PREMIER WELLNESS INTERNAL MEDICINE, LLC

Jennifer Attmore, M.D., P.A. Michelle Sun, M.D., P.A. Catheryne Zavodny, M.D., P.A.

Patient Registration

Name: _____ Age: _____ Birth date: _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

SSN: _____ Medicare #: _____

Employer: _____ Occupation: _____

Bus. Address: _____ City, State: _____ Zip: _____

Driver's License #: _____ State: _____ Marital Status: _____

Referred by: _____

Insurance Information

Insured's Name: _____ Birth Date: _____

Insured's Employer: _____ Insurance Carrier:_____

Group #: _____ ID #: _____ PPO? Yes ____ No ____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Information—If None, Check Here: ____

Insured's Name: _____ Birth Date: _____

Insured's Employer: _____ Insurance Carrier:_____

Group #: _____ ID #: _____ PPO? Yes ____ No ____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Information

Name:_____ Phone:_____ Relationship:_____

PREMIER WELLNESS INTERNAL MEDICINE, LLC

3900 W. 15th Street, Suite 404
Plano, Texas 75075
972/596-1803

PAYMENT POLICY

We hope to provide you with quality and affordable care for your internal medicine needs. We hope that this payment policy will answer your questions regarding patient and insurance responsibilities for services rendered in our office. Please read it carefully, ask any questions you may have, and sign in the space provided.

1. METHOD OF PAYMENT

Our practice accepts cash, checks (however a charge will be assessed for those that are returned by the bank), Mastercard and VISA.

2. INSURANCE

We participate in most insurance plans and Medicare. WE DO NOT ACCEPT MEDICAID. If our practice is not contracted with your insurance plan, payment in full is expected at each visit. If you are insured by a plan with which we do business, but you do not have an up-to-date insurance card, you MUST have your group number, the claims address, and your copayment amount, otherwise, payment in full for each visit is required until you can update your coverage. **KNOWING and PROVIDING YOUR INSURANCE BENEFITS IS YOUR RESPONSIBILITY.** Please contact your insurance company with any questions you may have regarding you coverage, including whether or not you have well or preventive coverage. Please allow your insurance carrier 45 days to process your claim.

3. CO-PAYMENTS AND DEDUCTIBLES

All co-payments 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 from patients will be considered fraud. Please help up in upholding the law by paying your co-payment at each visit.

4. NON-COVERED SERVICES

Please be aware that some and perhaps all, of the services you receive may be non-covered or considered not necessary by Medicare or other insurance companies. You must pay for these services in full after your insurance company makes their determination. Due to the contract language between physician and insurance company, you must understand that you are financially responsibility for all charges deemed to be “non-covered benefits” by your insurance even if the insurance’s Explanation of Benefits states the procedure is a “non-covered benefit” and “patient is not responsible”.

5. PROOF OF INSURANCE

All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver’s license and current valid insurance card to provide proof of insurance. The patient information form and copy of valid insurance card may need to be completed again upon change of that information, but no less than every twelve months. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the full payment of a claim.

5. CLAIMS SUBMISSION

We will submit your primary claim and your secondary claim. Due to increasing administrative costs, we will not submit third and fourth insurance claims. However, we will assist you in any reasonable way we can to help you get your claims paid, but your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. Please understand that the balance of your claim is your responsibility whether or not your insurance pays your claim.

6. COVERAGE CHANGES

If your insurance changes, please notify us before or at your next visit, so we can update your insurance information to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you for prompt payment.

7. SELF PAY PATIENTS

If you do not have insurance coverage, full payment is **expected** at the time of service. We will extend to you a 20% discount to those patients who pay **IN FULL** at the time of service.

8. NON-PAYMENT

If your account is over 90 days past due, you will be expected to pay the past due balance in full within 21 days. Partial payments will not be accepted unless approved by the office manager. Be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged as a patient from this practice. If this is to occur, you will be notified by regular and/or certified mail that you have 30 days to find another physician.. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. MISSED APPOINTMENTS

Our practice reserves the right to charge $25.00 for missed appointment not cancelled at least 24 hours in advance. These charges will be your responsibility and billed directly to you. Please help us to better serve you by being on time for your scheduled appointments.

Thank you for reviewing our payment policy. Please let us know if you have any questions or concerns. Our practice is committed to providing the best treatment for our patients. Our prices are representative of the reasonable and customary charges for our area.

_____ _____

Patient/Legal Guardian Signature **Date**

_____

Print Name

Premier Wellness Internal Medicine, LLC

Jennifer O. Attmore, M.D., PA
Michelle V. Sun, M.D., PA
Catheryne M. Zavodny, M.D., PA

Release of Medical Information Designation Form

I hereby authorize one or all of the designated parties listed below to request and receive any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

NAME RELATIONSHIP PHONE NO

_____

_____

_____

In the event of an accident or illness that leaves me unable to make medical decisions or in the event of my death, I wish to make my medical records available to:

NAME RELATIONSHIP PHONE NO

_____

_____

_____

Patient Printed Name: _____

Address, City, State, Zip _____

Date of Birth: _____

Today's Date: _____

Signature: _____

Consent for Use and Disclosure

Of Health Information

I hereby permit Premier Wellness Internal Medicine, LLC (Jennifer Attmore, MD, PA, Michelle Sun MD, PA, and Catheryne Zavodny, MD, PA) to release and furnish all medical and financial data related to my care that may be necessary now or in the future for purposes of treatment, payment or health care operations to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organization contracting with any of the above entities to perform such functions.

Patient Signature_____
Date Signed_____

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional upon your signing this consent.

Please see our Notice of Privacy Practices for a more complete description. You may review our Notice of Privacy Practices prior to signing this consent. If this consent is revised in the future, you may obtain a revised copy from the Front Office.

PREMIER WELLNESS INTERNAL MEDICINE, LLC

Jennifer Attmore, M.D., P.A.
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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's ,managed care organizations, IPA's, Medicare/Medicaid or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. This must be done in writing and within 180 days of the incident. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you register a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with this office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice.

This Notice of Privacy Practices is effective as of October 1, 2011.

Patient Signature _____ Date _____