Chancellor Primary Care

Faith, Health & Family

Patient's PCP ____ Dr. Ross ____ Dawn Hunt FNP-BC ____ Dr. Alexander Patient's Chart#

Patient Registration

Patient's Last Name	**First Name**	**Middle Initial**
Patient's address		
Patient's home#	**Patient's cellphone#**	
Patient's DOB	**Patient social security#**	
Patient's Sex: M or F	**Patient's marital status: S D M W Sep**	
Patient's employer	**Patient's work#**	
Patient's email		
Emergency Contact	**Emergency phone#**	
I give permission to call and/or leave detailed messages on the following phone/s: ALL HOME CELL WORK NONE		
Preferred Pharmacy:	**Location:**	**Mail Order Pharmacy:**

Patient Insurance

Chancellor Primary Care does not file claims to Tertiary carriers but, feel free to request documents from our office

Primary Insurance	**Secondary Insurance**
Subscriber	**Subscriber**
Subscriber ID#	**Subscriber ID#**
Subscriber's Sex: M or F	**Subscriber's Sex: M or F**
DOB	**DOB**

Please note: copies of ALL your Insurance cards along with a valid Picture ID are required at the time of service. We reserve the right to cancel and/or reschedule your appointment if you do not provide required insurance card/s at time of service. If there is a change in your insurance coverage you need to notify the practice with the change immediately or you will be held responsible for any balance/s.

Insurance Authorization & Assignment Agreement

I hereby authorize Chancellor Primary Care disclosure of health insurance information and/or to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above-named provider. I certify that the information reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information to other treating physicians and to my insurance company in order to determine insurance benefits to which I may be entitled. In the event that my insurance company does not provide coverage for services rendered, I take full financial responsibility for any charges that may incur.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION.
ALL INFORMATION LISTED ABOVE IS CORRECT OR I UPDATED ANY CORRECTIONS DIRECTLY ON THIS FORM TODAY.

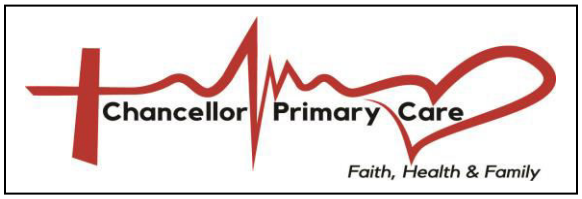
_____ _____

Patient's signature and/or Patient's Representative Today's Date

Financial Policy & Practice Guidelines

Patient Name _____

Patient Account# _____



- **Valid Insurance cards** I will provide all valid insurance cards and I am responsible for updating any and all insurance changes and provide updated valid insurance cards. I am also aware that if I do not give valid and active insurances cards or coverage information at the time of service and/or any denial or retractions on claims are paid incorrectly; that I will be responsible for paying the balance owed and will have to file those affected claims myself. Chancellor Primary Care does not file claims to Tertiary carriers but, our office will provide patients with any documentation if requested in the event that we can provide it.
- **Non-Participating Insurance Carriers & Open Access/HMO policies** If my insurance carrier has Chancellor Primary Care listed as a participating provider at the time of service, Chancellor Primary Care will submit claims to my insurance carrier. If Chancellor Primary Care is NOT a participating provider with my insurance carrier at time of service, I am responsible for full payment at time of service or when the claim comes back as denied. I understand if I have an HMO or an HMO Open Access policy that is the requirement of Chancellor Primary Care to have my doctor's name listed as my PCP.
- **Patient Credits** Any credits on my account will be credit only and not refunded unless I request one by contacting the office.
- **Returned Checks** Any checks returned unpaid by your financial institution will be subject to a $35.00 returned check fee.
- **Bankruptcy** Our practice holds the right to dismiss a patient and family members that includes any debt/s owed within their bankruptcy case.
- **Non-covered Service:** All health plans are not the same and do not cover the same services. In the event my health plan determines a service to be "non-covered", I will be responsible for the entire charge. I understand payment is due at time of service or upon receipt of a statement from Chancellor Primary Care.
- **Routine Physicals & Routine Vaccines** Preventative health checks may or may not be covered by my health insurance policy. I will review my individual health benefits for coverage before my visit. If this service is not covered under my policy, I will pay for any balance for this service. Please be aware most insurance companies DO NOT cover routine injections or vaccines. It is my responsibility to check on coverage for all injections & vaccines prior to receiving them.
- **Personal Injury Cases & Workman's Comp** I understand that Chancellor Primary Care does not bill for Workman's Comp, auto accidents, liability and/ or law suit related cases. I am responsible for payment at time of service. I will submit my own claims.
- **Minor Patients** For all services rendered to minor patients, I understand the adult accompanying the patient is responsible for co-pays, deductibles, co-insurance, and outstanding account balances at time of service. A parent or guardian is required to be present for a minor's appointment.
- **NCNS/Missed Appointments** In fairness to other patients and the physician, I will provide at least 24 hours' notice to cancel appointments, there will be a charge billed to me as NCNS for $35.00 and after 1 (one) missed appointment in one calendar year I may be dismissed from Chancellor Primary Care.
- **Insurance Assignment of Benefits & Release of Medical Information** I hereby assign all insurance benefits due me to be paid to Chancellor Primary Care. For any amounts not paid by me, I direct all insurers pay directly to Chancellor Primary Care all such benefits. I understand that I am responsible for any amounts not covered by insurance. A copy of this signature is as valid as the original. Additionally, I hereby authorize Chancellor Primary Care to release any medical information concerning my illness and treatments deemed necessary to process this claim and all future claims to all insurers having responsibility for charges incurred. Any contract for insurance coverage is made between my employer, the insurance company and me. Chancellor Primary Care has no influence over available benefits or the approval of a claim. Payment for all services is my responsibility. Payment is due and payable at the time of services rendered for all copays or non-covered services.

In-House Collection Policy

Our office does not use an outside collection agency & we feel that (4) attempts to collect an outstanding balance plus a phone call is enough notice making you aware your account is delinquent. We established our billing policy to keep down costs & we do not attach any hidden fees or interest to your account. Please contact our Medical Billing Administrator by calling (540) 870-6550 to setup a payment plan or for any additional questions. Below is the order of our In-House Collection process for Chancellor Primary Care:

- Patients will receive (2) Patient Statements after your insurance has sent payment or denial of your claim.
- After 90 days our 3rd attempt will result in a Past Due Letter mailed out concerning your unpaid balance.
- After 120 days our final attempt will result in a Final Notice Letter mailed out to the patient stating that if we do not receive payment within the next 10-15 days dismissal from our practice will be forthcoming.
- The last attempt will be our office trying to contact the patient by phone to collect the balance or setup a payment plan.
- At the last stage of trying to collect your unpaid balance your account will be reviewed by your Physician and they will decide if a Dismissal Letter will be generated from this practice due to non-payment or if the balance will be written off to uncollected Bad Debt account and flagged. Please be aware if that occurs you will be required to pay that entire balance in full before any appointment or medication can be offered in the future.

I have read and understand the financial policy of the practice and I agree to be bound by its terms for payment of all professional fees. By signing this statement, I and my designated parties have agreed that the insurance information provided to Chancellor Primary Care is the only active insurance coverage/s for this patient. I understand and agree that such terms may be amended by the practice. The patient/parent is ultimately responsible for all professional fees.

By signing below, I acknowledge I've read and I understand, accept, the following terms set forward by Chancellor Primary Care.

_____ _____

Patient's signature and/or Patient's Representative Today's date

Chancellor Primary Care
Faith, Health & Family

4510 Plank Road, Suite 200
Fredericksburg, VA 22407-0138
Office (540) 870-6550
Fax (540) 870-6552

Authorization for release of Private Health Information to a Designated Party

Physician Name _____ Patient's Chart # _____

Patient Name _____ Patient's Date of Birth _____

Designated Party_____ Designated Party_____

Relationship to Patient_____ Relationship to Patient _____

Address _____ Address _____

Phone _____ Phone _____

This Authorization grants permission to the Designated Party(ies) named above to item/s checked below:

_____ have access to my medical record information

_____ have access to my billing & insurance information

_____ have access to any test results

_____ make or confirm appointments

I authorize Chancellor Primary Care, PLLC to use and disclose my health information as described in this authorization. The patient or the patient's representative must read and initial the following statements:

· I understand that this information will expire only when revoked by the patient or patient's representative. I must revoke this authorization by notifying in writing the above-named Physician.

· I understand that this authorization is voluntary.

· I understand that once this information is released to the Designated Party(ies), the released information may no longer be protected by federal privacy regulations.

· I understand that my treatment cannot be conditioned on whether I sign this authorization.

_____ _____

Signature of patient or patient's representative
(Form MUST be completed before signing or will not be valid)

HIPAA Compliance Date

4510 Plank Road, Suite 200
Fredericksburg, VA 22407-0138
Office (540) 870-6550
Fax (540) 870-6552

Notice of Privacy Practices Acknowledgement (HIPAA)

Patient Acct #: _____

Patient Name: _____

Date of Birth: _____

I have received or been offered a copy of the Chancellor Primary Care's Notice of Privacy Practices (also Known as HIPAA). I understand that Chancellor Primary Care reserves the right to modify their Notice of Privacy Practices and that I may contact Chancellor Primary Care at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Signature: _____

Date signed: _____

Responsible Party Signature: _____
(If different than the Patient)

Date signed: _____

Chancellor Primary Care
Faith, Health & Family

4510 Plank Road, Suite 200
Fredericksburg, VA 22407-0138
OFFICE (540) 870-6550

Authorization request to obtain medical records

Medical Records may be faxed to this number **FAX (540) 412-0122**

Patient's Name (PLEASE PRINT) _____

Patient's Address _____

Date of birth _____ Home Phone number _____

I request that my medical records be transferred from the following office:

Physician_____
Address_____
Phone#_____ Fax#_____

Physician_____
Address_____
Phone#_____ Fax#_____

Extent of information to be released: Last two office notes, Last two lab results, Immunizations, Endoscopy records, Last 2 years of X-rays

_____ I DO _____ I DO NOT authorize the release of information related to Aids or HIV infection, psychiatric care and/or psychological assessments and treatment for alcohol and/or drug abuse.

Please forward my medical records to the following physician or mid-level:

_____ Dr. Jennifer Ross _____ Dr. Dawn Alexander
_____ Dawn Hunt FNP-BC _____ Dr. Jeff Singley

I understand that the copying fee for records provided by Chancellor Primary Care is as follows: $10.00 retrieval fee plus $ .50 per page for the first 50 pages and $ .25 per page for each additional page copied for personal use. Payment for the records and outstanding balances on your account must be paid in full prior to records being processed. Please be aware that there is normally no charge for copying medical records requested from physician to physician, but it is strictly up to each individual medical practice but in the case that your old medical office charges a fee, you will be responsible to pay and retrieve your medical records.

I understand that I have the right to access my medical records in accordance with the law and policies of Chancellor Primary Care. I understand that Chancellor Primary Care charges me for copies of my medical records for personal use and I acknowledge the fee schedule listed above.

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the dated signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person/s or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition treatment of me on whether or not I sign this authorization.

_____ _____
Signature of patient or patient's representative Today's date

Please mail medical records to the above office address, or fax records to **Fax Number FAX (540) 412-0122**