WELCOME TO OUR PRACTICE

Prairie Family Medicine
1130 W. Prairie Avenue
Coeur d'Alene, ID 83815
(208) 209-0288

PATIENT INFORMATION (please print clearly)

Name _____ Male/Female Preferred Name _____

Birthdate_____ SS# _____Referred by _____

Address _____City _____ State _____ Zip _____

Phone (Home) _____ (Work) _____ (Cell) _____

Marital Status (please circle one) S-M-D-W Employer _____

EMERGENCY CONTACT

Name _____Phone_____

RESPONSIBLE PARTY (Person to receive Billing Statement)

Name _____SS# _____Birth Date _____

Address _____City _____

State _____ Zip _____ Phone _____

Relationship to Patient _____

PRIMARY INSURANCE _____Subscriber's Name _____

Subscriber's SS# _____ Birthdate _____ Subscriber ID # _____

Group # _____Employer _____Relationship to patient _____

SECONDARY INSURANCE _____Subscriber's Name_____

Subscriber's SS# _____ Birthdate _____ Subscriber ID # _____

Group # _____Employer _____Relationship to patient _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

To the best of my knowledge, all of this information is true and correct. I understand that I am to pay for all services rendered to me and that I am willing to make specific arrangements to pay whatever parts not covered by my insurance on a timely basis. (Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.) In order to control your cost of billings we request that our charges for office visits be paid at the conclusion of each visit. I grant to my physicians to mutually exchange medical information with my referring physician(s) and/or their associates, to the extent necessary to determine liability for payment and to obtain reimbursement. I authorize disclosure of portions of the patient's medical records to my insurance carrier or medigap carrier. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fee and costs of collection. I herby assign all medical benefits to which I am entitled to my physician for services rendered to me or my dependent. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature _____ Date _____

Medicare Authorization Agreement: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Prairie Family Medicine for any services furnished to me by that physician/supplier.

Medicare Patient Signature _____ Date _____

Prairie Family Medicine PLLC
"Pediatric and Adult Medicine"
1130 West Prairie Ave. Coeur d'Alene, ID 83815
(208)209-0288 / Fax (208) 209-0289

Thank you for choosing Prairie Family Medicine as your primary care provider. We are committed to providing you with quality and the most effective medical care available. In order to do this, we feel that it is important for you to understand our office policies in regards to your medical care and the charges that are incurred while under our service. To be fair to all of our patients, we have established the following financial and office policies. Please read it, ask us any questions you may have, and sign in the space provided. It will be placed in your medical chart, and a copy will be provided to you upon request.

1. **Financial Information**
   We participate with most insurance plans, including Medicaid and Medicare. We gladly submit claims for our service to your insurance company but any charges that are not paid by your insurance are your responsibility. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Lack of insurance coverage or a deductible not being met does not release you from the responsibility of timely payment of a bill. We cannot determine insurance benefits for you, so if you are unsure of what your insurance requirements are, please contact your customer service member department. You will usually find this toll free number on the back of your insurance card.
2. **Co-payments and Deductibles**
   All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you come unprepared to pay your co-pay and we have to bill you for it, we will make accommodations twice, but note a $15 fee will be added to your co-pay each time.
3. **Non-Covered Services**
   Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance companies. You are still responsible for these services in full.
4. **Third Party Payors**
   If you believe that a third party (such as auto insurance or an employer) is responsible for your medical bills, you must still pay for your visit at our office in full at the time of service. You can then seek reimbursement from the third party for your expenses.
5. **Proof of Insurance**
   We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If you do not have your insurance card available at your first visit at our office, you will be asked to pay for your visit in full at the time of service.
6. **Collections**
   If your account is over 60 days past due and the account balance remains unpaid, we will refer your account to Valley Empire Collections to seek a judgment against you, and you will be discharged from this practice.
7. **Appointments**
   We make every effort to remain on schedule. Therefore, we ask that you arrive 15 min prior to your appointment time. If you fail to arrive the 15 minutes early of your scheduled appointment, you may be asked to reschedule for a later date. Your consideration of a 24-hour notice for a canceled appointment is greatly appreciated so that we may utilize that time for someone else. Repeated canceling of appointments without sufficient notice , or 2 "no-shows" will likely result in our inability to further schedule you. Our policy is to charge $20 for missed medical appointments and $50 for mental/behavioral health appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.
8. **Prescriptions and Refills**
   If you are in need of a medication refill, please assist us by requesting refills from your pharmacy, which will then send your request via fax directly to our office. Once reviewed, we will contact your pharmacy directly. We request a minimum of 48 hours to process your refill requests. We do not refill prescriptions on weekends or holidays. Please plan ahead carefully in this regard. Also, please be advised that we do not replace lost or stolen narcotic or controlled substance prescriptions so please keep these in a safe place.
9. **Office hours**
   Our regular office hours are Monday, Wednesday, Friday from 8:00 AM-6:00 PM, Tuesday and Thursday from 8:00 AM-7:00 PM. If you have an urgent illness or injury, we make every attempt for you to be seen by your provider of choice, but urgent care situations may require that you see an alternative provider within our practice. If you have an urgent care issue outside of office hours, you may call the on-call provider directly at 208-818-2313.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our policies and please let us know if you have any questions or concerns.

I have read and understand the payment policies and agree to abide by its guidelines:

_____ _____

Name of Patient (please print) Date

_____

Signature of Patient or Responsible Party

Please sign and return to the reception desk

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By signing this form, I acknowledge that I have received a copy of PRAIRIE FAMILY MEDICINE's HIPAA Privacy Practice Notice.

_____
Patient printed name (or legal representative)

_____ _____
Patient signature (or legal representative) Date

_____
Legal representative's relationship to patient

A good faith effort was made to obtain the patient's acknowledgment of the receipt of the Notice of Privacy Practices. The following identifies the efforts made and the reason the acknowledgment was not obtained.

_____ _____
Signature Date
PRAIRIE FAMILY MEDICINE
Staff Member