Norfolk Medical Group at Fountain Point

Child—Through Age 18 **Date:** _____

Last Name	First Name	MI	Birthdate	Sex M / F	Maiden Name

Street Address / Mailing Address	City	State	Zip

Home Phone	Work Phone	Cell Phone	Social Security #

Parent Email Address	Primary Care Physician

In Case of Emergency—Notify (Not living with patient)	Relationship	Telephone #

Preferred Method of Contact
☐ Home Phone ☐ Cell Phone ☐ E-Mail ☐ Mailing Address

I authorize NMG to leave a voicemail on my home or cell phone Yes ☐ No ☐

Primary Language (select one)
☐ English ☐ Spanish ☐ Other– Please List _____

Ethnicity
☐ Hispanic or Latino
☐ NOT Hispanic or Latino

Race
☐ White ☐ Black or African American ☐ Asian
☐ Other _____ ☐ American Indian ☐ Hispanic

Parent Responsible for Paying this Account (Custodial Parent)

Last Name	First Name	M.I.	Social Security #	Relationship to Patient

Phone Number ( )	Birthdate	Mailing Address	City	State	Zip

Occupation	Employer	Address	Phone Number

Other Parent

Last Name	First Name	M.I.	Social Security #	Relationship to Patient

Phone Number ( )	Birthdate	Mailing Address	City	State	Zip

Occupation	Employer	Address	Phone Number

INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group# _____

Policyholder name and birth date: _____

Relationship to patient: _____ Policyholder Social Security #: _____

Employer: _____ Effective Date: _____

Secondary Insurance _____ ID# _____ Group# _____

Policyholder name and birth date: _____

Relationship to patient: _____ Policyholder Social Security #: _____

Employer: _____ Effective Date: _____

PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST (over)

Updated: 4/7/23

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INSURANCE INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim.

SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES -ACKNOWLEDGMENT

We are required by law to protect the privacy of your health care information, offer a copy of our notice of privacy practices, and follow the guidelines described in that notice. Your signature acknowledges you have been offered this notice. If you wish to receive a copy of your health care information, you may do so by asking the receptionist.

SIGNATURE: _____ DATE: _____

FINANCIAL POLICY

Our office is committed to providing quality and cost-effective health care to our patients. In today's insurance environment, it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us. Insurances reimbursement is a contract between you and your insurance company. As a courtesy to you, we will file all primary and secondary claims for you. We will require a current copy of your insurance card in order to do this, and we will need to be informed of any change in insurance status. You will be responsible for all co-pays, deductibles, and co-insurance amounts not covered by a secondary insurance policy, along with the entire amount of any non-covered service. For your convenience, we accept cash, personal checks, Visa, and MasterCard. I agree that I am financially responsible for all services provided, and should it be necessary to refer the account to collections, I will be responsible for all collection fees, collection costs, attorney fees, and court costs involved with my account. I understand I am responsible for my spouse/dependent charges.

SIGNATURE: _____ DATE: _____

PREVENTATIVE CARE (Wellness/Annual Exams)

Your health insurance plan may not provide coverage for preventive services. It is important that you contact your insurance provider to determine if your plan offers benefits for this service and what their scheduling guidelines are for it. We use industry-standard codes and guidelines to submit claims to insurance companies based on the scheduled encounter and documentation in the patient's medical record. Current laws regarding fraud and abuse with billing procedures prohibit us from changing the procedure codes and/or diagnosis codes in order to get the claim paid by the insurance company.

SIGNATURE: _____ DATE: _____

E-PRESCRIBING

E-Prescribing is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety.

By signing below, you agree that Norfolk Medical Group, LLC can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Pharmacy: _____