Benson Hospital
Family HealthCare

Medical Group

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. A copy of this policy will be provided to you upon request.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part if 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.

Non-covered services: Please be aware that some –and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance 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.

Claim submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claims in 45 days, the balance will automatically be billed to you.

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Nonpayment: Should your account become 90 days delinquent, you will receive a letter that you have 10 days to pay your account in full. Patient payments will not be accepted unless otherwise negotiated with a member of the business office. Please be aware that if a balance remains unpaid, we will referyour account to a collection agency. The patient or guarantor will be responsible for all costs of collection including attorney fees, collection fees and contingent fees to collection agencies of not less than 35 percent. The contingency fees will be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

Minors: For all services rendered to minor patients, the parent or guardian who brings the patient to the appointment is responsible for payment.

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 understating our payment policy. Please let us know if you have any questions or concerns.

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

Patient Signature Date

Parent or Guardian Signature if Minor Date

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HEALTHCARE DIRECTIVES

Healthcare Directives provide your physician(s) and/or hospital with your preference of care related to life support issues (machines, drugs and treatment) if you are unable to state your wishes at the time care is rendered due to catastrophic circumstances.

_____ **I would** _____ **I would NOT** like to receive information, at this time, regarding Healthcare Directives, including living will and medical power of attorney authorizations.

Notice of Privacy Practices Acknowledgement

I hereby acknowledge that I have been presented with a copy of the Notice of Privacy Practices under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, authorize Benson Hospital Family Care and its affiliates ("Provider") to release my medical records, via fax or electronic submission, including any and all records containing HIV and substance abuse, to the referring physician, primary care of family physician and the insurance company. I further agree to physician orders and associated diagnoses being sent via fax or electronic submission, including diagnoses of HIV, mental illness and substance abuse, to other physicians, hospitals, pharmacies and/or other diagnostic/treatment facilities. I request payment of benefits under my medical insurance program(s) to Provider. I understand that I am financially responsible if services are not a covered benefit, or are deemed not medically necessary by my medical insurance program(s). I further understand that it is my responsibility to verify coverage of benefits by my medical insurance program(s). If I am insured by a medical insurance program that is not accepted by Provider, I am financially responsible for all services and agree to pay at the time services are rendered. I authorize and request insurance payments be made directly to Benson Hospital Family Care. I agree to notify Benson Hospital Family Care of any changes not paid by my insurance company. **A 24-hour prior cancellation notice is required. Multiple no-shows or late cancellations may result in dismissal from the practice.**

Signature:_____ **DATE:**_____

SP-4 (Rev. 04/15)

At Benson Hospital Family Care we are committed to keeping you healthy and helping you feel better when you are sick.

To keep you informed of timely health exams, immunizations, and important screenings, please identify your communication preferences. *Check all that apply.*

_____ Mail to your home

_____ Telephone call

_____ No Notification

Benson Hospital
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Release of Information

(This is not a release of medical records)

I,_____ hereby give my consent to communicate with the following people:

Name: _____Relationship:_____

Home Phone: _____ Cell Phone: _____

Check the box(s) that apply to what this person can do:

[ ] Emergency Contact [ ] Pick up prescriptions or samples

[ ] Pick up referrals [ ] Leave appointment reminder calls or call back request messages

[ ] By checking this box, you are authorizing us to release protected health information to this person i.e. test results

Please list any information that you would **NOT** like released to this person:

Name: _____Relationship: _____

Home Phone: _____Cell Phone: _____

Check the box(s) that apply to what this person can do:

[ ] Emergency Contact [ ] Pick up prescriptions or samples

[ ] Pick up referrals [ ] Leave appointment reminder calls or call back request messages

[ ] By checking this box, you are authorizing us to release protected health information to this person i.e. test results

Please list any information that you would **NOT** like released to this person:

For Patient Use:

[ ] OK to leave messages on:

Home phone:_____ Cell phone: _____

Work Voice Mail: _____ Other: _____

This form will be kept in your medical file for one (1) year or until you notify us of any changes you would like to make.

Consent for Treatment

I, _____ hereby give my consent for treatment at Benson Hospital Family Care. I agree to inform my Provider of my medical history, medications and substances that I take and any changes in my health. I agree to have the Provider provide treatment or treatment options, and maintain my electronic medical records. My permission will be obtained before any biopsies, injections, medications, treatment, or other foreign bodies enter my body; I also understand that the Provider or Medical Assistant will explain all benefits and risks associated with any suggested procedure as well as the risks and benefits of not receiving the suggested procedure.

Signature: _____**Date:** _____

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Patient Health Questionnaire (PHQ-9) Modified

Name:_____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms in the past **TWO WEEKS?** For each symptoms put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half The Days	(3) Nearly Every Day
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, irritable, or hopeless?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Feeling tired, or having little energy?				
5. Poor appetite, weight loss, or overeating?				
6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like reading the newspaper or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not Difficult At All ☐Somewhat Difficult ☐Very Difficult ☐ Extremely Difficult

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your health care clinician, go to a hospital emergency department or call 911.*

*Office Use Only: Severity Score*_____

Benson Hospital
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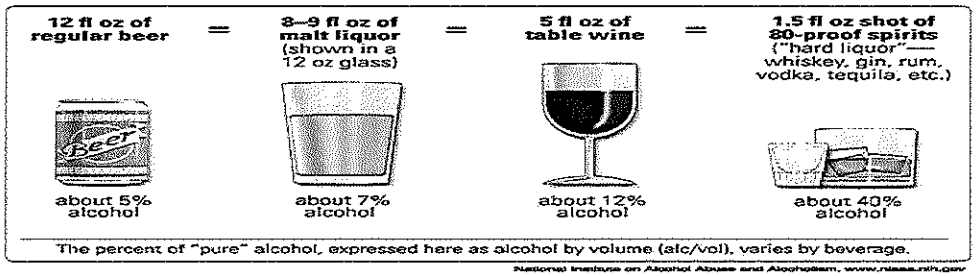
Patient Name: _____ Date of Visit: _____

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-4 times a week
   - ☐ e. 4 or more times a week
2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 or 9
   - ☐ e. 10 or more
3. **How often do you have six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

NOTE: in the U.S. a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:



Benson Hospital
Family HealthCare

Medication List

Please list all medications you take daily including supplements

Medication?	Dose?	How Do You Take It?	Who Prescribed It?

Allergies

Medication?	Reaction?

Preferred Pharmacy

Pharmacy Name?	Major Cross Street?

We look forward to seeing you at your new patient appointment.

Please note that Benson Hospital Family Care primary care providers perform an individualized assessment of your health, however not all providers manage chronic pain with long-term, ongoing opioids (i.e., narcotics). Referrals to pain management and other specialists may be used, as appropriate, to best support treatment plans in individual patients.

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HEALTH MAINTENANCE					
Date of Last Mammogram	/ /	Never	Date of Last Pap	/ /	Never
Date of Last Colonoscopy	/ /	Never	Comment:		

VACCINES	APPROX DATE
Influenza (flu shot)	/ /
Tetanus	/ /
Human Papilomavirus (HPV)	/ /
Zoster (shingles)	/ /
Measles, Mumps, Rubella (MMR)	/ /
Pneumonia (Prevnar 13 or Pneumovax)	/ /
Meningitis	/ /
Hepatitis A	/ /
Hepatitis B	/ /

Denson Hospital
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Social History

Alcohol Use	Yes	No		Drinks Per Week	
Comment:				Glasses of Wine	
				Cans of Beer	
				Shots of Liquor	

Sexually Active:	Yes	No	Partners:	M	F	Birth Control:	
Tobacco Use:	Yes	Never	Passive	Quit	Quit Date: / /	Years Smoked:	Packs Per Day:
Drug Use?	Yes	No	How Often Per Week?				

FAMILY HISTORY

					MOTHER'S SIDE				FATHER'S SIDE			
	Mother	Father	Sister	Brother	Aunt	Uncle	Grandmother	Grandfather	Aunt	Uncle	Grandmother	Grandfather
ALIVE												
DECEASED												
Aneurysms												
Arthritis												
Asthma												
Blood Clots												
Cancer												
Depression												
Diabetes												
Early Death												
Heart Disease												
High Blood Pressure												
High Cholesterol												
Kidney Disease												
Mental Illness												
Miscarriages												
Stroke												
Substance Abuse												

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			/ /	
LAST	FIRST	MI	DATE	MRN

MEDICAL HISTORY

Allergies	Yes	No		Chronic Lung Disease	Yes	No		Meningitis	Yes	No
Anemia	Yes	No		Depression	Yes	No		Nerve Muscle disease	Yes	No
Anxiety	Yes	No		Diabetes	Yes	No		Osteoporosis	Yes	No
Arthritis or Rheumatism	Yes	No		Emphysema	Yes	No		Seizures	Yes	No
Asthma	Yes	No		GERD (Heartburn)	Yes	No		Sickle Cell	Yes	No
Blood Transfusion	Yes	No		Glaucoma	Yes	No		CVA or TIA/ Stroke	Yes	No
Cancer	Yes	No		Heart Attack	Yes	No		Substance Abuse	Yes	No
Cataracts	Yes	No		Heart Murmur or Valve Problem	Yes	No		Thyroid Disease	Yes	No
Heart Failure	Yes	No		HIV / AIDS	Yes	No		Tuberculosis	Yes	No
Blood clots	Yes	No		Kidney Disease /	Yes	No		Ulcers	Yes	No
Heart Disease	Yes	No		Sleep Apnea	Yes	No		Liver Disease	Yes	No

OTHER

SURGICAL HISTORY

Appendectomy	Yes	No		Cosmetic Surgery	Yes	No		Joint Replacement	Yes	No
Brain Surgery	Yes	No		C-Section	Yes	No		Intestinal Surgery	Yes	No
Breast Surgery	Yes	No		Eye Surgery	Yes	No		Spine Surgery	Yes	No
Heart Surgery	Yes	No		Fracture Surgery	Yes	No		Tubes Tied	Yes	No
Gall Bladder Removal	Yes	No		Hernia Repair	Yes	No		Heart Valve Surgery	Yes	No
Colon Surgery	Yes	No		Hysterectomy	Yes	No		Tonsillectomy/Adenoidectomy	Yes	No

OTHER

For Office Use Only

To Our Patients

Dear Valued Patient,

To help provide better quality care for our patients we have an annual alcohol screening questionnaire to be filled out privately by all of our patients. This confidential screening is to help your PCP assess if alcohol is likely to be harming your health.

Even patients who do not have an alcohol disorder, but who are drinking in ways that are harmful, can benefit from this screening.

In addition, the Center for Disease Control is working to make alcohol screenings a routine part of health care to help identify patients at risk for health problems.

Benson Hospital

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the Benson Hospital's Notice of Privacy Practices that describes how my information is used and shared.

I understand that Benson Hospital has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer or by coming into the hospital.

My signature below constitutes that I have been provide a coy of the *Notice of Privacy Practices*.

_____

Patient Name

_____

Responsible Party (if different than Patient)

_____

Date

Benson Hospital

MR #:		PAT #:	
			HSV:
AGE:	DOB:		SEX:
ADMIT:			
ATT:			#:
PCP:			#:

PATIENT DEMOGRAPHIC VERIFICATION

Please verify the below information for accuracy.
If a change is needed please cross out the old information and provide the correct information.

Patient Name:			
Address:		City:	State: Zip:
Phone:		SSN:	
DOB:	Sex:	Marital Status:	
Patient Employer:			
Employer Address:			
Employer Phone:			
Emergency Contact:			Relation:
Emergency Contact Address:			
Emergency Contact Phone:			
Guarantor:			
Guarantor Address:			
Guarantor Phone:		Guarantor SSN:	
Primary Insurance:			
Policy #:		Group #:	
Secondary Insurance:			
Policy #:		Group #:	
Tertiary Insurance:			
Policy #:		Group #:	
Primary Care Physician:			

I have verified the above information and provided any corrections to my demographic information.

Signature of Patient: _____ Date: _____

I have verified that the above information is correct in the MEDHOST system.

Signature of Admit Clerk: _____ Date: _____

Last, First name: _____

Home Address:

Street _____

City, _____State _____

Zip Code _____

Mailing Address if different then above:

Number: _____

City, _____State _____

Zip Code _____

Phone number:

Home: _____ Cell Phone: _____

Message: _____

Primary Insurance: _____

Policy Number: _____

Group Number: _____

Name of Policy Holder: _____

Secondary Insurance: _____

Policy Number: _____

Group Number: _____

Name of Policy Holder: _____

Signature: _____

Date: _____

Benson Hospital

MR #:		PAT #:	
			HSV:
AGE:	DOB:		SEX:
ADMIT:			
ATT:			#:
PCP:			#:

CONDITIONS OF ADMISSION AND/OR EMERGENCY TREATMENT

MEDICAL AND SURGICAL CONSENT: The patient is under the control of his attending physicians and the hospital is not liable for any act or omission in following the instructions of said physicians, and the undersigned consents to any vaccinations, immunizations, X-Ray or examination, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered the patient under the general and special instructions of the physician. The undersigned recognizes that all physicians furnishing services to the patient including the radiologist, pathologist, anesthesiologist and the like are independent contractors and not employees of the hospital.

RELEASE OF INFORMATION: The hospital may disclose all or any part of the patient's record pertaining to this hospitalization (including information regarding alcohol or drug abuse of HIV related information) to any person or corporation which is or may be liable under a contract to the hospital or to the patient or to a family member or employer of the patient for all or part of the hospital's charge, including but not limited to, hospital or medical service companies, insurance companies, workmen's compensation carriers, welfare funds, or the patient's employer. The hospital may disclose any information concerning my case that is necessary or appropriate for the advancement of medical science, medical education, or medical research.

PERSONAL VALUABLES: The hospital maintains a secure area for the safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs, fur coats and fur garments or other articles unless placed therein, or otherwise deposited with the hospital for safekeeping. For items deposited for safekeeping, the limit on the hospital's liability in case of loss or damage shall be $500.

☐ The use of the safekeeping facility is declined at this time.

ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned is entitled to hospital benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to hospital for application on patient's bill. And it is not agreed that the hospital may receipt for any such payment and such payment shall discharge the said insurance company for any and all obligations under the policy to the extent of said payment. The undersigned and patient being responsible for charges not covered by this assignment.

FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as agent or as patient, and whether or not he is insured or is a member of a health maintenance organization, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All bills are due and payable within thirty days of the date they are issued by the hospital and if not paid within thirty days, the undersigned agrees to pay a delinquency charge of 6% per annum on the unpaid balance.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENT: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

EMERGENCY ROOM RECORD RELEASE OF INFORMATION AUTHORIZATION: In order to facilitate continuity of care, I hereby give Benson Hospital permission to copy all or any part of my Emergency Room Record and forward it to my primary care physician or other provider.

The undersigned has read and understands the foregoing, receiving a copy thereof, and is the patient, or is duly authorized by the patient as patient's agent to execute the above and accept its terms.

<ESIG:DESC=Patient or Other>

Signature of Patient or Legal Representative _____ Date _____

Relationship to Patient _____

<ESIG:DESC=Witness>

Signature of Witness _____ Date _____