



NP Family Practice & Midwifery Care

1397 Medical Park Blvd Suite #140

Wellington, FL 33414

TEL: (561) 508-3989

FAX: (888) 250-3281

www.npfamilyandmidwife.com

We would like to welcome you as a patient to NP Family Practice & Midwifery Care. Our practice is dedicated to the healthcare of men & women and provides complete Primary Care & OB/GYN services. Practitioners/APRN/ CNM/MD's are available within our practice.

The Providers of NP Family Practice & Midwifery Care are associated with most of the hospitals in Palm Beach County. Office visits are by appointment only, but every effort will be made to accommodate urgent problems. A medical provider is always available after office hours and is reached by calling the office number and being transferred to our answering service. Please remember to disable caller ID's and Call block functions on your phone. If a call back is not received within a reasonable period of time please call back. If, for any reason, you are not able to reach our on-call physician and a true medical emergency exists, please call 911 for immediate assistance. Although our on-call physicians are available for your convenience to deal with medical problems and emergencies, prescription refills, patient update questions, and other non-urgent medical issues should await regular office hours. **Bills may be forwarded for non-urgent telephone consultations and may not be covered by your insurance plan, hence creating a financial obligation for you.**

Our practice participates with most insurance plans; hence we are obliged to follow the policies of your plan regarding authorizations, verifications, co-pays and deductibles. Co-pays are required prior to your physician's visit, and you will be responsible for any deductibles that your coverage imposes. If you are unable to pay your co-pay at the time of your visit, a service charge will be added to your bill for the services on that day. Patients will not be seen without authorization, and it is our responsibility to ensure that your Primary Care Physician or insurance plan has forwarded the appropriate authorization or referral. This is done not only to ensure payment of claims but to avoid the patient being responsible for all medical bills that might arise out of a problem discovered at an unauthorized visit. At times your physician, or you yourself, may request certain laboratory studies be done either as part of a health screen or to evaluate a complaint that you may have. These tests may not be covered by your insurance. It is impossible for NP Family Practice & Midwifery Care and its staff to have knowledge of which tests may be covered by each insurance carrier. If you are concerned about coverage, you should contact your insurance carrier before you have the testing done. NP Family Practice & Midwifery Care does not take any responsibility for fees that are denied by your insurance carrier or for the consequence of any delays in the performance of test while you may be investigating coverage.

For women receiving obstetrical care, payment of applicable deductibles and co-pays must be completed by the 28th week of pregnancy. **Failure to complete these payments may result in dismissal from our practice.** Patients without insurance coverage are expected to provide payment prior to service.

Every effort will be made to keep you informed of test results, but it is your responsibility to ensure that you have been contacted regarding any outstanding tests. It is possible that a result was lost, a message missed, or it is possible that our staff was not aware of a test completed. Remember, no news, is no news, not good news. Be sure you have been contacted regarding tests. Our Providers and staff are available to answer questions and will make every effort to be sure that you understand your diagnosis, the reasons for tests requested, the outcomes of these tests, and the risks, benefits, and other alternatives to procedures recommended. If you do not understand any of these issues or do not feel that you have been properly informed, please ask questions. The practice of medicine is not an exact science and adverse outcomes can and do arise, despite our best efforts to the contrary. Only by asking questions we can be sure that you understand the issues discussed.

Receipt is acknowledged by

Date



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PATIENT INFORMATION FORM

Personal:

Patient Name: _____ Birthdate: _____ SEX: _____

Address: _____ City: _____ State: _____ Zip code: _____

Mobile Phone: _____ Marital Status: S M D W Race: _____

Ethnicity: HISPANIC NON HISPANIC Primary Language: _____

Pharmacy name: _____ Pharmacy phone: _____

YES or NO Consent to Reconcile Medication History EMAIL: _____

Emergency Contact: _____ Number: _____ Relationship: _____

Employment:

Current Employer: _____ Type of work: _____

Referred By: _____

Insurance:

Attach copy of card

Company Name: _____ HMO PPO or OPEN ACCESS (circle one)

ID or Subscriber #: _____ Group #: _____

Claims Address: _____ Phone: _____

Treatment and payment agreement:

I authorize treatment for this and all follow up physician visits.

I authorize release of any medical information necessary to process insurance claims.

I authorize payment and assignment of insurance benefits to this office.

I understand **I am responsible for any copay, deductible and coinsurance at time of service** and any balance deemed patient responsibility by the insurance carrier.

Signature: _____ DATE: _____



Notice of Privacy Practices

Your medical record is called Protected Health Information (PHI) under Federal Law 104-191- The Health Insurance & Patient Accountability Act of 1996 (HIPAA-1996). As of March 1, 2003 all medical practices are required by law to notify you of your privacy rights, and we will post any changes to these rights on the examination room bulletin board.

Use of Protected Health Information with your authorization.

By signing the authorization to be treated on our "Patient Registration" you agree that your PHI may be used or disclosed by our staff for the purpose of Treatment, Payment, health care Operations (TPO), or judicial proceedings and that we call you by name in our waiting room. You also may have authorized a release of your PHI by a written statement from your employer, attorney or insurance carrier. Your PHI may be required for our business records, our computer/billing system, pharmacies, other physicians, laboratories, your employer, or therapists before they will process our request for TPO. You may revoke any authorization, provided we receive it in writing.

What we mean by:

Treatment - other treating personnel, pharmacists, testing facilities.

Payment - for billing and electronic records your diagnosis and treatment dates are disclosed.

Health care operations - compliance audits, public health, office administration or contractual requests.

Judicial proceedings - any court orders, subpoenas, legal audits, or lawful demand.

Use of Your Protected Health Information without your authorization.

Your PHI may be disclosed as required by law, for public health activities, victims of abuse, health and oversight proceedings, law enforcement, judicial and administrative proceedings, funeral homes, research purposes, or specialized governmental functions. In such cases we will release information only if we have received a written request with documentation that the PHI disclosed is expressly authorized by the order.

What we mean by:

Law - if the law requires we will notify you of such disclosure.

Public health activities - FDA, communicable disease, work related injury, instances of abuse or neglect.

Health and oversight - a legal oversight agency for any investigation in which you are not involved.

Law enforcement - properly issued subpoena, warrant, court order, or legal summons.

Disclosure of Protected Health Information requiring your authorization.

Our office does not E-mail or fax information, unless you request it in writing. We will not disclose your PHI to family members, personal representatives or guardians unless you request it. In an emergency we may disclose only relevant information if in our professional judgement it is in your best interest. You may request that we modify or do not use or disclose any or part of your PHI in order to carry out treatment, payment or health care operations. This right to restrict does not extend to disclosures as required by law. You may inspect or request a copy of your PHI (In writing) to be sent to you or an alternative location or by alternative means. Our office has the right to charge a fee to cover supplies, labor costs, and postage. There may be an additional charge to prepare a summary or explanation of the records. The records shall be sent within 30 days from receipt of the written request and payment. If these copies cannot be sent within 30 days we will notify you.

I authorize the following people to have unlimited access to my PHI (any and all of my medical information):

Print Name Relationship Date

Print Name Relationship Date

I have reviewed this notice of Privacy Practices and understand the address location and contact information for the complete HIPAA-1996, and the Privacy Officer for this office is available upon my request, and also that compliance complaints can be made to the Department of Health and Human Services.

Print Name Signature Date



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ACKNOWLEDGEMENT AND AUTHORIZATION:

I understand that I am financially responsible for all services rendered, that there is a \$35 return check fee and that 35% will be added to my balance if my account must be referred to an agency for collection. There is a \$25 charge for late payments. Additionally, I understand that if I am covered by an insurance that requires a referral number, it is my responsibility to obtain that referral number prior to my visit.

- If you are hearing impaired and require an interpreter, we will provide one for you. We do require 2-3 days' notice, and arrangements must be made at the time of scheduling your appointment.
- If you need a wheelchair, all offices have one on site. Please notify us an hour before your appointment.
- If you are visually impaired and have any special needs, please let us know at the time of scheduling your appointment.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

Upon request, I can receive and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact NP Family Practice & Midwifery Care at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

It is important for us to honor the confidentiality between patient and physician.

PLEASE CHECK YOUR PREFERENCE BELOW.

_____ You may discuss my medical information ONLY with me.

_____ I give my permission to discuss my medical information with the following people:

1. _____ Relationship: _____

2. _____ Relationship: _____

2. _____ Relationship: _____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider.
- I authorize NP Family Practice & Midwifery Care to release medical information required to process my claim.
- I have read and understand the Financial Policy for NP Family Practice & Midwifery Care
- I authorize NP Family Practice & Midwifery Care to obtain/have access to my medication history.
- I authorize my provider's office to contact me by mobile phone (text/voicemail) or home phone (voicemail) for medical information.
- I agree with all the above statements, except the following: _____

Signed _____ Date: _____



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Insurance and Self Pay Waiver

Primary Insurance: _____ Primary ID: _____

Secondary Insurance: _____ Secondary ID: _____

INSURANCE:

Please be advised that all services that we provide for you in our offices will be billed to the insurance company you provided us at the time of registration. You may become the liable party (responsible for payment of part or your entire bill) should your insurance company fail to pay us for any services including those services that may be denied as experimental or investigational.

If you apply for Medicaid coverage, we will NOT retroactively file your claims.

It is your personal responsibility to know the details of your insurance coverage, not the responsibility of your doctor's office.

SELF PAY

Please be advised **all labs, cultures and/or pap smears are not included in the amount you paid to our office**. The laboratory will be billing you directly for these services. NP Family Practice & Midwifery Care is not involved in the financial transactions between you and any laboratory that performs services on your behalf. Note: It is your responsibility to decline testing that you may not wish to receive. We may be required to do age specific testing that may be above the usual panel of tests. There are also instances when an initial lab test is abnormal and certain confirmatory testing is necessary. When this occurs, you will be responsible for the cost of the additional testing, which will be billed to you directly by the facility.

Due to the ever growing and changing insurance markets, we are unable to verify if we are participating with your insurance company. It will be left up to you to pre-verify that we are participating with your insurance company on their networks. If we do not participate in your insurance plan, you will be responsible to pay for the service being rendered.

By signing below, I attest that I have read, accept and understand the above insurance waiver for all my services.

Patient Name /Date

Signature of Patient



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Missed Appointment Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call NP Family Practice & Midwifery Care soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call us at 561-508-3989 between the hours of 8:30am-4pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than **24 hours** before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient a **\$35 missed appointment fee**.

Print Name

Date

Signature

