Valley View Wellness Medical Center

Complete care for your family

General Information:

I _____ (patient's name) acknowledge that all information previously presented is still true and accurate. I understand if any updates are not provided to Valley View Wellness Medical Center regarding changes in my general information, it will result in my account being place on hold until current information is provided.

Date of Birth: _____ Email Address: _____

Home Phone #: _____ Cell Phone #: _____

Emergency Contact Name and Number: _____

Mailing Address:

_____

Street City State Zip

HIPPA Authorization-

I, _____, understand Valley View Wellness Medical Center is not authorized by me to use or disclose my protected health information for a purpose other then treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of Valley View Wellness Associates, or any other individual listed below to disclose my protected health information as describe on this form to the recipients listed below. I understand that when the information is used or disclose pursuant to the authorization, it may be subject to redisclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according:

Names of person(s) other then myself authorized by this form to use and disclose my protected health information (family members, etc.):

_____

Signature: _____ Date: _____

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4 Types of Patient Responsibility

1. ***Co-Pays*** – They are almost always indicated as fixed amounts based upon the terms of the patient's insurance policy and will always be collected at the time of visit.

2. ***Co-Insurance*** – If the insurance policy indicates the insurance payer covers 90% or 80%of the cost for an office visit, the patient is responsible for the difference.

3. ***Deductible*** – A deductible is a specific amount of money that must be paid before the patient's insurance company will pay any money towards the claim.

4. ***Self-Pay*** – Patients without any insurance coverage or with a plan the practice does not accept are considered self-pay. The total amount of the visit must be in paid in full the day of the appointment.

****It is the patient's responsibility to know their insurance plan and coverage. The office is not required to verify information prior to any appointments you make. Please call the customer service number on the back of your card with any questions prior to your scheduled appointment.**

Patient Name - _____

Date - _____

Signature - _____

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ATTENTION PATIENTS!!

Please be advised that your blood work may be sent to laboratories that may be "OUT OF NETWORK" with your insurance.

We have access to three different labs here:

- ***Pacific Medical Lab***
- ***Quest***
- ***Labcorp***

Please advise which lab you would like to have your bloodwork to go to below. If at any time you need to change this information, please let your Medical Assistant or Provider know.

If you have a specific laboratory that is designated to your insurance that is not on the list above, we are happy to provide you with a lab order to take to that lab.

Please be advised that if you choose one of our labs and receive a statement from them, it is your responsibility to handle that bill with them. We do not have access to their billing information or have the authority to handle any issues. Please call them directly.

I would like my bloodwork to go to _____

(List lab from above)

Patient Name - _____

Date - _____

Signature - _____

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2021 Insurance Changes and Law Disclaimer

Dear Valued Patient,

We are a Medicare, PPO, and CASH provider only. There are many new insurance changes that we cannot verify due to the volume of phone calls. We will bill your insurance as a courtesy to our patients, but it is the patient responsibility to be aware of any policy changes. You will be responsible for your Deductible, Copayment and Co-Insurance, if applicable. Please speak with the Office Manager with any questions or concerns.

Insurance Disclaimer: "A quote of benefits and/or authorization does not always guarantee payment or eligibility. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at the time of service."

Insurance Liability of Payment: Your health insurance company will only pay for services that they deem reasonable and necessary under your agreed health plan. Every effort will be made by our office to have all services and procedures covered by your health insurance company. If your health insurance company determines that a service is not reasonable or necessary, or that a service is not a covered benefit under your plan, then the patient becomes responsible for the amount due.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that I am responsible for any Co-Payments, Deductibles and Co-Insurance that may apply.

No Show Fee: There will be a charge to your account of $25.00 if you do not show for your appointment without calling to cancel or reschedule. You must cancel or reschedule within 24 hours of your scheduled appointment time to avoid this fee.

Sincerely,

Michael Z. Kurtz, D.O.

Print Name - _____ Date - _____

Signature - _____

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Preventive Blood Work / Physicals

Every insurance carrier has their guidelines on what they deem as preventative lab work. It is the **patient's responsibility** to find out what is covered under their current insurance plan. Please see below a list of our standard preventative blood work. Please let the provider know in advance if you do not want any of these done.

- ***CBC***
- ***COMPREHENSIVE METABOLIC PANEL***
- ***LIPID PANEL***

NOT COVERED BY ALL INSURANCES:

- ***TSH***
- ***FREE T3***
- ***FREE T4***
- ***HORMONE PANEL (MALE OR FEMALE)***
- ***PSA FREE AND TOTAL (MEN ONLY)***
- ***ANEMIA PANEL***

If you have any questions regarding any of these tests above, please ask your provider. **I understand I will be held responsible for any charges not covered by my insurance plan for blood work I have asked for during my visit today.**

Patient Name - _____

Date - _____

Signature - _____