PATIENT INFORMATION

Account # _____ **Date:** _____

Patient Demographics

Patient Name: _____
LAST FIRST MIDDLE

Patient Sex: □ **Male** □ **Female Date of Birth:** _____

Address: _____
STREET CITY STATE ZIP

E-mail Address: _____

Emergency Contact Name: _____ **Phone:** _____

Legal Guardian Name *(if minor)*: _____

Insurance Subscriber *(if not patient):* _____ Subscriber DOB: _____

Emergency Contact Name: _____ Phone: _____

Contact Preferences: *Please only list numbers you wish us to use to contact you/leave general messages/appointment reminders.*

Cell: _____ Home: _____ Work: _____

Primary Phone Type: □Cell □Home □ Work

Previous Medical Treatment History:

Primary Pharmacy Name/City: _____

How did you hear of Lakeview Clinic? _____

Do you have a Primary Care Provider outside of Lakeview: _____

Name/Address of Doctor/Office where you were treated last: _____

_____

Race (select all that apply):
□ White
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian
□ Other
□ Decline to Specify

Ethnicity:
□ Non-Hispanic or Latino
□ Hispanic or Latino
□ Decline to Specify

Primary Language: _____

If NOT English, do you require interpretation services? □ Yes □No

Patient Name: _____
Patient DOB:_____
Account #: _____

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Lakeview Clinic as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. We ask that you read and sign this form to understand financial responsibility.

Insurance: Lakeview participates with most insurance plans, including Medicare. The patient (parent/guardian if minor) is responsible for knowing insurance coverage and service benefits. Please contact your insurance company with any questions you have regarding your coverage. Some services you may receive may be non-covered or not considered reasonable or necessary by your insurance plan.

The patient is responsible for providing updated policy information to Lakeview Clinic at the time of service and when policy information changes. You will be asked to provide a copy of your valid insurance and photo ID during registration/check-in.

Claims: Lakeview Clinic will submit claims on your behalf directly to your insurance carrier. Your insurance carrier may require you to submit additional information directly, and you are responsible for providing that information. The claim balance is your responsibility whether or not your insurance pays your claim.

Co-payment and Prepayment: All copayments must be paid at the time of service. Patients without active insurance will be required to pay a deposit toward services rendered, understanding that any services over the cost of that deposit will be billed to the patient.

Ancillary Services: You may receive ancillary medical services while a patient of Lakeview Clinic, such as anesthesia, interpretation of tests, laboratory services, imaging services (e.g., x-rays, MRIs), and pathology specimen examination. By signing below, you understand that some physicians may not provide services in your presence but are actively involved in diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges as a result of these ancillary services. You agree to pay all charges due for such services after benefits paid on your behalf by any third party are credited to your account.

Additional Charges: Patients may incur and are responsible for the payment of additional charges at the discretion of Lakeview Clinic, including but not limited to (i) charges for returned checks, (ii) charges for a missed appointment without 24 hours advance notice; (iii) charges for extensive phone consultations and after-hours phone calls requiring treatment, or prescriptions; (iv) charges for copying and distribution of patient medical records; (v) charges for extensive forms preparation or completion; or (vi) any costs associated with collection of patient balances, all as allowed by law.

Non-payment on Account: Patient account balances over 30 days are considered past due and will start to incur an interest charge of .5% monthly. Lakeview may require payment on past due balances in order to schedule future appointments unless the patient has already made payment arrangements with the Business Office. If there is no payment on the patient's balance after 90 days, Lakeview will send a letter regarding making payment arrangements. If no payment is made 60 days after the letter is sent, and a payment plan has not been set up with Lakeview, the account may be transferred to a collection agency.

Printed Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Lakeview Clinic Ltd.

Patient Name_____
Date of Birth_____
Account #_____

Consent for Treatment:

I authorize Lakeview Clinic, LTD (Lakeview) to provide treatment to myself or the above-named patient. This could include (but is not limited to) lab tests, x-rays, immunizations, medication, prescriptions, education, or other procedures. I understand I have the right to refuse treatment.

Benefit Assignment:

I request that payment of insurance benefits be made directly to Lakeview on my behalf for any services provided to me. I understand that I am financial responsible for all charges related to services for myself or my dependent(s). It is my responsibility to know my insurance policy and benefits coverage. If, for any reason, my insurance carrier doesn't pay a portion of my bill, I agree to pay balances promptly.

Medicare Authorization: I request the payment of authorized Medicare benefits be made on my behalf to Lakeview for any services furnished to me by Lakeview. I authorize any holder of hospital or medical information about me to release to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services. I understand Medicare may deem certain services as non-covered. Should I choose to receive those services, after being so informed, I assume responsibility for the payment of those services rendered.

Release of Information:

I consent to and authorize Lakeview to use and disclose my protected health information (PHI) and other information outside of Lakeview for the purpose of treatment, care management, payment, and healthcare operations, including but not limited to Accountable Care Organization activities.

Blood Testing: I understand that while recieving care, a healthcare worker may accidentally be exposed to my blood or other bodily fluid. If this rare event occurs, I consent to my blood being tested for the presence of infectious diseases to protect the healthcare worker.

Electronic Prescribing: I authorize Lakeview to retrieve my medication history from my pharmacy through their eprescribing system.

Notice of Privacy Practices:

I acknowledge that I have been informed of Lakeview's Privacy Practices available in the clinic reception area or upon request.

My signature below means I have read this information and understand it. A copy of this of this authorization may be used in place of the original.

Signature: _____ Relationship to Patient: _____

Printed Name: _____ Date: _____