2019 HIPAA PATIENT UPDATE

Name: _____ Date of Birth: _____

Gender: Female / Male Mailing Address: _____

APT/Unit: _____ City, State, Zip: _____

Race (circle one): Black/African American; Asian; White; American Indian; Declined; Other (Please list) _____

Ethnicity (circle one): Hispanic/Latino; Non-Hispanic/Latino; Declined Primary Language: _____

PCP: _____ Insurance: _____ Policy Number: _____

Subscriber Name: _____ Subscriber Relationship: _____

Circle One: Single; Married; Widowed; Separated; Divorced; Minor/Student SS#: _____

Patient Employer: _____ Employer Phone: _____

Referred By (circle one): Self / Friend/ Family/Medical Provider (Please list) _____

Type of Contact (Home, Cell etc.)	Area code & Phone Number	Leave Message	Type of Message
		Yes / No	Detailed / Brief
		Yes / No	Detailed / Brief

With whom do you allow us to share your personal medical information?

Name: _____ Relationship: _____ Emergency Contact: Y / N

Contact Number: [Type of Phone (circle one) Home / Cell / Work]: _____

Name: _____ Relationship: _____ Emergency Contact: Y / N

Contact Number: [Type of Phone (circle one) Home / Cell / Work]: _____

***** Regarding Appointment Confirmation Only *****

Please note: As a service to our patients, Starling Physicians, PC uses an automated confirmation service to remind you of your appointment. In the event the call is not answered, a message is left.

Type of Preferred Automated Confirmation (circle one and complete your applicable choice below): Call / Email / Text*/ None

Preferred Contact Information: _____ Cellphone: Y* /N

*Indicating in the affirmative that this is your preferred method of contact acknowledges that you are aware of and will accept any usage charges that may apply from your cell phone carrier.

Signature: _____ Date: _____

With my signature, I am confirming the information above is correct to the best of my knowledge. I also acknowledge that it is my responsibility to alert Starling of any changes to my HIPAA information.

PATIENT AUTHORIZATION

AUTHORIZATION AND RELEASE

I hereby authorize payment directly to Starling Physicians, P.C. of medical benefits otherwise payable to me. I understand I am financially responsible for charges not covered by this assignment. I hereby authorize Starling Physicians, P.C. to release information requested to support my claim.

FOR MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made on my behalf to Starling Physicians, P.C. for any service provided to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services.

_____

Signature of Patient, Parent or Guardian of Insured Date

PATIENT FEEDBACK

We would like to get your feedback regarding your visits to Starling. Please provide us with your email address below if you would like to share your experiences with us regarding our services through patient surveys:

E-mail: _____

MISSED APPOINTMENT POLICY

Please be advised that Starling Physicians, P.C. reserves the right to charge for missed appointments. If you do not keep your appointment and have not called to cancel or reschedule prior to 24 hours of the scheduled appointment, a charge may be applied to your account.

COLLECTION OF PATIENT RESPONSIBILITY POLICY

Please be advised that under your insurance contract you are responsible for your co-payment, co-insurance or deductible. It is the policy of Starling Physicians, P.C. to collect all co-payments due at the time of service. Additionally, it will be requested that you pay any outstanding open balances at time of service.

By signing you acknowledge that you have been informed of these policies.

_____

Signature of Patient, Parent or Guardian of Insured Date