# OLYMPUS FAMILY MEDICINE

## Patient Information Update Form

### PATIENT INFORMATION

LEGAL NAME: _____
Last First MI

DATE OF BIRTH: _____/_____/_____ PREFERRED NAME: _____
MM DD YYYY

EMAIL: _____

CURRENT ADDRESS:

_____
Street Address Apartment Number

_____
City State Zip

Please Indicate Your Preferred Contact Method Below:

- Cell Ph: _____
- Home Ph: _____
- Work Ph: _____

PARTNER NAME: _____ Marital Status: **S** **M** **D** **W**
Last First

EMERGENCY CONTACT: _____ Phone # _____
Last First

OCCUPATION/EMPLOYER: _____

PREFERRED PHARMACY: _____
Pharmacy Name Address/Location Phone #

PLEASE INDICATE YOUR ETHNIC ORIGIN:

- ☐ WHITE
- ☐ BLACK / AFRICAN AMERICAN
- ☐ AMERICAN INDIAN / ALASKA NATIVE
- ☐ ASIAN (Please Specify)
- ☐ HISPANIC / LATINO
- ☐ NATIVE HAWAIIAN / PACIFIC ISLANDER
- ☐ CHINESE
- ☐ VIETNAMESE
- ☐ INDIAN
- ☐ PERSIAN
- ☐ JAPANESE
- ☐ TAIWANESE
- ☐ PAKISTANI
- ☐ INDEONESIAN
- ☐ KOREAN
- ☐ CANTONESE
- ☐ ARMENIAN
- ☐ OTHER ASIAN
- ☐ 2 OR MORE ETHNIC ORIGINS: (Not Hispanic / Latino)

### UPDATED ALLERGIES

Are you **allergic** to any **new** medications or other substances? **YES** ☐ **NO** ☐
(If yes, please list item & reaction(s) below:)

**Medication/Substance Causing Allergy**: **Reaction:**

_____ _____

4461 Coit Road, Suite 307 · Frisco, TX 75035 · Ph. 972-377-0322 · Fax 972-502-9515

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by the staff of *Olympus Family Medicine* in providing and arranging your medical care.

*Olympus Family Medicine* is furnishing you with the attached notice, which provides information about how we may use and/or disclose protected health information about you for treatment, payment, heath care operations and as otherwise allowed by the law.

## HIPAA PRIVACY ACT INFORMATION RELEASE FORM

May *Olympus Family Medicine* release medical information to anyone other than you?

___ **YES**, please release information to the following: ___ **NO**, only release information to me.

**Name**: _____ **Name**: _____

**Relation**: _____ **Relation**: _____

**Phone**: _____ **Phone**: _____

**Check which of the following methods we may leave detailed information pertaining to your health:**

____ Preferred Phone # _____ - _____ - _____ Okay to leave detailed Voice Mail? **Y** ☐ **N** ☐

____ Email (Non-Encrypted) _____

**By signing this form, you acknowledge that you have received a copy of *Olympus Family Medicine's* Notice of Health Information Practices and have provided instructions regarding release of your individual healthcare information.**

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____

Print Name of Patient

# OLYMPUS FAMILY MEDICINE

## PAYMENT AND PATIENT POLICIES

**Below you will find our patient policies. These are non-negotiable and are not to be altered. Failure to initial agreement with ALL of the following policies will result in your inability to receive care from Olympus Family Medicine. Thank you for your understanding in this matter.**

***Please Initial All Below***

x_____ **Co-Payments, Co-Insurance and Deductibles:** **ALL** Co-Payments, Co-Insurance, & Deductibles **MUST** be paid at time of service. The amount paid when services are rendered is an estimated amount based on the information we receive from your insurance company. Final determination of charges will be made after your insurance has been filed. We will send you a statement for any remaining balance. For your convenience, we accept MasterCard, Visa, Discover, and American Express. **Procedures-** Most insurance companies require patients to pay a **separate** Surgical Deductible for procedures such as cryo-surgery, biopsies, device insertion, and other surgical procedures. Check with your insurance BEFORE the procedure is performed. You are responsible for payment of the deductible at the time of service.

x_____ **Insurance:** All patients must provide a valid Driver's License and an **active** insurance card at the time of service. If you fail to provide us with correct insurance information, you will be required to pay the full amount of the service. It is YOUR responsibility to know your benefits. Please notify the receptionist of any insurance changes when arriving for your appointment. We file your insurance as a courtesy to you. **ALL payments are due at the time of service** including Copays, Co-Insurance, and Deductibles.

x_____ ***YOU are responsible for knowing your insurance policy and benefits.*** Your health insurance policy is a contract between you and your insurance company. As a courtesy, we file your claim with your insurer if you agree to have payments made directly to *Olympus Family Medicine*. If your insurance company does not provide payment within **90** days of the filing date, **YOU** will be required to pay the full amount of all services rendered or denied. If we later receive a check from your insurer, we will issue you a refund in the form of an account credit or check.

x_____ ***YOU are responsible for payment of all charges for services NOT covered by your insurance company.*** We do our best to determine your insurance benefits and coverage; however, due to the constant changes in insurance coverage, we cannot guarantee that Medicare or other insurance companies/policies will cover the services rendered. Your insurance company will make the final determination upon receipt of the claim. Medicare patients might have an additional ABN form to sign for potential non-covered services and in-house or laboratory testing.

x_____ **Billing:** Our billing is out-sourced to *Physicians Group Management (PGM).* Any balances owed to *Olympus Family Medicine* are due upon receipt of the billing statement via mailed check, online payment, or in-office payment. Please call *Physicians Group Management (PGM)* at: **1-888-336-8283** for all office billing inquiries. All billing questions concerning laboratory or radiology must be directed to the facility where services were performed (*LabCorp, Quest, etc.*).

x_____ **Delinquent Accounts:** If your account becomes delinquent **after 90 days**, and a payment is not made in an attempt to resolve the balance, your account will be turned over to a collection agency due to delinquency and you will be required to pay **all balances in full before any further services are rendered by our office**.

x_____ **Appointments***:* Please plan to arrive 10-15 minutes before your appointment time to update any changes in contact information or insurance. We require a **24-hour** notice to cancel or reschedule an appointment. Failure to do so, including late cancellations and missed appointments, will result in a **$50 charge**. No-shows will not be tolerated. Patients who repeatedly miss their appointments may have their care terminated with *Olympus Family Medicine*.

x_____ **Laboratory Results and Radiology Results**: In general, all labs and radiology results will be discussed at routine follow-up appointments and **WILL NOT BE HANDLED OVER THE PHONE**. Routine results are typically available for the provider to review in 7 business days. Some specialty labs can take up to 10 business days. Your provider will determine if you need an appointment or if the results are urgent and can be discussed over the phone. Results for sexually transmitted disease labs require an appointment. All billing questions concerning laboratory or radiology must be directed to the facility where services were ordered. **LabCorp:** 1-800-788-9892 ; **Quest Diagnostics:** 1-866-697-8378 ; **BioReference Laboratories:** 1-800-229-5227.

x_____ **Call Back Requests***:* The doctor will **NOT** take calls for non-urgent conditions during regular business hours. Returned calls and messages are typically conducted at the end of the business day; however, in most cases, the provider will call you within **24-hours.** Please leave a detailed message along with your Name, Date of Birth, and Phone Number.

x_____ **Medication Refills***:* We require **24-hours notice for routine medication refill requests**. Please do NOT have the pharmacy fax a refill request to our office. If you need a refill of a medication, it is the patient responsibility to alert the office, not the pharmacy. Please do NOT let your medications run out before calling us to request a refill. NO medications will be refilled on weekends. You MUST make an appointment for any refills of antibiotics, controlled substance medications, and narcotics. **Narcotics will NOT be prescribed without an appointment.**

x_____ **Pharmacy***:* If your insurance company requires you to use a specific pharmacy in order to receive prescription medicine benefits, please notify us. If your insurance company requires prescriptions to be sent from the doctor's office to the mail-order pharmacy, please fill out ALL appropriate forms with the required information and we will fax them to the number you provide. If you need to update a pharmacy, please be sure to let our office staff know.

x_____ **Forms***:* All requests to fill out forms such as FMLA, Disability Determination, Leave of Absence, Jury Duty Exemptions, and others require an office visit. The provider reserves the right to deny signing any requested forms.

x_____ **Referrals***:* If you need a referral, we will submit the referral paperwork to a specialist. If the specialist has NOT contacted you within **5 days**, please call us. Before booking an appointment with a specialist, YOU are responsible for checking that the specialist or facility is in-network on your insurance plan. We may send referrals to the physician or facility of your choice. **All HMO's** require a referral BEFORE seeing a specialist and require 72 hours to process.

x_____ **Medical Records***:* Medical Records will be released after a signed release is received from the patient. Patients requesting copies of medical records will be charged a base fee of $25.00. ALL Medical Record Requests will be addressed within **10 business days** of receipt of both the patient release form and appropriate payment.

x_____ **Inclement Weather**: In the case of inclement weather, we follow the Frisco ISD policy for closures and delayed openings. We will call you to reschedule your appointment on the first business day that we re-open.

x_____ **Annual Physicals**: Please allow 8-12 weeks to schedule an Annual Physical. **Two weeks prior** to your appointment, please come in for fasting lab work. The focus of an Annual Physical Exam is preventive care. The provider will review your lab work, perform a physical assessment, answer questions, update your treatment plan, and refill any maintenance medications for chronic conditions. Acute issues will **NOT** be addressed at an Annual Physical appointment. Well Woman Exams will **NOT** be covered in the Annual Physical appointment. You must schedule a follow-up appointment to discuss those conditions. It is the patient's responsibility to know and understand their insurance coverage. If any services recommended by your provider are not covered under your insurance plan, you must decline the service before it is performed in office. Otherwise, the cost of the denied service will be your responsibility.

*Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our above policies.*

**By signing this form, you acknowledge that you have read and understand all of *Olympus Family Medicine's* Patient and Payment Policies listed above. You also attest that all of the information provided previously on this form is accurate and reliable to the best of your knowledge.**

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____

Print Name of Patient, Parent or Legal Guardian