TEMESCAL CREEK MEDICINE

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COMMUNICATION & SHARING OF PATIENT INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. Please indicate by signature below that you are authorizing us to use private patient information as indicated in our notice of Privacy Practices.

PRINT NAME: ________________________ **RELATIONSHIP** (IF OTHER THAN PATIENT): __________

SIGNED: ______________________________ **DATE:** ________

As a policy we will not share information outside of allowances in the Privacy Policy. If you would like to specifically permit sharing with family, spouses, partners or others please include names and relationships below:

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PLEASE REVIEW AND INITIAL BELOW:

_____I understand that Temescal Creek Medicine uses standard (non secure) email for administrative and clinical communication. I have reviewed the TCM email policy (www.tcreekmed.com) and I have provided an appropriate email address for this use. *By initialing above I am indicating I wish to communicate with the office using standard email.*

_____I understand that it is sometimes helpful to leave voice message on cellular and home phones. *By initialing above I am agreeing to allow Temescal Creek Medicine to leave administrative as well as clinical voice messages at the phone numbers I have provided to them.*

CREDIT CARD BILLING AUTHORIZATION

I, ______________________________________, authorize Temescal Creek Medicine P.C. to keep my signature on file and to charge my account for any balance owing on my account. I authorize charges to commence on _________________(today's date). I understand that this form is valid until I give a 30-day written notice to cancel the authorization to Temescal Creek Medicine.

PATIENT NAME:____

CARD HOLDER'S NAME (AS SHOWN ON CARD):____

CREDIT CARD BILLING ADDRESS:____

CITY, STATE, ZIP:____

VISA OR MASTERCARD (**CIRCLE ONE**)

ACCOUNT # _______________________________________

CVV: _____________

EXPIRATION DATE________/________

CARDHOLDER SIGNATURE: ______________________________

FINANCIAL POLICY:

INSURANCE/CASH PAYMENTS

Patients are financially responsible for services provided and are expected to pay at the time of service. It is your responsibility to understand your benefits and deductibles. We are OUT OF NETWORK for all PPO insurance products. Your insurance policy is a legal contract *between the patient and his/her insurance company, not with Temescal Creek Medicine*. If requested, we are happy to provide necessary forms to submit to your insurance company for reimbursement. Issues and questions of actual reimbursement are between the patient and the insurance company.

HMO PATIENTS:

If you are a member of an HMO, one of the Temescal Creek Medicine physicians **MUST** be listed as the PCP on your insurance card for this coverage to be in effect. Copayments will be collected at the time of service. The patient is responsible for payment of all non covered services at the time of service. If you are not listed with Temescal Creek Medicine at the time of service, you are responsible for all visit charges

MEDICARE:

We are Participating Providers in Medicare, which means that we accept Medicare's assignment as payment in full, once your deductibles and co-payments have been made. We will bill Medicare for you. If you have a Medicare supplemental or secondary insurance we will bill them once as a courtesy. All unpaid balances are the responsibility of the patient. Payment of deductibles and co-insurance is required at the time of service. *Please note*: Medicare does not cover several services offered at Temescal Creek Medicine such as telephone consultation and email visits. Please closely review our Advanced Beneficiary Notice for details.

CANCELLATION AND NO SHOW CHARGE

In order to run an efficient business we rely on patients keeping scheduled appointments. We set aside time and resources based on our schedule. If you cancel an appointment with less than 24 hours notice and we cannot fill the appointment time, you will be charged the full cost of the visit. If you "No Show" for the visit there is also a charge for the full cost of the visit.

ASSIGNMENT OF BENEFITS/INSURANCE AUTHORIZATION (HMO AND MEDICARE ONLY)

I, the undersigned, authorize my insurance company/companies to direct payment for medical services rendered to myself or dependents directly to Temescal Creek Medicine. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand and agree to the above stated policies. This authorization and agreement shall be considered valid until revoked in writing. A copy is as valid as the original.

I acknowledge I have read and understand the above financial policy and Assignment of Benefits.

SIGNED: ___________________________________ **DATE:** ______________________