**Scholls Family Care**

**New Patient Acknowledgement, Consent & Authorization Form**

**Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This form serves to document patient understanding and approval related to the following five (5) issues:**

**1. Receipt Acknowledgement for Notice of Privacy Practices**

I have been offered a copy of the Notice of Privacy Practices (hereinafter “NPP) for Scholls Family Care. I understand the NPP provides a complete description of possible uses and disclosures of my health information. If at any time now or in the future I disagree with any portion of the NPP, or wish to restrict or revoke the use or disclosure of my Protected Health Information, I will provide notice of such disagreements, restrictions, or revocations according to the processes outlined in the NPP.

**2. Authorization to Release Information**

I authorize Scholls Family Care to release any clinical, demographic, and/or claim-related information for purposes of claims administration, provision of healthcare services, business operations, and/or compliance with carrier rules to the following applicable parties: Any and all health care providers who Scholls Family Care reasonably believes is participating in my healthcare; Third party health insurance carriers or benefit administrators; U.S. Social Security Administration, or its Carriers; U.S. Centers for Medicare & Medicaid Services, or its Carriers; Workers Compensation Board, Compensation Insurance Carrier, and my employer; the No-Fault Insurance Carrier for No-Fault Accident Cases.

**3. Assignment of Benefits**

I authorize payment of medical and surgical benefits by third party carriers, Medicare and/or it’s authorized Carriers to be made directly to Scholls Family Care. I authorize Scholls Family Care to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services provided. I authorize release of medical information about me or the patient listed above to my Health Insurance Plan as needed to determine benefits payable.

**4. Financial Responsibility for Non-Covered Services, Account Balances and Miscellaneous Fees**

I have been provided a copy of the Scholls Family Care Payment and Billing Policy and agree to the terms therein. Additionally I agree to pay the following applicable charges that are not covered by my insurance:

* Missed Appointment Fee (without providing us 24 hours advanced notice) $50
* Returned Check Fee $50
* Forms Fee (for processing any forms requiring provider signature) $20
* Records Copying for Patient $.80/page + postage
* Collections Fees (if your account is sent to collections) As applicable

**5. Responsibility to Comply with Rules & Procedures of My Health Benefits Carrier or Insurance Company**

I will comply with all rules and procedures required of me by my health benefits carrier including, but not limited to: Providing valid and verifiable government-issued photo identification and insurance information prior to obtaining services from Scholls Family Care. Obtaining all required Referrals or Authorizations prior to obtaining services. Providing full payment at time of service for any copay, coinsurance and/or deductible required of me.

**I UNDERSTAND, AUTHORIZE, AND AGREE TO THE ABOVE:**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature (or Guardian/Representative\*) Date Relationship if Guardian or Rep**

\*Required if patient is a minor or an adult who is unable to acknowledge receipt.