FAMILY HEALTH ASSOCIATES
Patient Information

Date _____

Patient _____ **Birthdate**: _____
Last Name First Name Middle Initial

Street Address _____ **City** _____ **State** _____ **Zip Code** _____

Mailing Address _____ **City** _____ **State** _____ **Zip Code** _____

Social Security # _____ **Email address**: _____

Gender Identity: ☐Male ☐ Female ☐Transgender Male ☐Transgender Female
☐Neither Male or Female ☐Other ☐ Declined

Sexual Orientation: ☐Straight ☐Gay ☐Lesbian ☐Bisexual ☐Other ☐Unknown ☐Declined

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Race: ☐Asian ☐Black/African American ☐Caucasian/White ☐American Indian/Alaskan Native
☐Native Hawaiian/Pacific Islander ☐Unknown

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic or Latino **Preferred Language:** _____

Home Phone # _____ **Cell Phone #** _____ **Work Phone #** _____

Which is your preferred phone? ☐Home ☐Cell ☐ Work **Preferred contact?** ☐Voice ☐ Email ☐Text ☐None

Employed by _____

In case of emergency, who should be notified _____ **Relationship** _____ **Phone #** _____

Second contact person _____ **Relationship** _____ **Phone #** _____

Who is responsible for this account? _____ Relationship to patient _____

Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Social Security # _____ Birthdate _____ ❑ Male ❑ Female Employed by _____

Name of primary Insurance Company _____ Employer: _____

Subscriber Name _____ SS # _____ DOB _____

Name of secondary Insurance Company _____ Subscriber Name: _____DOB_____

Do you have Medicare? ❑ Yes ❑ No Medicare # _____ Medicare Part D Provider _____

Name of Preferred Pharmacy _____ City: _____

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Authorization for Treatment

By signing below I am allowing Family Health Associates (FHA) to provide health care related treatment and consultation to the previously-named patient and that I may refuse treatment or services at any time. I understand FHA does not guarantee any outcome for any services or treatment either stated or implied.

Signed _____ Date _____ Relationship to patient _____

Assignment, Release and Authorize

I, assign directly to Family Health Associates, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signed _____ Date _____ Relationship to patient _____

HIPAA (Health Insurance Portability and Accountability Act)

I understand that I have the right to receive and review a written description of how Family Health Associates will handle my health information. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Family Health Associates and my right regarding my health information.
I understand that the **Notice of Privacy Practices** may be revised from time to time, and that I am entitled to receive a copy of any revised **Notice of Privacy Practices**. I also understand that a copy or summary of the most current version of Family Health Associates' **Notice of Privacy Practices** in effect will be posted in the waiting/reception area.

Signed _____ Date _____ Relationship to patient _____

Permissions (these permissions will stay in effect until changed by patient or parent/guardian)

I give my permission for FHA to speak with and/or leave messages with regarding treatment, billing and/or appointment status (name of each person and relationship to patient)

_____

_____

Signed _____ Date _____ Relationship to patient _____

FAMILY HEALTH ASSOCIATES
Patient Information

CASH PAY POLICY
Patients without medical insurance will be required to pay a deposit at the time of service. All Office Visits require a minimum $168.00 deposit. Final amounts due are based upon the length and complexity of the service(s) rendered and cannot be guaranteed prior to your appointment. Patients will be billed for any balances remaining after applicable cash pay deposits and discounts have been applied. The office can supply cash pay cost estimates for office visits and procedures upon request. Labs sent for processing will be billed separately and are not applicable to this policy.

► _____ (Please initial) I acknowledge that I have reviewed and understand the above cash pay policy.

Financial Agreement
Insurance: Family Health Associates participates with Medicare, Medicaid and many commercial insurances and agrees to file claims with your primary and secondary insurance as a courtesy to you. While Praxis may have an agreement with your insurance plan, it is your responsibility to verify whether your specific policy is in network prior to scheduling an appointment with our providers. Failure to do so may result in you paying an increased out-of-pocket expense for your visit. It is also your responsibility to coordinate and understand your coverage and benefits. Although our office can provide you with a cost estimate for our services, it is the insurance company that makes the final determination of eligibility, coverage and total balance payable from you. Our office will attempt to collect copays and deductibles at the time of your appointment; any remaining balances will be due and payable within 30 days of your insurance plan determining your responsibility.
Liability Claims: If the reason for your visit is related to a work-related injury or auto accident, you are responsible for providing Family Health Associates with the claim number, date of injury, the workman's compensation or insurance carrier's name, billing address and/or any other information necessary to file the claim. If you do not provide this information at the time of service, you may be held responsible for the full balance from your visit(s). Our practice will only bill the patient's Personal Injury Protection (PIP) coverage for auto accidents, we do not bill at-fault/third party coverage.
Fee Schedule: Family Health Associates' fee schedule is subject to change based on current Relative Value Units (RVU) and what is usual and customary for our service area. Our services are provided on a voluntary basis and our fees will be provided to you upon request. You are responsible for payment regardless of any other company's arbitrary determination of usual and customary rates. Our practice does not accept assignment of 'reference-based pricing' for those companies that do not utilize an insurance network. We do offer a 20% cash pay discount off our standard fee schedule for individuals being balance billed due to non-contracted, non-covered, or out-of-area coverage when services are rendered voluntarily. Emergent services rendered by our providers involuntarily will not receive a surprise bill in compliance with ORS 743B.287.
Patient Responsibility: When an account balance becomes your responsibility, the balance is due upon receipt of the first account statement from Praxis Health. It is your responsibility to ensure Praxis and FHA have your current contact information on file in order to ensure prompt receipt of your payment and avoid past due balances. If any part of the account balance becomes delinquent, then the account balance may be forwarded to an outside agency for collection. If you need to set up a payment plan,

please contact our Patient Billing Advocates by e-mail at billing@adaugeohealthcare.com or toll free at (877) 708-1119.

Returned Checks: A fee of $35.00 will be charged for any checks returned due to stop payment or insufficient funds.

By signing below, I certify that I have read and understand the Family Health Associates Financial Agreement and accept financial responsibility for payment of any fees associated with my care.

_____ _____

Patient or Guardian Signature **Date**