authorization. I understand that the information used or disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by Federal and State privacy laws. I understand that I have a right to receive a copy of this authorization if I request one. I also understand that this authorization will not expire.

**X\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Printed Name if not signed by Patient \*Relationship/Authority to Act on behalf of the patient

**This form and any personal representative documentation must be scanned into the patient’s medical record.**

2017

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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nombre y apellidos Fecha de nacimiento:**

**I have been presented with a copy of The Medical Centre of Lehigh Acres Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state laws.**

**By signing below I acknowledge the receipt of TMCOLA’s Notice of Privacy Practices:**

**Con su firma usted reconoce que está recibiendo sus derechos a su privacidad.**

**X**

Signature of Patient or Personal Representative Date

\*Printed name if not signed by Patient \*Relationship/Authority to Act on behalf of the patient

\*If not signed by the patient you must provide TMCOLA with a copy of the document of authority that makes you the patient’s personal representative (i.e. Health Care Power of Attorney, Health Care Surrogate, Health Care Proxy, Guardian, etc.) We also need a copy of your driver’s license.

**For Internal Use Only:**

If a written acknowledgement was not obtained from the patient or the patient’s personal representative, the person responsible for obtaining the written acknowledgement must document the reason for failure below:

Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Name and Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This form and any personal representative documentation must be scanned into the patient’s medical record.**

Revised: 01/03/2017

2017



**FINANCIAL POLICY**

This is an agreement between **The Medical Centre of Lehigh Acres, Inc** **(TMCOLA)** and the Patient named on this form.

The words **“you”, “your” and “yours**”, mean and refer to, the Patient. The word **“account”** refers to the account that has been established in the Patient’s name in which charges are made and payments are applied. The words **“we”, “us”,** and **“our”** refer to **TMCOLA.**

As a courtesy to you, we will bill your primary insurance company on your behalf. We will estimate what your insurance company may pay, but this is not a guarantee of payment. Your insurance company will make the final determination of your eligible benefits. You acknowledge that you understand that insurance coverage for benefits is an agreement by and between you and your insurance company. Therefore, you are accepting responsibility for the charges that your insurance company does not pay.

**Referral/Authorization:** Your insurance company may require a referral and/or preauthorization of some medical services. Should your insurance company require a referral and/or preauthorization for services, it is your responsibility to obtain said referral and/or preauthorization. By failing to obtain the proper referral and/or preauthorization, the insurance company may reduce or deny payment for services.

**Managed Care:** All insurance companies require that Patient co-payments and deductibles are payable at time of service. If you are unable to pay at time of service, an additional charge of **$25.00** will be assessed to the balance to cover the additional collection costs. This service fee is Patient responsibility and cannot be billed to insurance.

**Medicare:** We participate in Medicare Part B and we will bill all services on your behalf. You are responsible for your annual Medicare deductible and the 20% Patient responsibility. You are responsible for any services that Medicare does not cover. We will bill your secondary insurance on your behalf.

**Self-Pay:** If you are paying for services yourself (self-pay), then all payments for the services rendered are due at the time of service. If you are unable to pay at time of service for certain services, any remaining balance will be billed to you upon prior approval from the billing department.

**Worker’s Compensation:** At this time we are not affiliated, nor are we contracted with any worker’s compensation carriers.

**Personal Injury Cases/Motor Vehicle Accidents:** At this time we are not accepting patients involved in auto accidents or slip and fall occurrences. If a medical evaluation is necessary we will not billed your insurance company or accept letter of protection. You the patient must pay (self-pay) for the medical evaluation.

**Patient Balances:** If you have a Patient Balance on your account, you will be billed for the entire amount due. Your bill will show separately any previous balance, any new charges on your account, and any payments or credits applied to your account during that billing cycle. Your bill may also show pending payments from your insurance company, if applicable. The Patient Balance will be clearly indicated.

**CONTINUE TO READ AND SIGN IN THE LAST PAGE**

**PROCEDA A LEER Y FIRMAR LA PROXIMA PÁGINA**



2017

**FINANCIAL POLICY**

Unless you have made other arrangements for payment of the Patient Balance approved by **TMCOLA’**s Billing Office writing, the amount indicated as Patient Balance is due upon receipt. Your balance will be past due if payment is not received within 30 days from the issue date printed on the statement. TMCOLA reserves the right to add any fees incurred for additional billing and/or collection services. For your convenience, we accept payment via all major credit cards, including bank debit cards.

If necessary**, TMCOLA** Billing Services may set up a regular payment schedule for you. **TMCOLA** reserves the right to report your account to credit reporting agencies if your balance goes into a past due status. Nonpayment of past due Patient Balance may result in **TMCOLA** inability to provide you with continued care.

You understand that if your account is submitted to an attorney, collection agency, involved in court litigation, or reported to a credit reporting agency, the fact that you received treatment/services at our office may become a matter of public record.

Transferring of medical records must be requested in writing along with a Medical Records Release form.

**By signing below, you acknowledge and agree that:**

You understand that it is your responsibility to provide **TMCOLA** with current and accurate billing information at the time of service and you will notify **TMCOLA** immediately if there are any changes to this information.

You agree to the terms and conditions contained herein. You understand that any charges not covered by your insurance company along with any co-payments and deductibles, are your responsibility.

You authorize your insurance benefits to be paid directly to **TMCOLA** for services rendered.

Agreement is effective on date agreement is signed below.

**PATIENT NAME:**

**Signature of Responsible Party:X**

**Responsible Party/Relationship:**

**(If other than the patient.)**

**FIRMA DE GARANTE DE LA CUENTA Y SI NO ES EL PACIENTE INDIQUE EL PARENTESCO**

**Date:**

**This form and any personal representative documentation must be scanned into the patient’s medical record.**

Revised: 01/03/2017