LIFEWAY FAMILY PHYSICIANS
PATIENT INFORMATION

Date: _____ ****PLEASE CIRCLE BEST CONTACT PHONE #**

Patient Name (First) (MI) (Last) Birth Date Sex Marital Status Social Security #

Home Address City State Zip Home Phone

e-mail Address Cell Phone

Employer's Name and Work Address Work Phone

SPOUSE / GUARANTOR / BILLING INFORMATION

Spouse / Guarantor Name (First) (Last) Relationship to Patient Birth Date Social Security #

Home / **Billing/Mailing** Address (If different) City State Zip Home Phone

Spouse / Guarantor Employer's Name and Work Address Work Phone

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name

*Subscriber's Name (First) (Last) *Birth Date *Subscriber's SSN *Relationship to Patient

SECONDARY INSURANCE

Insurance Company Name

*Subscriber's Name (First) (Last) *Birth Date *Subscriber's SSN *Relationship to Patient

Whom do you want to direct your medical care if you become incapable of making an informed decision on your own behalf?

Name Relationship to Patient Phone

LIFEWAY FAMILY PHYSICIANS

TREATMENT & PAYMENT POLICIES

Thank you for choosing Lifeway Family Physicians for your health care. We believe it's important that you have a clear understanding of our Treatment and Payment Policies, and we ask that you **read and sign** the following prior to receiving services at our office. Please ask for clarification of any statement that you do not understand.
****ANY CHANGES TO THE FOLLOWING OFFICE POLICIES WILL BE POSTED IN THE WAITING ROOM****

TREATMENT POLICY

I hereby agree to:

- Treatment of (Patient name) _____ by Lifeway Family Physicians, P.C., their associates and/or medical staff members.
- Have blood tested for infectious diseases if a Lifeway employee is accidentally exposed to the patient's blood and/or body fluids. *Virginia State Law requires testing for HIV and Hepatitis B and C, and that the results of these tests are provided to the person who was exposed.
- Follow Lifeway's ***Patient Rights and Responsibilities*** (Available upon request)

PAYMENT POLICY & ASSIGNMENT OF BENEFITS

I understand that payment is expected at the time of service, except for the insurance portion of those plans with which Lifeway Family Physicians, P.C. "participates". AS A COURTESY, insurance claims are filed with these companies. Thus, I assign and direct any and all third-party payments for services provided by Lifeway Family Physicians to be paid directly to Lifeway Family Physicians P.C. I fully understand that my insurance policy is a contract between myself and my insurance company. **I am responsible for any charges not covered by my insurance**, including but not limited to co-payments, deductibles, and fees for non-covered services. LIFEWAY FAMILY PHYSICIANS WILL WAIT NO LONGER THAN 30 DAYS FOR INSURANCE PAYMENT. **I am aware that insurance plans specifically require that co-payments be paid at the time of service**, and that patients who do not pay their co-pay at the time of service will not be seen. **Further, the patient's insurance deductible portion is due at the time of service.**
Patients who do not have a current/active insurance card are required to pay for their visit in full before being seen.

PAST DUE BALANCES, PENALTIES AND COLLECTION PROCEDURES

Any balance remaining on the account after insurance pays their portion, is due upon receipt of our Billing Statement. Patient account inquiries should be directed to our Billing Office at (757) 481-3770. Individuals experiencing financial hardship may contact the Billing Office to set up a Payment Plan. Unless a specific payment plan is arranged and followed, Lifeway Family Physicians may turn delinquent accounts over to a collection service and/or initiate legal action, at which time Patient will be dismissed from the practice. Patient agrees to pay ALL COSTS associated with the collection of past due account balances; including but not limited to administrative and attorney's fees, court costs and interest equal to 35% of the unpaid bill, accruing from the date of service for which the balance is owed. If a check is returned for insufficient funds, the patient will be assessed a $25 Service Fee and any other fees or charges recoverable under Virginia Law.
Patients who fail to give 24 hours' notice when unable to keep their scheduled appoint will be assessed $50 for Routine Office Visits and $100 for Physicals. All fees must be paid prior to patient scheduling another appointment.
Patients who arrive more than 15 minutes late are considered to have missed their appointment.
Missing 3 appointments without proper notification may result in patient dismissal.

I have read, understand and agree to follow Lifeway Family Physicians' Treatment and Payment Policies and Patient Rights and Responsibilities Policy. Patients who fail to do so may be asked to find a new physician.

Patient/Guarantor_____ Date_____

A COPY OF LIFEWAY'S NOTICE OF PRIVACY PRACTICES IS AVAILABLE UPON REQUEST

Communication of Personal Health Information

Timely, private communication of test results and other medical information is an essential part of medical care. We also contact patients by phone to confirm appointments, schedule tests, coordinate referrals, and handle insurance and payment issues. Depending on the nature and urgency of the matter, after attempting to reach you, we may:

1. Leave a detailed message at the provided phone number(s) and/or request that you call the office.
2. Mail and/or e-mail detailed information to the provided address, and/or request that you call the office.
3. Try to reach your Emergency Contact(s) in urgent situations.

****WE STRONGLY ENCOURAGE YOU TO PROVIDE AT LEAST ONE EMERGENCY CONTACT****

Printed Name of Emergency Contact #1 _____ Phone # _____ Printed Name of Emergency Contact #2 _____ Phone # _____

Other than yourself, whom do you allow to pick up prescriptions, orders, notes, make appointments for you, etc?
Please use back of page, if more space is needed

Printed Name _____ Relationship to Patient _____

Printed Name _____ Relationship to Patient _____

Who may we speak with concerning your medical situation and/or billing inquiry?

Printed Name _____ Relationship to Patient _____

By signing below, I authorize Lifeway Family Physicians to contact me in the ways described above, at the address, phone number(s) and/or E-Mail address provided on the Patient Information form, for matters concerning medical treatment and/or payment.

Lifeway has permission to call my Emergency Contacts.

Printed Name of Patient _____ **Signature of Responsible Party** _____ **Date** _____

P:HIPAA/Patient Forms