315 Franklin Plaza • Louisburg, NC 27549
P: 919-496-4976 • Fax: 919-496-4978

PATIENT INFORMATION

Today's Date: _____/_____/_____ Gender: ☐ Male ☐ Female

Last Name: _____ First Name: _____ M/I: _____

Date of Birth: _____ Age: _____ SS #: _____
(required by some insurances)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____
(This Email will be used for communication regarding important patient notices, announcements, or special offers)

Employer: _____ Work Number: _____

Employer Address: _____

Referring Doctor: _____ Office Number: _____

Doctor's Address: _____

Pharmacy: _____ Pharmacy Number: _____

Pharmacy's Address: _____

PRIMARY INSURANCE

Company: _____ Insured's Name: _____

If NOT the patient, please provide the following: _____

Insured's Date of Birth: _____ Insured's ID/SS #: _____

Insured's Employer: _____

SECONDARY INSURANCE

Company: _____ Insured's Name: _____

If NOT the patient, please provide the following: _____

Insured's Date of Birth: _____ Insured's ID/SS #: _____

Insured's Employer: _____

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PATIENT FINANCIAL POLICY

Thank you for choosing Impact Primary + Urgent Care. While your health and well-being is our primary concern, we realize that the cost of healthcare is an issue for many patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask our staff if you have any questions.

INSURANCE

It is your responsibility to provide Impact Primary + Urgent Care with current insurance information. We will ask you for your insurance card at your first visit and keep a copy for our records. We may occasionally request a copy at a later date in order to update your records, so please bring your insurance card to each visit. We will help you receive the maximum benefits your insurance allows. However, please remember that your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you, and provide necessary information, including primary and secondary insurance, as well as any changes in insurance information. Failure to provide complete insurance information may result in reduced insurance benefits for you.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that they will not cover. Your insurance company makes the final determination of your eligibility and benefits. In the event that your health plan determines a service to be "not covered", you will be responsible for the entire charge. Also, please be aware that if we are out-of-network for benefits, we will bill you for any remaining balance that is your responsibility. This balance is due upon your receipt of our statement. In the event that you are unable to pay the balance in full, we encourage you to contact the Business Office promptly for assistance in arranging reasonable installment payments. Be aware that if your treatment requires biopsy or culture, you may receive a bill from a third party.

CO-PAYS

Co-payments may be required by your insurance plan. All co-payments must be paid when you check in at our front desk, prior to your appointment. If you do not have your co-payment your appointment may be re-scheduled.

DEDUCTIBLES AND COINSURANCE

For patients who have insurance plans which have deductibles and coinsurance that apply to them, please be aware that prior to any procedure, you will be responsible for payment of any deductible or coinsurance that may apply to this specific procedure. Also, be aware that it is your responsibility to check with your insurance carrier concerning deductibles and coinsurance.

SELF-PAY ACCOUNTS

Self-pay accounts are for patients without insurance coverage. It may also include patients covered by insurance plans in which Impact Primary + Urgent Care does not participate or patients without an insurance card on file with us. It is your responsibility to know if Impact Primary + Urgent Care participates in your plan. If there is a discrepancy with our information, you will be considered self-pay until you provide information proving otherwise.

PAST DUE ACCOUNTS

If your account becomes past due, please contact the Business Office so that we can assist you with a payment plan. If your account has been referred to a collection agency or attorney, you must pay the balance in full, including any collection fees. If you require further treatment and your account is in collections, the full balance will be due and you will

be required to pay the cost of the next visit in full prior to being seen.

RETURNED CHECKS

You may be assessed a fee for a returned check. This amount will be applied to your account in addition to the insufficient funds amount. Your account may be assigned "self-pay" status, requiring upfront payments, following a returned check.

REFERRALS & PRE-AUTHORIZATION/NOTIFICATIONS/CERTIFICATIONS

Your insurance company may require a referral from another physician and/or a pre-authorization/notification/certification. While it is your responsibility to obtain these, someone in the office will help you if necessary. Please make sure that all referrals are in our office prior to your visit. Failure to obtain these may result in a lower payment or no payment from your insurance company and the balance will be your responsibility.

MINORS

The parent(s) or guardian(s) presenting the child for treatment is responsible for full payment and will receive the billing statements. In addition, we may pursue payment from a non-custodial parent or guardian.

PATIENT AUTHORIZATION, ACKNOWLEDGEMENT AND AGREEMENT

I hereby authorize payment of health insurance benefits (and, if applicable, government benefits) directly to Impact Primary + Urgent Care for services furnished to me. I authorize the release of any of my healthcare information necessary to process my claims. I further authorize the release of my healthcare information to other healthcare providers, hospitals, and facilities involved in my treatment.

I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, co-insurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, and pre-authorizations.

I HAVE READ THE ABOVE PATIENT FINANCIAL POLICY AND/OR IT HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS, AND THAT I AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Print Patient's Name: _____ Date: _____

Signature: _____

If Legal Representative, provide relationship to Patient: _____

Witness Signature: _____

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NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered or received a copy of Impact Primary + Urgent Care's NOTICE OF PRIVACY PRACTICES. I understand that Impact Primary + Urgent Care is a healthcare provider and may share my health information for treatment, payment, and healthcare operations. I understand that if I have questions or concerns regarding my privacy rights, that I may send all correspondence in writing or by phone to:

Impact Primary + Urgent Care
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All complaints must be made in writing.

I further understand if the NOTICE OF PRIVACY PRACTICES should be amended, modified, or changed you will be notified at your next visit.

Patient/Guardian Signature: _____ Date: _____/_____/_____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I authorize my insurance benefits to be paid directly to Impact Primary + Urgent Care on my behalf. I also authorize Impact Primary + Urgent Care or my insurance company to release any information needed to process my claims. I understand that I am financially responsible for any co-pay, co-insurance, deductible, and other non covered services or materials the day services are rendered. I also understand I am financially responsible for any balance remaining after my claim has been processed.

Patient/Guardian Signature: _____ Date: _____/_____/_____