OLIVE BRANCH RHEUMATOLOGY

MEDICAL INTAKE FORM

Name: (Last): ___________________________ (First): ______________________________ (Middle): ______________

Date of Birth: ______________________ Age: ________ Sex: □ Male □ Female

PERSONAL MEDICAL HISTORY: list all current and previous medical conditions

__________________________ ___________________________ _________________________

__________________________ ___________________________ _________________________

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__________________________ ___________________________ _________________________

SURGICAL HISTORY:

Procedure	Date	Procedure	Date

DRUG ALLERGIES: ____

MEDICATIONS:

MEDICATION NAME	Dosage	Frequency	To treat what condition?

OLIVE BRANCH
RHEUMATOLOGY

PATIENT NAME: _________________________________ DOB: ____/______/_________

SOCIAL HISTORY:

Occupation: _______________________ Housing (circle one): House Apartment Assisted living Nursing home Unstable housing Homeless

Smoking: □ Yes □ No □ Former ________ (how many) packs/day for ________ (how many) years

Alcohol: □ Yes □ No □ Former ________ (number) drinks per day / week / month (circle one)

Substance use: □ Yes □ No □ Former ____

Exercise routine: _____________________________________ Sleep: _________ (how many) hours/night

FAMILY HISTORY:

Relative	Medical Condition	Relative	Medical Condition

OBSTETRICAL HISTORY – FEMALES ONLY

Total number of pregnancies _______

Live births ______

Miscarriages ______

Stillbirths ______

Premature babies ______

Elective terminations ______

Who are your other medical providers?

Medical Provider	Specialty	Phone	Fax

PATIENT INFORMATION

Name: (Last): ______________________ (First): ______________________ (Middle): _________

Date of Birth: _______________________ Age: ________ Sex: ☐ Male ☐ Female

SSN:_______________ Phone: (Home) (____) _____________ (Cell) (____) ______________

Address: ____

City: ______________________________ State: _______ Zip Code: _____________

Email address: ____

Marital status (circle one): Single Married Separated Divorced Widowed

Emergency Contact: (Last): __________________________ (First): ________________________

Relationship: ________________________ Phone: (Home) (____) ______________________

Full Address: ____

Patient Employer/School: _________________ Employer/School Phone: (____) _____________

Primary Care Provider: ______________________________ Phone: (____) _________________

Referring Provider: __________________________________ Phone: (____) _________________

Preferred Pharmacy #1: ______________________________ Phone: (____) _________________

Preferred Pharmacy #2: ______________________________ Phone: (____) _________________

PRIMARY INSURANCE INFORMATION

Responsible Party (responsible for payment): ☐ Self ☐ Spouse ☐ Parent ☐ Other: ____

Insurance Carrier & Plan:____________________________________ Effective Date: ___________

Member ID#: ___________________________ Group #: ___________________________________

Responsible Party (responsible for payment): ☐ Self ☐ Spouse ☐ Parent ☐ Other: ____

Subscriber Name (if not patient): (Last): _____________________ (First): ____________________

Date of Birth: ______________________________ SSN: __________________________________

SECONDARY INSURANCE INFORMATION

Insurance Carrier & Plan:____________________________________ Effective Date: ___________

Member ID#: ___________________________ Group #: ___________________________________

Responsible Party (responsible for payment): ☐ Self ☐ Spouse ☐ Parent ☐ Other: ____

Subscriber Name (if not patient): (Last): ____________________ (First): ___________________

Date of Birth: _____________________________ SSN: __________________________________

Is ***Medicare*** your secondary insurance? ☐ Yes ☐ No

➔ If YES, why do you have Medicare as your secondary insurance?

☐ Employed ☐ End-stage kidney disease ☐ Motor Vehicle Accident ☐ Worker's Comp ☐ PHS ☐ VA ☐ Black Lung ☐ LGHP ☐ Other

PATIENT NAME: ____________________________________ DOB: ____/______/__________

OLIVE BRANCH RHEUMATOLOGY – FINANCIAL & RESPONSIBILITY POLICY

Please read the following information thoroughly. This serves as your financial obligation and commitment to your appointments as a patient with Olive Branch Rheumatology.

Medical Insurance: Insurance plans are selected by you and/or your employer. Your benefits are determined by you, your employer, and your insurance carrier, not your medical provider. Your insurance coverage is a contract between you and your insurer. Medical insurance is not a guarantee of payment and insurance companies typically will not pay in full for all of your treatments. You are responsible to know the scope of your insurance coverage and its limitations. If you receive a statement from our office and disagree with how your insurance carrier processed the claim, you need to contact your insurance carrier. You are responsible for payment of any deductible, co-payment, and co-insurance amounts at the time of service according to the terms of your insurance policy. Your account with us and payment of all charges are your responsibility, not your insurance company's responsibility. A written pre-determination of benefits from your insurance company is required to accurately determine your out-of-pocket cost. As the patient/patient’s guardian, it is your responsibility to obtain your pre-determination of benefits from your insurance company. You will be required to pay for services rendered, in full, if our office is unable to verify your insurance information prior to treatment.

Delinquency: We reserve the right to charge and collect a fee of $95.00 for broken (“no-show”) appointments – appointments that are cancelled or broken without proper 24 hours of advanced notice. Appointment times are reserved exclusively for you. If you are not present at your confirmed appointment, this takes away another patient’s opportunity to have that appointment time, is waste of valuable office time, and a financial burden on the practice. If you miss 2 or more appointments and our office was not properly notified, you may not be able to schedule further appointments with our practice in the future. You may be dismissed from our practice. A returned check fee of $35.00 will be added to your account balance and is collectible. Any account balance overdue longer than 90 days is considered delinquent, immediately collectible, subject to 5% interest on a monthly basis and will be sent to collection agencies with notice given to you in advance. You are responsible for any interest, legal, or collections related fees. Payment in full of any past due balance and related fees are expected before any further treatment is rendered.

Full Payment & Deposit: Payment in full (co-pay + deductible + any credit on the account + estimated insurance portion) is due at the time of service. We will submit a medical insurance claim for you and a payment is expected to be received from your insurance company usually within 4 to 6 weeks. Any outstanding balance after final insurance payment is your responsibility. A deposit equal to half of your portion of payment is required to reserve your next appointment time. Exceptions are payment plans already in effect.

A $35.00 service charge will be charged for any checks returned for any reason for special handling

Communications: Olive Branch Rheumatology uses a variety of communication methods including phone, mail, text messages, e-mail to communicate with patients for the limited purposes of appointments, available services, billing, and other healthcare-related communications. By signing the agreement, you agree that Olive Branch Rheumatology may disclose limited protected health information to other person(s) who may answer your electronic communications such as phone, text messages, or e-mail. These may include information about appointments, available services, billing, or other healthcare-related communications.

As guarantor of my account, I understand that I am solely responsible for all of the fees for medical treatment. I further acknowledge that I have received a copy of Olive Branch Rheumatology’s financial policy and agree to its contents. We reserve the right to amend or change this policy without notice.

Printed name:____

Patient signature: ____ Date: ____________________

Olive Branch Rheumatology
2500 Grubb Road Suite 114, Wilmington DE 19810
Phone: 302-992-8310
Fax: 302-434-9022

Effective January 1, 2022, all providers of medical services must comply with the “No Surprises Act”. In summary, patients need to be notified on or prior to their visit as to whether or not the provider is In or Out of Network with their insurance plan.

Due to our obligation under the “No Surprises Act”, we are including a “No Surprises Act Advanced Explanation of Benefits”. This document should be included in the Registration Documents for all patients as it *requires signature prior to or at the next scheduled 2022 visit*.

By returning the signed “No Surprises Act Advanced Explanation of Benefits” you understand our obligation to notify you of this Act and you also understand your responsibilities as a patient/patient caregiver.

Please return a signed “No Surprises Act Advanced Explanation of Benefits”, at or prior to your next scheduled 2022 visit, via fax (302-434-9022), or in person. **Note: Patients will not be able to be seen without this signed document.

If you have any questions regarding this notification, please feel free to call out office at 302-992-8310. We appreciate your assistance in ensuring we maintain our compliance, and look forward to a happy, healthy 2022 with you.

Sincerely,

The Olive Branch Rheumatology Staff

NOTIFIER: Olive Branch Rheumatology
2500 Grubb Road Suite 114, Wilmington DE 19810
Phone: 302-992-8310, Fax: 302-434-9022

No Surprises Act Advance Explanation of Benefits

Purpose: To educate patients and patient caregivers of the importance of understanding the patient's insurance plan(s) and benefits PRIOR to each visit. To provide Out of Network options to patient PRIOR to providing medial services to the patient. To maintain compliance with the No Surprises Act.

Effective Date: January 1, 2022

I understand that, as a patient or patient caregiver, I am ultimately responsible for knowing my/ my patient's insurance plan type and understanding the insurance benefits as defined in the health insurance plan's coverage documents.

I understand that it is my responsibility to provide my/my patient's insurance coverage information PRIOR to or AT THE TIME OF SERVICE, AND to notify the healthcare provider of any changes to my/my patient's insurance coverage PRIOR to my/ my patient's next scheduled visit with the healthcare provider.

I understand that the healthcare provider, or the healthcare provider's staff, is responsible to make an effort to notify me/my patient of Out of Network status PRIOR to my/ my patient receiving medial services from that healthcare provider.

I understand that there may be instances in which the healthcare provider is an Out-of-Network Provider, and it is my ultimate responsibility to make payment arrangements with the healthcare provider PRIOR to my/my patient receiving medical services from that healthcare provider.

I understand that if I DO NOT provide insurance coverage information or make payment arrangements PRIOR to receiving services from the healthcare provider, my healthcare provider reserves the right to bill me directly for medical services, and I am ultimately responsible for payment upon receipt of the statement; my insurance will not be billed retrospectively.

I understand that my healthcare provider has a Self-Pay Fee Schedule, available upon my/ my patient's request, in which discounted rates may be applicable if my/ my patient's insurance information is not provided at the time of service- OR – my/ my patient's healthcare provider is Out of Network with my/ my patient's insurance plan.

______________________________ ______________________

Patient/Caregiver Signature **Date**

______________________________ ______________________

Printed Patient Name **Patient Date of Birth**

Relationship to Patient (Circle One): **Self** **Patient Caregiver**

Definitions:

No Surprises Act - An Act derived by the Biden-Harris Administration, through the US Department of Health and Human (HHS), Labor, and Treasury, and the Office of Personnel Management, in an effort to "restrict excessive out of pocket costs to consumers from surprise billing and balance billing. Surprise billing happened when people unknowingly get care from providers that are outside of their health plan's network and can happened for both emergency and no-emergency care." [1] [2]

Patient- A person receiving or registered to receive medial services/ treatment.

Patient Caregiver- A person who provides direct care to the patient to ensure the patient's physical, emotional, and financial well-being. Also defined as Healthcare and/or Financial Power of Attorney, Guardian, Responsible Party, Guarantor. Etc.

Healthcare Provider- A person or company that provides a medical service(s).

Medical service- Any healthcare related service.

In Network Provider- A medical services provider that is apart of a health plan's network of providers with which they have negotiated a discount by means of a contract.

Out of Network Provider- A medial services provider that IS NOT part of a health plan's network of providers; does NOT have a contract in place.

Insurance Benefits- The health care item or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents or as defined by Federal or State regulated programs.

Insurance Plan Types- The type of insurance plan a patient is enrolled in that is used to determine how medical benefits are applied to the patient's medical service(s) received from a healthcare provider. [3]

[1] https://www.cms.gov/newsroom/press-releases/hhs-announces-rule-protect-consumers-surprise-medical-bills

[2] https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf

[3] https://www.ncsl.org/research/health/health-insurance-plan-types-and-definitions.aspx

A. **Notifier: Olive Branch Rheumatology**
2500 Grubb Road Suite 114
Wilmington, DE 19810
Phone: 302-992-8310
Fax: 302-434-9022

B. **Patient Name:** ______________________________

SELF-PAY ADVANCE BENEFICIARY NOTICE (ABN)

I want to receive Medical Services from Olive Branch Rheumatology and have chosen the Self Pay Option.

Do not bill my insurance.

I am responsible for payment and agree to pay the medical service provider at the time of service.

I understand with this choice I am responsible for payment, and I cannot appeal to see if my insurance would pay. I cannot appeal if my insurance is not billed.

Signing below means that I have received and understand this notice. I may request a copy.

ESTIMATED SELF-PAY COST FOR APPOINTMENT DATE _______________: $ ____________________________

Signature:	**Date**:

Patient Code of Conduct & Office Policy

1. Your outstanding balance and copays are due at the time of service. Refusal to settle your outstanding balance may be grounds for denial of service and/or discharge from the practice.
2. Disrespectful, combative, violent behavior or yelling toward Olive Branch Rheumatology staff will not be tolerated.
3. If you miss 2 scheduled appointments without 24 hours of advance notice, you will be discharged from the practice.
4. There is a 15-minute grace period for late arrival for appointments. If you arrive after this timeframe, your appointment may need to be rescheduled.
5. Failure to meet the necessary requirements for drug toxicity monitoring, such as routine laboratory monitoring, may result in you no longer being able to obtain refills of your medications, and/or discharge from the practice.
6. No weapons or firearms are allowed on the practice's premises. Leave them in your home or car.
7. No recording of videos will be allowed at any time on the practice premises.
8. Medication refills called into the office can take up to 72 hours to be sent to the pharmacy. We will only call you back if there is an issue with your refill.
9. Calls and voice messages left after hours or on the weekends when the office is closed will only receive a response if urgent. All other calls will be returned once the office re-opens.

I understand and agree to the Olive Branch Rheumatology Patient Code of Conduct and Office Policy, and understand that a breach of the terms may result in denial of service and/or discharge from the practice.

______________________________ ______________________________ __________

Signature Printed Name: Date: