

BOYLE AND TOTH FAMILY MEDICINE, LLC

____ Mr. ____ Mrs. ____ Ms. ____ Miss DATE: _____

Name _____
Last First M.I.

Sex: _____ Male _____ Female

Address: _____
Street Apt. #

City State Zip

Social Security # _____ - _____ - _____ Date of Birth ____/____/____

Phone (____) _____ (____) _____ Ext ____ (____) _____
Home Work Cell

Emergency Contact: _____ (____) _____
Name Relationship Phone

Billing Information: _____
Name of Person Responsible For Bill Relationship

Address Phone

Insurance Name: _____ Customer Service # _____

Do You Have a Directive (A Living Will) _____ YES _____ NO

Authorization and Assignment: I hereby authorize the release of medical information to my insurance company and assign to Susan H. Boyle and James M. Toth and its authorized physician(s) all payment for services rendered to me or my dependents. This assignment will remain in effect until revoked by me in writing. A copy of this authorization may be used in place of the original. Insurance claims will be files only if the physicians are participating providers for my plan; however it's my responsibility to know my covered benefits. Should my insurance not reimburse the office in a timely manner, I am responsible for the balance.

Authorization for Treatment: I authorize and consent to examination by clinicians and physicians of Boyle and Toth Family Medicine. I also authorize and consent to diagnostic procedures and or treatment.

Patient or Parent / Guardian Signature: _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Boyle and Toth Family Medicine, LLC to use and disclose my protected health information (**PHI**) about me to carry our treatment, payment and healthcare operations (**TPO**). Boyle and Toth Family Medicine’s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I, _____, have been made available, upon my request, a copy of Boyle and Toth Family Medicine’s Notice of Privacy Practices. Boyle and Toth Family Medicine, LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Boyle and Toth Family Medicine, LLC Privacy Office at 4855 River Green Parkway Duluth, GA 30096.

With this consent, Boyle and Toth Family Medicine may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out **TPO**, such as appointment reminders, insurance items, patient statements, and all calls pertaining to clinical care, including laboratory results among others, or by process of US mail.

With this consent, Boyle and Toth Family Medicine, LLC may mail to my home or other alternative location any items that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Boyle and Toth Family Medicine’s use of my **PHI** to carry out **TPO**.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Boyle and Toth Family Medicine may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient’s Name

Printed Name of Patient or Legal Guardian

Date

2010 Financial Policies for Boyle and Toth, Family Medicine, LLC

Billing Policy

Our office will be happy to file your charges for services rendered to your insurance company. If you are a participating member of any insurance plan, we will expect you to pay your co-payment and/or any other fees that are not covered at the time of your visit. If you are unable to pay at the time of service, you must bring in/call with payment within 24 hours of your original appointment to avoid a \$25.00 penalty unless otherwise discussed with the office manager. In exchange for filing your insurance, you agree to provide current insurance information and picture I.D. We understand that filling out forms is at times tedious; we do our best to simplify this process. It is the policy of this office that at every office visit you complete our demographic form and provide your insurance card for verification. If you are unable to present us with a valid insurance card and/or we are unable to verify what we have on file, you will be a self-pay patient and will be responsible to pay for your visit in full on the same day services are rendered. If we are able to verify that your insurance is active, but are unable to obtain any copay/coinsurance information while you're in the office, you will be required to pay 20% of the total charges included in your visit. If your insurance is one that we do not participate with or you are a self-pay patient, you are required to pay in full for your visit upon check out. Starting in 2010, patients who receive medical care by telephone or e-mail will be charged for this service.

We participate on many plans and it is difficult to be 100% accurate with the changes that insurance companies make in regard to laboratory work, referral requirements, precertifications, etc. We attempt to keep our office staff fully educated on the most recent changes and updates. We feel strongly that it is also the patient's responsibility to be aware of the requirements and limitations of their own benefits and insurance plans. Any patient who is seen and fails to notify our office of any changes in their insurance that in turn deems their services as non-covered will be billed directly for these charges. Unpaid balances will be assessed a \$25 late fee if not paid in full after the second statement. Patient's account left unpaid after the late fee is applied will be turned over to collections, patient dismissed from the practice, and a charge of 30% of the total account balance will be applied to balance due.

Prescription Refills

The doctors do not accept prescription refills by telephone request. Please contact your pharmacy for refill requests. If your refills have run out, please schedule a follow-up appointment. Keep in mind, the doctors strive to provide refills until your next appointment. A \$15.00 processing fee must be paid in full if your prescription requires prior authorization through your insurance company.

Mailings

If you request an item to be mailed to you (prescriptions, copy of test results, etc.), please provide us with self-addressed stamped envelopes. Otherwise, the item can be faxed to you or placed at the front desk for patient pick up during office hours.

Check Policy

We are happy to accept your personal check for payment toward your account balance. However, if funds are not available in your account and your check is returned to us as a NSF (or for any other reason), you will be assessed a \$40 service fee plus the amount of the original check. All funds and future payments of any kind must then be paid by cash, credit card or money order.

No Show Policy

Any time that you miss an appointment in our office or cancel an appointment without giving us 24 hours notice, you will be assessed a \$25-\$100 no-show/late cancellation fee. This fee will be your responsibility and must be paid in full prior to your next visit. Dismissal from our practice may result following 3 No Shows.

I have read and hereby understand the above policies.

Signed name by Patient

Date

Print name by Patient

***If you would like a copy of this signed policy please ask the receptionist**