VMAC
VALLEY MEDICAL ARTS CLINIC

Patient Information Form

Please fill out this form completely and legibly. All information is required in order to ensure prompt payment from your insurance company and to provide us with all relevant contact information in case we need to reach you or if there is an emergency. We appreciate your help with this!

Patient Demographics

Last Name:_____

First Name:_____

Sex:_____

Date of Birth:_____

SSN:_____

Address:_____

City/State:_____

ZIP:_____

Home Phone:_____

Mobile Phone:_____

Can we send you text messages? Y / N

Work Phone:_____

Email:_____

Preferred

Language:_____

Ethnicity:_____

Marital Status:_____

Guardian (for minors)

Last Name:_____

First Name:_____

Middle Name: _____

Suffix:_____

Emergency Contact

Name:_____

Relationship:_____

Home Phone:_____

Mobile Phone:_____

Next of Kin

Name:_____

Relationship:_____

Phone:_____

Employment

Employer:_____

Employer Phone:_____

Occupation:_____

Industry:_____

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Patient Insurance Guarantor Information

Patient Name:_____

Please provide the following information about your the policy holder of your insurance. All information is necessary in order to ensure that we bill the correct insurance plan. Please write legibly and fill out the form completely. Ask our Front Desk Staff if you have any questions. Thanks!

Primary Insurance Holder (Guarantor)
Patient is Guarantor: Y / N
If you circle Y, You don't need to fill out the information below

Last Name:_____

First Name:_____

Middle Name:_____

Suffix:_____

Date of Birth:_____

Address:_____

Zip Code:_____

City:_____

State:_____

SSN:_____

Phone:_____

Email:_____

Secondary Insurance Guarantor
Patient is Guarantor: Y / N
If you circle Y, You don't need to fill out the information below

Last Name:_____

First Name:_____

Middle Name:_____

Suffix:_____

Date of Birth:_____

Address:_____

Zip Code:_____

City:_____

State:_____

SSN:_____

Phone:_____

Email:_____

You must provide us with your insurance card(s) and a picture ID so we can have the most accurate information. We cannot bill your insurance without the most recent copy of your card. If you don't have your insurance card with you right now, we must bill you for any services received until you provide the insurance card.

PROVIDER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures of health information
We use health information about you for treatment, to obtain for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as law enforcement in specific circumstances. In any other situation, we will ask for your written authorization beore using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop future uses and disclosures.

We may change our policies at any time. Before we make a significant change to our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contract the person listed below.

Individual rights
In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we will charge you normal photocopy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes and other than when you explicitly authorize it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add missing information.

Complaints
If you are concerned that we violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

If you have any questions or complaints, please contact:
Rick Jordan
Address: 5201 N 10th Street McAllen, TX 78504
Phone: (956) 631-5411

Patient Financial Policy

Updated 1/2017

Thank you for choosing Valley Medical Arts Clinic to serve your medical needs! Part of taking care of those needs includes making sure you understand your financial obligations regarding your care. So, please, read this document carefully because it details our policies regarding patient payments, insurance plans and other important financial matters. Our goal is to make the financial part of your visit as painless and hassle-free as possible. If you have any questions, you can ask for our Billing Department or our Office Manager and they can help clear up any misunderstandings.

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-If you have health insurance, your insurance package makes you responsible for copays, coinsurance, deductibles and other charges that they don't cover. We expect payment toward these patient responsibilities at the time of service. Our providers cannot waive copays, deductibles or other patient responsibilities. Insurance plans require us to collect copays/ coinsurance/deductibles for all visits to the office, even if you come in to get lab work, blood pressure checks and other services that are not strictly provider visits.

-If you do not have health insurance, we offer a discount for our services. Payment is expected in full at the time of service.

-We accept cash, checks and all major credit cards for payment. If you cannot pay for your services at the time of visit, we may ask you to reschedule your visit. If you have any further questions regarding this policy, please ask to speak with our Billing Department or the Office Manager.

-Except in very limited circumstances, we do not expect patients to carry balances on their account. All payments are due at the time of service. We send monthly statements for balances due. If you have a past-due balance, you must pay it at your next visit. After two statements are sent to you without a payment from you, we will send a letter to warn you that you may be discharged from the practice for failure to pay. After 30 more days, if we don't receive a payment from you, we will send you a final letter discharging you from the practice. If we must discharge you, we will notify you by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

-There are a large number of insurance companies and benefit plans and their benefits and policies are very different from each other (even within the same insurance company). We want to simplify the process for you and our staff. Thus, we collect an estimated payment towards deductibles and co-insurances at the time of service. After your insurance pays us, they may make you responsible for more than what we collected at the time of service. In this case, you will receive a statement from us detailing what you previously paid, what the insurance paid and what your responsibility is. When you receive a statement, this means that we have already received payment from your insurance plan, made all appropriate (*continues on reverse)*

adjustments and the balance due is your responsibility. We expect you to pay these amounts promptly. If the balance is unpaid at your next visit, we will ask you to pay these amounts at the time of the visit. In the rare case that we charged you too much, you will have a credit on your account which you can use towards future visits. You can also request a refund of any credits on your account.

-It is your responsibility to fully understand your insurance plan . Keep in mind that your insurance plan and associated benefits are a contract between you and your insurance company; we do not have any control over what your insurance does or does not pay for. Therefore, if you have questions about your coverage or your responsibilities under your insurance plan, you should first call your insurance company. If you feel that the amount we have billed you for is in error, you can speak with our billing department who can research the issue and make any corrections, if appropriate. Once that has been done, we expect prompt payment.

-You must keep us informed of any changes in your insurance coverage, address, phone number, email and any other personal information as soon as they occur. If you do not promptly notify us of these changes and it results in a delay in filing a complete and accurate claim, you will be responsible for the charges involved. Additionally, we may need to contact you regarding important medical information so it is vital that we have up-to-date contact information from you.

-Your insurance company may need to contact you by phone or mail if they require additional information from you to pay us. Please respond to them promptly. If you do not, the insurance will deny payment and all charges will be your responsibility.

-If your plan requires you to choose a Primary Care Provider (PCP), you must call your insurance company to change your PCP to one of our doctors before your visit. If you do not change your PCP to one of our providers, the insurance will deny coverage and you will be responsible for the charges. Additionally, we will not be able to make referrals to other providers if we are not listed as your PCP.

-If you are insured with a Marketplace plan and receive help (a “subsidy”) from the government to help you pay for it, you are responsible for making any premium payments to your insurance plan on a timely basis. If you miss premium payments, your insurance plan will notify us that you are in a grace period. We must collect in full at the time of service when you are in a grace period. We will refund any such payments when your insurance company indicates that you are no longer in a grace period.

-Many times, an insurance company will pay us for your services and then make a later determination that such services should not be covered. They will then request that we refund them. In most cases, those charges will then become your responsibility and you will receive a statement from us for the charges. Prompt payment is expected You must contact the insurance company to determine why they didn’t pay for your services.

-Injuries related to a Motor Vehicle Accident, “Slip and Fall” or any other accident-related reason: where an automobile/personal injury/property insurance may be liable for coverage or

where a lawsuit may be involved, we must charge you in full for services received. We do not bill auto/property and other types of liability insurance. We do not take Letters of Protection from attorney's offices. Due to the varying coverages for accidents from regular health insurance plans, we do not bill health insurance for accident-related claims. We will offer you our self-pay discount for these services. You can then seek reimbursement from the liability insurance and/or your health insurance if appropriate.

-If we receive a returned check from you, we must charge a $25 returned check fee. After 2 returned checks from you, we will no longer be able to accept a check payment on your account.

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Financial Policy Acknowledgement Form and Authorization to Bill Insurance and Keep Signature on File

By signing this form, I acknowledge that I have read and understood the Financial Policy and that I have had the opportunity to have any questions answered. Further, I agree to abide by the terms of this policy. If I'm using insurance, I hereby authorize Valley Medical Arts Clinic, PA to release medical information to my insurance company to secure payment of benefits. I also authorize the use of this signature on all insurance submission and as authorization for my insurance company to send payment to Valley Medical Arts Clinic on my behalf.

_____ _____

Signature of Patient/Responsible Party Date

Acknowledgement of Receipt of Privacy Practices Statement and Authorization on Information Release to VMAC

I acknowledge that I have received the notice of privacy practices from Valley Medical Arts Clinic, PA. I also **do / do not (circle one)** authorize VMAC to contact me by phone or text regarding my appointments and other limited medical information. I also **do / do not (circle one)** grant VMAC the authority to download my medication history from online databases.

_____ _____

Signature of Patient/Responsible Party Date