Patient Update Form

First Name________________Last Name__________________MI ____ Gender M F
Date of Birth_________________________ Marital Status S M W D P

Address ____
City ____________________________________ State _______ Zip ___________________
Best # to reach you ____________________ Home phone _________________________
Cell phone _________________________ Work phone __________________________
Confidential Email __________________________ Employer ___________________________
Employed (please circle one) Full-time Part-time Not Employed Student
Pharmacy of Choice___________________Pharmacy address ___________________________
Pharmacy phone _________________________

Emergency Contact ____
Relationship________________Phone Number______________

Primary Insurance Company _________________________
Policyholder ___________________ Social Security # ____________ Date of Birth _________
Relationship of Policyholder to patient ____
Address (if different than above)____
City ____________________________________ State _______ Zip ___________________
Home phone ______________
ID/Policy #_________________Group #______________Employer ______________________

Secondary Insurance Company _________________________
Policyholder ___________________ Social Security # ____________ Date of Birth _________
Relationship of Policyholder to patient ____
Address (if different than above)____
City ____________________________________ State _______ Zip ___________________
Home phone_______________Cell Phone _______________ Work Phone ________________
ID/Policy #_________________Group #______________Employer ______________________

I hereby authorize (a) payment of insurance benefits otherwise due to me to be made directly to Leavitt Family Medicine, PLLC, (b) release of information including protected health information to insurance companies as needed to file payment for services incurred, (c) Leavitt Family Medicine, PLLC to obtain records from other sources as may be necessary in the diagnosis or treatment, and (d) understand that I am financially responsible to Leavitt Family Medicine, PLLC for charges related to services provided or incurred by me or my dependents.

Signature (Responsible Party)______________________________Date ____________________
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Financial Policy

Thank you for choosing Leavitt Family Medicine, PLLC.

It is our policy that all fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made.

As a service to our patients, we will file a claim with your insurance company. The filing of insurance does NOT release the patient from responsibility for charges for services which have been provided. Please make sure we have a current copy of your insurance card. ***If we do not have the correct insurance information on the date of service and your claim is denied, you are responsible for payment.*** It is your responsibility to verify if our office is in network with your plan.

Accounts which are not paid within a reasonable period of time, and for which no special arrangements have been made, will be subject to placement with collection agencies following due notice.

Having read and understood the above statements, I agree to the terms set forth:

1. I understand my copay, deductible or non-covered service fee is due and payable at my appointment or I will need to reschedule my appointment.
2. I understand that I am financially responsible for all charges, even if they are not covered by insurance.
3. If my insurance does not pay, I understand that I am responsible for those charges.
4. In the event that I do not pay in accordance with the above policy and my account is sent to a collection agency, I agree to pay all costs of collection, including attorney fees.
5. If my account is sent to collection, I understand I will be dismissed from this practice.
6. I understand if I fail to show up for a scheduled appointment without calling to cancel with 24 hours notice, I will receive a bill for the missed appointment. I understand a third missed appointment is grounds for dismissal from the practice.

I, the patient or guarantor/guardian hereby authorize the release of all applicable medical information including, without limitation, copies of all records and test results produced to the designated attending, referral and/or follow-up physicians and such other healthcare practitioners or organizations which will be providing subsequent monitoring, care or treatment in connection with care provided by Leavitt Family Medicine, PLLC. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third- party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to Leavitt Family Medicine, PLLC. I further agree that a photocopy of this document is to be considered as valid as an original.

Signature of Responsible Party________________________________Date _________________

Printed Name_________________________________Relationship to patient _______________