Cobblestone Family Health

John H. Amick, D.O., P.C John A. Burroughs, M.D.
1133 W. Kansas St., Liberty, MO 64068 816-781-7400
www.ourfamilydoctors.net

Patient Information
2017

***First Name**	***Middle Initial**	*** Last Name**	***Jr ./ Sr.**	*** Male / Female**

***Birth Date**	***Social Security Number** _____--_____--_____	*** Marital Status** Married Single Widowed Divorced
***Home Phone**	***Work Phone**	***Cell Phone**
RACE: Please Circle One White Black Hispanic Asian Am Indian Other	**Ethnicity: Please Circle One** 1: Not Hispanic or Latino 2: Hispanic or Latino	**Preferred Language: Please Circle One** English Spanish Other:

Preference for reminders: Phone Printed Electronic **Please Circle One**	**Provider Preference: Dr. Amick Dr. Burroughs** **Please Circle One**

***Patient Address**	*** City**	*** State**	*** Zip Code**	***County**

***Patient's Employer**	***Address**	***City**	***State**	***Zip Code**

Occupation	***Work Phone**	****Insurance Subscriber Birth Date**
*** *Insurance Subscriber Name**	****Insurance Subscriber Social Security** _____--_____--_____	**E-Mail Address**

***Spouse First Name**	***Middle Initial**	***Last Name**	*** Spouse Birth Date**

***Spouse Employer**	***Address**	***City**	***State**	***Zip Code**

***Spouse Work Number**	***Spouse Cell Phone**	*****Relationship to Insured**

Who referred you to this office?	*** Emergency Contact Person, How Related & Phone Number**

***List of names we may release medical information to:**

***Date** *** Signature**

***Insurance Subscriber; is the person who receives health insurance benefits on behalf of themselves and their dependents.*

****How are you related to the person who has the insurance policy (Self, Spouse, or Parent)*

Please give the receptionist your current insurance card, so it can be scanned into the computer system.

All areas with the * must be completely filled out. If the information is incorrect, or there is a lack of information, your insurance company <u>will not pay for services provided by this office</u>.
<u>These services will then become your responsibility, and you will be billed for them.</u>

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Patient Responsibility/Information Release

2017

OFFICE HOURS – By appointment only Monday – Friday. Same day appointments should be available if you call before 10:00 a.m. on the day you wish to be seen. Our office will attempt to contact you about your appointment two days prior to it***. If you fail to notify us that you will not be able to make your scheduled office visit, you will be billed a $20.00 no show fee. Your insurance company will not pay this fee and will be your responsibility.***

OFFICE FEES – Our medical charges are consistent with other area physician's standard reasonable fees**.** ***These fees are dependent upon the complexity of your problem.***

OUR FINANCIAL POLICY -- Payment is expected at the time of your office visit. We accept VISA, MasterCard, Discover, Debit Card, Personal Check, & Cash. ***If an account is unpaid after 90 days you will be blocked from making an appointment until it is paid. If after 120 days it is still unpaid it will be sent to a collection agency.***

Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

If you require hospitalization, we will bill your insurance company for all services provided by our physicians while you were hospitalized. You are responsible for any balance due**.**

All co-pays must be paid prior to your appointment and your insurance card must be presented to the receptionist before each office visit. If you fail to pay your co-pay at the time of your visit you will be charged an additional $10.00. **This fee is for the additional processing time it will take to complete the billing, due to non payment of the co-pay. Your insurance company will not pay this fee and will be your responsibility. There will be a $30.00 fee for all returned checks**.

DISABILITY / FMLA / LEAVE OF ABSENCE FORMS – There will be a $25.00 charge for all disability, FMLA, and leave of absence forms. This fee must be paid in advance. Our office requires seven to ten business days to complete the forms. Some cases may require an office visit with the doctor.

AFTER HOURS / WEEKEND CALLS--We provide care 24/7. Should you need to speak to a physician after hours, call our office at (816)781-7400. Your call will be transferred to our answering service. One of our physicians will call you back as soon as possible. ***If it is a life threatening emergency, call 911***.

PRESCRIPTION REFILLS -- ***If you need a refill on your prescription(s) call your pharmacy and they will contact us. This includes mail order pharmacy refills, or transfers of prescriptions from one pharmacy to another.*** All requests made by noon should be responded to before the end of that business day. Attempts will be made to fill requests after 12 pm but may require a 24 hr turn around. Friday afternoon requests may take longer and may not be completed until Monday a.m.

RETURN CALLS -- If you call by noon every attempt will be made to have an answer to your question before the end of the day. Usually within 5 hrs. Calls after 12 pm – every attempt will be made to answer these by day end, but may not be returned until 9:00 am on the next business day. To help us return your calls as fast as possible, please leave a phone number where you can be reached throughout the day and a number you can be reached after 5 pm.

By my signature, I understand that I am directly responsible to this office for all charges, and that I must provide current insurance and health history information. I also understand that all co-payments, co-insurance, and payments for services not covered by insurance are due the date services are rendered. I am also responsible to pay this office for any collection expenses associated with charges that remain unpaid after 30 days, including rebilling charges, cost of funds and attorney's fees. I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Cobblestone Family Health for any administration and its agents any information needed to determine these benefits payable to related services. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes release of medical information to the agency. I understand my signature requests that payment be made and authorizes release of medical information by any means necessary to file my claim. **Unless I specify otherwise, I authorize you to discuss my medical health and tests with immediate members of my family, spouse, parent or guardian. I have read and understand the practices policies and I agree to be bound by its terms. I also understand and agree that such terms and fees may be amended by the practice.**

X_____

Patient Signature (or responsible party, if minor) **Today's Date**

X_____

Please print the name of the patient.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

(Please Check One)

☐ I,_____, have received/read a copy of
Patient
Cobblestone Family Health Notice of Privacy Practices.

☐ I,_____, refuse to accept/read a copy of
Patient
Cobblestone Family Health Notice of Privacy Practices.

_____ _____
Signature of Patient Date

Please print and complete this form and give to a Cobblestone Family Health receptionist.