ORTEGO FAMILY MEDICINE ALLERGY & ASTHMA

Trina Ortego, FNP-C

Patient's Social Security #: ______________________________

Patient's Name: ____________________________ Birth Date: _____________________ Sex: M / F

Mailing Address: __________________________ City: ____________________________ State/Zip: ____________

Responsible Party's Name: ___________________________ Relationship to patient: _________________________

Responsible Party's Social Security #: _________________________ Date of Birth: _________________________

Address (if different): ______________________ City: ____________________________ State/Zip: ____________

Primary Phone #: ________________________________ Secondary Phone #: _____________________________

Consent to call YES NO   Consent to text YES NO

Email: ____

INSURANCE INFORMATION

Primary Ins: ____ S.S./Policy #: _______________________________

Employer: ____ Group #: ___________________________________

Policyholder name & DOB: _____________________________ Relationship to patient: ______________________

Secondary Ins: __________________________________ S.S./Policy #: __________________________________

Employer: _____________________________________ Group #: ______________________________________

Policyholder name & DOB: _____________________________ Relationship to patient: ______________________

EMERGENCY CONTACT (A FRIEND OR RELATIVE)

Name: ____ Relationship to patient: ______________________

Phone #: ______________________________ Address: ____

City: _______________________________________ State/Zip: _______________________________________

ASSIGNMENT OF BENEFITS

Date: _____________ I, __________________________, hereby assign all medical benefits to the providers of **ORTEGO ALLERGY ASTHMA & FAMILY MEDICINE**. I hereby authorize said assignee release all information necessary to secure the payment of said benefits. I understand that I am financially responsible for all charges,whether in person or through telehealth, whether or not paid by insurance. Charges are to be paid at the time of service unless other arrangements are made in advance with our office manager. It is my understanding that delinquent accounts are turned over for collection with an additional delinquency charge on unpaid balances. Should the delinquent account be placed with a collection agency or attorney, there will be a 35% collection fee added to the delinquent balance.

Signature of responsible party: ____

ORTEGO FAMILY MEDICINE ALLERGY & ASTHMA

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AM. EXPRESS
INSURANCE, MEDICAID AND MEDICARE

REGARDING INSURANCE

We require that all deductible and co-pay amounts be paid at the time of service. **The balance is your responsibility** whether your insurance company pays or not. Your insurance policy is a contract between you and your company. We are not a party to that contract. Please be aware that some, and perhaps all of the services provided may be a non-covered service and not considered reasonable and necessary under all insurance plans. We do allow 45 days to make full payment in these situations.

RESPONSIBILITY FOR PAYMENT

Adult patients are responsible for full payment at the time of service. The adult, parent, or guardian accompanying a minor at the time of service is responsible for full payment at that time. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to Visa, Master Card, Discover, American Express, or payment by cash or check at the time of service.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

****NO SHOWS (MISSED APPOINTMENTS) ****

_________ So we can serve all our patients in a timely manner, please give us advance notice if
INITIAL you are unable to keep a scheduled appointment. Excessive abuse of scheduled appointments may result in discharge from our clinic.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF ORTEGO ASTHMA ALLERGY & FAMILY MEDICINE.

X____ Date: ______________________

Signature of responsible party

ORTEGO FAMILY MEDICINE ALLERGY & ASTHMA

PRIVACY PRACTICES/ASSIGNMENT OF BENEFITS

Please sign in each blank

Assignment of Benefits. _________________ I hereby assign to Ortego Family Medicine Allergy & Asthma any insurance or other third-party benefits available for healthcare services provided to me. I understand that Ortego Family Medicine Allergy & Asthma has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Ortego Family Medicine Allergy & Asthma, I agree to forward to Ortego Family Medicine Allergy & Asthma all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Consent for Office Operations. _________________I hereby give my consent to Ortego Family Medicine Allergy & Asthma to contact me by automated calls, text messages and/or email. I am aware that these messages may be about appointments, test results and more. I also give my consent to Ortego Family Medicine Allergy & Asthma to access and input information into LINKS on my behalf. I also consent to telehealth visits if necessary

Consent for Clinical Services. __________________I hereby give my consent to Ortego Family Medicine Allergy & Asthma to solicit medical and personal history from me, whether in person or through telehealth, and maintain information as part of my personal file in the clinic. As a patient, I will accept all tests, examination and prescriptions and accepts to be treated by an Advanced Practice Registered Nurse. I understand that all information in my file will be kept confidential and will not be given to any person/agency within the office of Ortego Family Medicine Allergy & Asthma without prior approval by me. I hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures, tests, cultures, and urine drug screens when approved.
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending Nurse Practitioner, physician or other assigned designees.
- Download medication history automatically from pharmacy benefit managers

ORTEGO FAMILY MEDICINE ALLERGY & ASTHMA

PATIENT AUTHORIZATION AND RELEASE OF CONFIDENTIAL INFORMATION

Requestors such as insurers, managed care companies, federal and state agencies and/or schools occasionally review medical charts or request pertinent information with which they ensure compliance with the company procedures or provide necessary services (such as facilitate treatment or authorize prescription refills, dispense medication at school, etc.). I understand information in my chart will be preserved and protected, and I hereby consent to such medical chart review and/or transmission of necessary information. I also release this physician, his agents, and any such requestor from liability for any reasonable review or release. This information may be provided to requestor by email, fax, or telephone.

Signature of Patient/Parent if a minor: ____

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ____

Signature: ____ Date: ______________

PLEASE FEEL FREE TO TAKE ONE OF OUR HIPAA NOTICES LOCATED IN FRONT WAITING ROOM.

AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL/BILLING INFORMATION

Patient Name:_______________________________ Date of Birth:________________________

I AUTHORIZE Ortego Family Medicine Allergy & Asthma to verbally disclose medical/billing information to the individuals listed below.

I agree to the verbal release of information from past, current, or future visits.

I agree that a photocopy of this authorization will be treated in the same manner as the original.

Information related to Mental Health, Chemical Dependency, or HIV testing and/or therapy will only be released to the patient.

Name of Individual	**Relationship to Patient**	**Information to be disclosed (Medical, billing)**

This information will remain in effect until cancelled or revoked by patient. To cancel or revoke this authorization, I will forward a written notice to Ortego Family Medicine Allergy & Asthma.

This information once released will no longer be protected under the Federal Privacy Laws.

___________________________	_____________	__________________
Signature of patient/guardian	Date	Relationship to patient
___________________________	_____________	__________________
Witness if patient is unable to sign	Date	Reason patient is unable to sign

CONSENT TO TREATMENT OF MINOR CHILD

Name of Child:_______________________________________ Date of Birth:________________

Parent/Legal Guardian:____

As the parent/legal guardian of the above name minor child, I hereby give my consent for the following individuals to bring said minor child in for medical treatment at Ortego Family Medicine Allergy & Asthma. I give permission to the person(s) listed below to consent to all medical treatment recommended by the Advanced Practice Registered Nurse who is providing medical care to said minor child, whether in person or through telehealth.

Full Name	**Relationship to Child**
______________________________________	______________________________
______________________________________	______________________________
______________________________________	______________________________
______________________________________	______________________________

This consent will remain in effect until revoked in writing.

_______________________________________ ______________________________

Signature of Parent/Legal Guardian Date

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Witness