Financial Policy

Overview of Financial Responsibilities

Practice Responsibilities: To submit claims to insurance, and statements to the patient/responsible party based on the information made available to us. To provide patients with the network and billing information that is available to us.

Patient/Parent/Guardian Responsibilities: To understand her own insurance network and benefits. To assure that our office is provided with the most current information known about their insurance, and to inform us of any changes in insurance or demographics (address, phone numbers, etc). To within 30 days any balance signed and patient responsibilities (e.g., co-pay, deductible, and co-insurance).

PATIENT INFORMATION

Patient Name (First, Middle, Last)	Date of Birth

Insurance Subscriber Name (if not Patient)	Relationship to Patient	Insurance Subscriber DOB	Insurance Subscriber SS#

Detailed Policies

☐ Initial Here

Patient must understand their OWN network, plan benefits, and plan limitations. Your health insurance is an agreement between you and your insurance. All charges are ultimately your responsibility, whether you have insurance or not. Not all services are covered under all plans, regardless of whether our doctors consider the care medically necessary. Because there are so many plans, it is not possible for us to know the specific details of your coverage. By making a copy of your card, it does not confirm that we are part of your Network. We always do our best, but failure of our office staff to identify out-of-network plans does not waive your responsibility for payment of services rendered.

We are in network with most traditional PPO plans: Our current and best understanding of our network participation is on our website, but we are **our-of-network:** United Healthcare PPO, all HMOs, most State Exchanges plans, most Narrow PPOs, all HMO/IPA plans, Medicare Advantage HMOs, Medicaid/Medi-Cal/CalOptima, Worker's Compensation plans, and most Blue Shield and Anthem Blue Cross Individual/family plans purchased outside of employer group plans. Our recommendation is to call your insurance about a week before your appointment and ask if your plan's network includes our office, and what patient cost sharing may be applied. You authorize your insurance to pay us directly.

☐ Initial Here

Bring patient's Insurance Card to every visit. Patients with insurance are responsible for ensuring that our insurance records and other information are up to date. Patients who have not presented a valid active insurance card will be considered self-pay/cash-pay- and they must pay a minimum of $ 50 visit fee at arrival. Patients will have full responsibility for charges if we cannot process a claim due to incomplete, inaccurate or obsolete information. If your insurance changes, you must notify us immediately (even if you do not yet have your card); delays caused by patients can result in the claim being uncollectible from insurance, resulting in patient having full responsibility for all charges.

☐ Initial Here

Co-Pay, Self-Pay, and Cosmetic services are due at the time of Service. Co-Pay is always expected at date of service. There is a $ 5 billing fee for all Co-Payments that must be billed after the date of service. For patients with high deductible plans, a $ 50 payment will be collected on date of service towards the office visit. In some cases, we will ask for additional payment towards coinsurance or deductible prior to treatment.

☐ Initial Here

All procedures and lab services have fees, in addition to the visit fee. Co-pay is usually for office visit only, and does not typically cover procedures (e.g., any type of freeze, removal, incision, injection or other treatment). Estimates for medical procedures are not typically given by the doctor; estimates can be provided, but procedures will typically need to be rescheduled for another day. An skin or tissue sample must be treated as if it could be cancerous, even if it is removed primarily at the patient's request, and will result in both excision/biopsy fees and pathology fees. Labs, imaging, special stains, and other test sometimes must be ordered, and may be furnished by independent sources to complete a diagnosis. We are not responsible for those charges; Contact those billing facilities for billing questions.

☐ Initial Here	**Bills are DUE UPON RECEIPT.** We are required to collect CO-PAY, DEDUCTIBLE, AND CO-INSURANCE. Past due balances will be assessed a $ 10 statement fee for each additional statement we must send. Any self-pay, out of network, or other courtesy adjustments will be recinded if account becomes over 30 days past due. We may charge 18% interest or as allowed by law for any delinquent payment. We exhaust efforts to resolve balances prior to use of a collection agency, however, additional fees up to 50% of your charges may accrue from collections activity. Returned checks will be assessed $ 25 fee.
☐ Initial Here	**Credit Card On File.** Our Group frequently keeps CC on file to streamline the payment process. We reserve the option to utilize your CC on file to pay copayments, coinsurance and other patient responsibilities.
☐ Initial Here	**Appointment Cancellation Fees.** We make numerous efforts to remind you of appointments. Out of courtesy to other patients that need appointments, please notify us if you need to cancel at least one full business day prior. To encourage early notice, the following fees will apply for late cancellation or no shows. $ 50 for a regular appointment and $ 100 for a medical procedure, surgery or cosmetic appointment.
☐ Initial Here	**Your health information is protected.** We must release patient health information to complete medical operations (e.g., to pharmacies, labs, insurance, other physicians, etc.) Any other release requires your written consent. Our Notice of Privacy Practices is available to you. We may leave a detailed message on your home or cell phone with Health Information.

PLEASE LIST ANY OTHER INDIVIDUALS WITH WHOM WE CAN ALSO DISCUSS THE PATIENT'S CARE IN DETAIL (e.g., spouse, parent, child, etc.)

Name of Health Contact	Relationship to Patient	Primary Phone

Agreement by Patient (or Parent or Guardian). I have read each policy. I understand them and I agree.

______________________________ Signature of Patient (or Parent or Guardian)

______________________________ Date

______________________________ Printed Name of Patient (or Parent or Guardian)

______________ Date of Birth

______________ Social Security Number

______________________________ Street Address (Street, City, State, Zip)

______________________________ Preferred Phone Number ___Cell ____Home _____Work _____Other

______________________________ Email

Thank you for taking the time to understand our Billing Policies. Please contact our office with any questions. 949-716-2400

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	NAME YOU PREFER TO BE CALLED	SEX

ADDRESS	APT #	CITY	STATE	ZIP

SOCIAL SECURITY #	BIRTHDATE	HOME TELEPHONE #	CELL PHONE #

WORK TELEPHONE #	E-MAIL ADDRESS

EMPLOYER	EMPLOYER ADDRESS	POSITION/ TITLE

HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT NAME & TELEPHONE NUMBERS

WHO IS YOUR PRIMARY PHYSICIAN?	TELEPHONE #

PHYSICIAN ADDRESS

GUARANTOR/ POLICY HOLDER INFORMATION

LAST	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT
			SPOUSE PARENT OTHER:

ADDRESSS IF DIFFERENT FROM PATIENT

BIRTH DATE	SOCIAL SECURITY #

GUARANTOR/ POLICY HOLDER'S EMPLOYER	EMPLOYERS ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION

1.PRIMARY INSURANCE PLAN	GROUP NUMBER	POLICY NUMBER

TYPE OF PLAN OR COVERAGE

HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER

POLICY OWNERS NAME (GUARANTOR)	IPA	PRIMARY CARE PROVIDER

2.SECONDARY INSURANCE PLAN	GROUP NUMBER	POLICY NUMBER

TYPE OF PLAN OR COVERAGE

HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER

POLICY OWNERS NAME (GUARANTOR)	IPA	PRIMARY CARE PROVIDER

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment in 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office. It is also customary to pay for professional services when rendered unless prior arrangements are made. I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Pacific Thoracic Surgery. Inc. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration and healthcare financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim or other insurance claim. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made payable to Pacific Thoracic Surgery, Inc. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.(section 1128b of the social security act and 31 u.s.c 3801-3812 provides penalties for withholding this information.) There is a $25.00 charge for all returned checks. All unpaid balances are subject to 1.5% interest or minimum $6.00 service charge after 90 days. If your account must be forwarded to a collection service and/or an attorney because of nonpayment, you will be responsible for all collection fees and/or attorney fees charged by these services.

PATIENTS SIGNATURE____________________ GUARANTORS SIGNATURE____________________ DATE________

HEALTH HISTORY FORM

Patient Name: ______________________________ **Date of Birth:** ____________

Personal Medical History: **Have you ever had (please circle all answers Yes or No)**

Condition			Condition			Condition		
High Blood Pressure	No	Yes	Anxiety	No	Yes	Pneumonia	No	Yes
Heart Disease	No	Yes	Depression	No	Yes	Meningitis	No	Yes
Heart Murmur	No	Yes	Epilepsy	No	Yes	Gonorrhea	No	Yes
High Cholesterol	No	Yes	Osteoporosis	No	Yes	Chlamydia	No	Yes
Diabetes	No	Yes	Thyroid Disease	No	Yes	Syphilis	No	Yes
Anemia	No	Yes	Asthma	No	Yes	Genital Herpes	No	Yes
Stomach pain or Reflux	No	Yes	Hives or Eczema	No	Yes	Genital Warts	No	Yes
Arthritis or Rheumatism	No	Yes	Migraines	No	Yes	Tuberculosis	No	Yes
Kidney disease	No	Yes	Gallbladder Disease	No	Yes	AIDS/HIV	No	Yes
Neuritis or Neuralgia	No	Yes	Colitis or other Bowel Disease	No	Yes			
Bone or Joint disease	No	Yes	Jaundice or Liver Disease	No	Yes			
Sciatica, Back pain	No	Yes	Cancer *	No	Yes	* Type of Cancer: ____________		

If "yes" to any of the above, please describe further: ______________________________

If you have, or have had, any symptoms in the following areas to a significant degree, please briefly explain.

Skin:
Head/Neck:
Ears/Nose/Throat:
Lungs:
Chest/Heart:

Back/Joints:
Intestinal:
Bladder:
Menstruation:
Circulation:

Recent Changes in the following:
Weight:
Energy level:
Mood:
Other pain or discomfort:

Other Medical Problems & Surgeries:

____

____

List All Current Medication and Dosages: (include non-prescription)

____

____

Allergies to medications or food:

____

Describe the allergic reaction:

____

Do you drink alcohol? No Yes Number of drinks ______ per week Quit date: ____________

Do you or have you ever smoked? No Yes How many cigarettes per day: ________ How many years: ________
Quit date: ____________

Do you use drugs? No Yes What kind: ____________________ How many years: ________

Are you currently (circle one): Married Single Divorced Widowed

How many children do you have? ________ Ages: ________________

Occupation: ____________________ Employer: ____________________ Highest level of education: ____________

Please list the last date you had any of the following:

Pap Smear ____________ Mammogram ____________ Prostate Exam ____________ Colonoscopy ____________

Family Medical History: *example: cancer (type), diabetes, heart disease, mental illness, stroke, seizure, etc.*

Father: ______________________________
Mother: ______________________________
Siblings: ______________________________
____

Paternal grandfather: ______________________________
Paternal grandmother: ______________________________
Maternal grandfather: ______________________________
Maternal grandmother: ______________________________

Pacific Thoracic Surgery

Dr. Ledford Powell
24411 Health Center Drive, Suite 630
Laguna Hills, CA 92653
949-716-2400/Fax 949-716-2401

Medications

Medication	Dose	Date	Date (re-new)	

Assignment of Benefits Form

Name of insured: ____

Insurance I.D. Number: ___________________________________

I hereby assign all medical benefits to which I am entitled to Dr. Ledford Powell/Pacific Thoracic Surgery, Inc. This applies for all insurance carriers, including Medicare, private insurance, and any other health/medical plan. This form will be kept on file.

I understand that it is my responsibility to report any changes in insurance coverage.

I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier, or any other medical entity for continued medical care.

I understand that I am financially responsible for any amount not covered by insurance.

Signature: ____

Date: ____

Revised 04/12/2010

PATIENT RESPONSIBILITIES

As a partner in your healthcare, you have the following responsibilities:

1. I will provide accurate health information to your doctor and update us with any health changes.
2. I will follow treatment plans recommended to me by my physician, including completing testing, making an appointment with a specialist, and taking my medications. I will be sure to clearly comprehend any treatment plan and ask questions when I do not understand. I understand that *not* following my treatment plans may put my health at risk.
3. I will keep my appointments and reschedule any missed appointments. I understand that my doctor schedules these appointments to follow up on my response to treatment and to monitor my medical conditions. If I do not follow up, I may put my health at risk and may have medical conditions go undetected.
4. I understand that the goal of the office is to provide me with test results in a timely fashion. If I do not hear from the office, I will call the office for test results. I understand that not hearing from the office about a particular test does not necessary mean that the test result is normal.
5. I will inform my doctor if my medical condition changes, does not improve, or worsens. This will allow my doctor to re-evaluate my condition and make changes in treatment. If I do not inform my doctor, I may put my health at risk.
6. I will take charge of my health and make positive choices for my health including not smoking, not using illegal drugs, eating a healthy diet, and getting appropriate exercises.
7. I will treat all providers and office staff respectfully and courteously.
8. I will fulfill my financial obligations for care provided to me in a timely manner.
9. I will keep my scheduled appointments and give adequate notice of rescheduling or cancellation.
10. I will take responsibility to understand my Health Plan and be aware of my benefits, deductibles, and Health Plan limitations. I will ask my Health Plan if I have any questions regarding my health coverage.
11. If you need information or inquiring about Advance Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will,) please call the Member Services Department of your Health Plan.

I have been informed of my responsibilities and I understand them fully.

Print Name: ____ Date: ______________

Signature: ____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Pacific Thoracic Surgery Notice of Privacy Practices and that I have read (or had the opportunity to read, if I so do chose) and understood the Notice.

______________________________ ______________________
Patient Name (please print.) Date

____
Parent or Authorized Representative
(if applicable)

____
Signature