Today's Date: ____________

PATIENT INFORMATION

First Name: ________________________ MI: ___ Last Name: ______________________ SSN#:____________________

Date of Birth: ___________ Age: ______ Sex: ____ Gender Identity: ___________Sexual Orientation: _______________

Marital Status: S___ M___ D___ W___ Email Address: _____________________________________

Race: _________________________ Ethnicity (Circle One): Hispanic/Non-Hispanic Primary Language: ____________

Street Address: __________________________________ Mailing Address (If Different):__________________________

City: _____________________________ State: _________________________ Zip Code: _________________________

Home Phone: ____________________________________ Mobile Phone: ______________________________________

Work Phone:_____________________________________ Employer/Occupation:_______________________________

ACCOUNT RESPONSIBILITY (If different than above)

Who is responsible for this account? ________________________________ Relationship to patient: ________________

Mailing Address: ____ City: ______________________ State: _________

Cell Phone: __________________ Home Phone: __________________ Date of Birth: __________SSN#: _____________

MEDICAL INSURANCE

Name of Primary Insurance Company: ____

Subscriber Name: ____ Group # ____________________________

Member ID: ______________________________________ Subscriber Date of Birth: _____________________________

Name of Secondary Insurance Company: ____

Subscriber Name: ________________________________ Group # _________________ Member ID: ________________

Subscriber Date of Birth: ______________________ Medicare ID (If on Medicare): _______________________________

CASH PAY POLICY

Patients without medical insurance are required to pay total amount due at the time of service

By signing below, you state that you have read and understand the above cash pay policy.

Patient/Guardian Signature: ____

CLINIC BILLING AND EXPECTATIONS

Please sign below to indicate you have read and understand the following:

1. **Responsibility for payment of your account always remains with you**; and although you may have a pending insurance claim, we will require you to pay regardless of the circumstances involved. Please contact us immediately if there is a problem with your payment.

2. Copays and other estimated out of pocket amount due are to be collected at the time of service.

3. You will receive a monthly statement showing itemized charges and the total amount due on your account. Payment in full is required within the office/telemedicine appointment unless arrangements are made with our office.

4. Family and Aesthetics Medical Centers may need to contact you for additional information or to collect any amounts you may owe. You give your express agreement and consent to allow Family and Aesthetics Medical Centers to call you at any telephone number provided or obtained.

5. A $55.00 fee will be charged to your account if you do not cancel your appointment 24 hours in advance.

6. There is a $45.00 fee for all returned checks and for stop payments.

7. If you arrive more than fifteen minutes late to an appointment, you may be asked to reschedule.

8. Family and Aesthetics Medical Centers requires 7 business days to respond to all medication refill requests. Medications will not be refilled after clinic hours. Please contact your pharmacy to initiate refill requests.

9. Please allow 7 business days for completion of any forms. (FMLA, short/long term Disability, Physicians medical statements) There is a $25.00 charge due from the patient not the insurance company for any forms that need to be completed.

CONSENT FOR TREATMENT

By signing below, you state that you have read and understand the above **CLINIC BILLING AND EXPECTATIONS.**
I am requesting Family and Aesthetics Medical Centers to provide health care related treatment and consultation to the below named patient, and that I may refuse treatment or services at any time. I understand Family & Aesthetics does not guarantee any outcome for any services or treatments, either stated or implied.

Patient Name (Please Print):____Date of Birth: ___________

Signature (Patient/Guardian): _______________________________________Date:__________________

Acknowledgment Privacy Policy Offered

My health information may be created or reviewed by Family and Aesthetics Medical Centers and may be in the form of written or electronic records or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedure, prescriptions, and similar types of related health information.

I understand that I have the right to receive and review a written description of how Family and Aesthetics Medical Centers will handle my health information. This written description is known as a **Notice of Privacy Practices**. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Family and Aesthetics Medical Centers and my right regarding my health information. I may obtain a copy of the **Notice of Privacy Practices** at the reception desk or view it on the clinic website.

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 the Praxis Medical Group's **Notice of Privacy Practices** in effect will be posted in the waiting/reception area and on the clinic website.

By signing, I agree that I have reviewed and understand the above information and that I am entitled to receive a copy of Family and Aesthetics Medical Centers Notice of Privacy Practices.
Notice of Privacy Practices copies are available at the reception desk.

Patient Confidential Communication

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. To protect the privacy and confidentiality of your information, please complete the following.

I give permission to Family and Aesthetics Medical Centers to leave messages regarding:

☐ Appointments ☐ Billing information

☐ Limited medical information, such as: normal results (Abnormal results and sensitive information will never be left on voice message), generic recommendations, medication information or referral status or updates on any of the following phone numbers listed on patient information form:

And/or with the following person(s):
Name:______________________________ Relationship: ___________ Phone number:_____________
Name:______________________________ Relationship: ___________ Phone number:_____________
Name:______________________________ Relationship: ___________ Phone number:_____________

This release will be revoked by written permission only. I understand that I must send a written request to Family and Aesthetics Medical Centers to revoke this request. When translation services are utilized, you give express consent that it may be done using a wireless mobile device.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

Patient Name (Please Print):___________________________________Date of Birth: ___________

Signature (Patient/Guardian): __________________________________Date:_______________

Formulary Benefits Management (FAM) Consent Form

Formulary Benefit data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (FAM). FAM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the FAM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below, I give permission for Family and Aesthetics Medical Centers to access my pharmacy benefits data electronically through RxHub. This consent will enable Family and Aesthetics Medical Centers to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a histories list of all medications prescribed for a patient by any provider

In summary, we ask your permission to obtain formulary information and information about other prescriptions by other providers using RxHub. This consent will be in place until revoked in writing.
I give permission for Rx History consent: (yes/no) _______________

Care Management Services Financial Agreement

With the transformation of health care across the country, there were new government billing guidelines established in 2015 for services identified as "Care Management". These services are non-face to face and include but are not limited to follow ups for emergency room visits, inpatient hospitalizations, as well as coordination of care for ongoing chronic conditions. Examples: Diabetes, Hypertension.

These services are rendered by multiple means, to include but are not limited to telephone and/or email contact, directly with client or their designated health contact, other health care professionals, as well as verbal and written reports.

These services may be billable to your insurance plan; any insurance payment processing will depend on your individual plan coverage. By signing below, you agree to allow us to provide these services for you.

I give permission for care management services: (yes/no) __________________

By signing below, you state that you have read and understand the above statements regarding F.A.M consent and are Management Services financial agreement.

Patient Name (Please Print):____Date of Birth: ____________

Signature (Patient/Guardian): ____Date:___________________