MANSFIELD F·A·M·I·L·Y PRACTICE

Please circle the provider you would like to see: Dr. Sandra Hughes Dr. Ayaz Madraswalla Dr. Ross Winakor

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PATIENT INFORMATION

LAST NAME: ____________________ **FIRST NAME:** ____________________ **MI:** ________

DOB: ____________________ **SOCIAL SECURITY NUMBER:** ____________________

STREET ADDRESS: ____________________

CITY: ____________________ **STATE:** __________ **ZIP:** ____________________

MAILING ADDRESS (*If different than above*): ____________________

CITY: ____________________ **STATE:** __________ **ZIP:** ____________________

HOME PHONE: ____________________ **CELL PHONE:** ____________________

PLACE OF EMPLOYMENT: ____________________ **WORK PHONE:** ____________________

PREFERRED CONTACT? □ HOME □ CELL □ WORK **OKAY TO LEAVE A DETAILED MESSAGE ON:** □ HOME □ CELL □WORK

EMAIL: ____________________ **WOULD YOU LIKE ACCESS TO OUR PATENT PORTAL?** □ YES □ NO

MARTIAL STATUS: □ M □ S □ D □ W □ O **BIRTH GENDER:** □ MALE □ FEMALE **IDENTIFIED GENDER:** ____________________

RACE: □American Indian/Alaska Native □Native American/Pacific Islander □Black/African American □Asian □White □Other

ETHNICITY: □ Hispanic/Latino □Not Hispanic/Latino □I DECLINE TO ANSWER RACE/ETHNICITY

PARENT/LEGAL GUARDIAN *(if minor):* ____________________ **PHONE NUMBER:** ____________________

PARENT/LEGAL GUARDIAN *(if minor):* ____________________ **PHONE NUMBER:** ____________________

EMERGENCY CONTACT: ____________________

RELATIONSHIP: ____________________ **PHONE:** ____________________

PREFERRED PHARMACY ____________________

ADDRESS: ____________________ **PHONE:** ____________________

REASON FOR VISIT: □ Annual Physical *Date of Last Physical:* __________ □ Health Concerns/Questions you would like to discuss with the doctor: ____________________

Have you been seen at another location for this concern? If yes, where: ____________________

PRIMARY MEDICAL INSURANCE

INSURANCE PLAN NAME: ____________________

MEMBER ID #: ____________________ **GROUP #:** ____________________

SUBSCRIBER NAME: ____________________ **SUBSCRIBER DATE OF BIRTH:** ____________________

SUBSCRIBER'S EMPLOYER: ____________________ **SUBSCRIBER'S SSN:** ____________________

SUBSCRIBER ADDRESS: ____________________

SECONDARY MEDICAL INSURANCE

INSURANCE PLAN NAME: ____________________

MEMBER ID #: ____________________ **GROUP #:** ____________________

SUBSCRIBER NAME: ____________________ **SUBSCRIBER DATE OF BIRTH:** ____________________

SUBSCRIBER'S EMPLOYER: ____________________ **SUBSCRIBER'S SSN:** ____________________

SUBSCRIBER ADDRESS: ____________________

MANSFIELD F·A·M·I·L·Y PRACTICE

Authorization for Disclosure of Health Information

(Who do you give us permission to speak with on your behalf?)

I, (Patient's Name) ____ Date of Birth: ___________ direct the
(please print)
health care providers at Mansfield Family Practice to disclose and release my (patients name) protected health information to the following individuals:

Name: ____ *Relationship:* _________________________

Contact Number: _____________________________

Name: ____ *Relationship:* _________________________

Contact Number: _____________________________

The above-named individual(s) have my permission to request information on my behalf including appointment date/times, insurance/billing and the following concerning my healthcare:

HEALTH INFORMATION TO BE RELEASED, upon the request of the person named above --(Check all that apply):

- ☐ A. Release my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)
- ☐ Immunizations
- ☐ Other: ____

- OR -

- ☐ B. Release my health record, as above, **but DO NOT DISCLOSE** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Pregnancy
  - ☐ Other (please specify): ______________________________________

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods,

  - OR -

- ☐ Date or event:____unless I revoke it.
  (NOTE: You may revoke this authorization in writing at any time by notifying us in writing.)

____ ______________________________

Name of Individual Completing this Authorization *Date*

____ _______________________________

Signature of Individual Completing this Authorization *Relationship to patient*

MANSFIELD F·A·M·I·L·Y PRACTICE

Authorization For Release of Records
TO MANSFIELD FAMILY PRACTICE

I, (Patient's Name) ____ Date of Birth ________________

(please print)

Authorize:

Name of Healthcare Facility: ____

Address: ____

Phone Number: _________________________________ Fax Number: ___________________________

To Release medical records to:

Mansfield Family Practice
34 Professional Park Road, Storrs, CT 06268
Fax: 860-429-8738
Phone: 860-487-0002

HEALTH INFORMATION TO BE RELEASED, upon the request of the person named above --(Check appropriate box):

- ☐ A. **Release my complete health record** (including but not limited to diagnoses,lab tests, prognosis, treatment, and billing, for all conditions, including records from any specialists.)
- ☐ Immunizations
- ☐ Other: ____

OR

- ☐ B. Release my health record, as above, **but DO NOT DISCLOSE** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Pregnancy
  - ☐ Other (please specify): ____

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying us in writing.)

____ _____________________________________

Name of Individual Completing this Authorization *Date*

____ _____________________________________

Signature of Person Giving Authorization *Relationship to patient*

MANSFIELD F·A·M·I·L·Y PRACTICE

Permission to Treat a Minor

Name of Minor____ Date of Birth____________________

There may be a situation that arises when parents/guardians cannot be available to bring their child/children to our office for care. When your child is in the care of someone else, we must have the information below to treat your child.

In presenting my child/children for diagnosis and treatment, and when accompanied by the below listed individual(s), I hereby consent to the rendering of such care. This includes medical treatment from the providers of Mansfield Family Practice, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's conditions

I authorize the below designated individual(s) to arrange for routine or emergency medical treatment, if necessary, to preserve the health of our/my child. I acknowledge that I am responsible for all charges in connection with the care and treatment rendered.

I understand it is my responsibility to inform this office of any change in my child's medical status. I understand if I fail to complete this form, Mansfield Family Practice will not treat my child, unless accompanied by anyone other than the registered parent/guardian as listed on the Patient Registration Form.

I/We have read this form and understand its contents. I/We hereby give consent to:

Name: ____

Relationship to patient: _______________________ Phone number: ________________________________

Name: ____

Relationship to patient: ________________________ Phone number: _______________________________

Parent/Guardian Printed Name: ____

Signature:____ Date: ______________________

MANSFIELD F·A·M·I·L·Y PRACTICE
STATEMENT OF FINANCIAL POLICY FOR OUR PATIENTS

We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this statement of financial policy. Please read it, ask us any questions you may have, and sign the space provided. A copy will be provided to you upon request.

1. **Insurance:**

   Insurance coverage and requirements vary greatly. Although we try, we cannot keep up on all the changes. Ultimately it is your responsibility to know what your insurance requires. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but do not have an up-to- date insurance card, payment in full for each visit will be required until we can verify your insurance coverage.

   If you have any questions, we urge you to contact your insurance company.
   Co-pays are due at the time of your appointment.
   If you have different insurance for your prescriptions, it is important that we have that information as well.

2. **Non-Covered Services:**

   Please be aware that some-and perhaps all-of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. Payment will be required in full for these services at the time of the visit. You will be required to sign a waiver to acknowledge that you are aware that your insurance will not cover these services and that you are financially responsible for payment of this service.

3. **Proof of Insurance:**

   All patients must complete and sign our Patient Information Intake Form prior to being seen by a physician. We must obtain a copy of your driver's license and a copy of your current valid insurance card. If you fail to provide us with the correct information in a timely manner, you will be responsible for the balance of the claim.

4. **Claims submission:**

   We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

5. **Coverage Changes:**

   If your insurance changes; you are required to notify us before or at your next visit so we can make the appropriate changes to help you receive your maximum benefits.

6. **Nonpayment:**

   If your account is over 90 days past due, you will receive a letter stating that you need to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to an outside collection agency and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

7. **Missed Appointments:**

To help us serve you, please keep your scheduled appointments or call 24 hours prior to your appointment to reschedule. When you do not keep a scheduled appointment, and do not cancel, we are unable to care for another patient that needs us. We have a no-show fee of $25.00 that your provider may charge if you no-show more than once. Excessive missed appointments may lead to discharge from the practice.

8. Late Appointments:

You will be considered late for a scheduled appointment if you arrive 10 minutes after the time of the appointment. We know that traffic is impossible to predict, so please allow extra driving time.

9. Form Completion Fee:

We will complete the forms you may need for school/camp physicals, disability, FMLA, etc. within 7 days. A form completion fee may apply of $25.

10. Parents/Guardians:

Are responsible for any monies due for the services/treatments provided to the child/children in which you I am the guardian.

11. Making Payments:

Payment may be made on our website: MFPStorrs.com.

12. Prescription Refills:

We will fill or refill prescriptions within twenty-four (48) hours. Refill requests made off hours will be processed the following workday.

13. Returning Phone Calls/Correspondence:

We will make every effort to return your communications during normal business hours in a timely manner. We appreciate your patience as we navigate through staffing challenges. We encourage you to contact us through the patient portal. Please understand; you may need to be seen in our office to properly diagnose and treat.

If you have a life-threatening situation, call 911 or go to the nearest emergency room.

14. HIPAA PRIVACY STATEMENT:

HIPPA Privacy Statement is required to be completed by all new patients and **updated on a yearly basis** by all patients in order to disseminate information and records concerning your medical health care and services that you receive at this office. This form describes the way we may use and disclose protected health information about you and also describes your rights and obligations regarding the use and disclosure of that information.

Thank you for understanding our financial/payment policy. Please let us know if you have any questions or concerns.

________________________________ ________________________

Signature of Patient or Responsible Party Date

MANSFIELD F·A·M·I·L·Y PRACTICE

Benefits Assignment and Financial Responsibility

____

Last name **First name** **DOB**

____

Address

RELEASE OF INFORMATION: I authorize **Mansfield Family Practice** to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights, and claims for reimbursement of claims, costs, and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that COPAYMENT IS DUE AT THE TIME OF SERVICE. I understand I am financially responsible for charges not covered by my insurance company. I also understand if my account is past due, I will receive a letter stating that my account may be headed to collections if I do not pay. I understand I will be responsible for any attorney fees and costs to Mansfield Family Practice if this matter is referred to collection and I, and my family members may be dismissed from the practice.

PHONE & PORTAL COMMUNICATIONS: I understand that should I choose to receive new medical advice by phone or portal communication in place of an in-office visit, a claim will be submitted to my insurance company and I am responsible for any co-pays and/or deductibles as per my contract with my insurance company.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

______________________________ ______________

Patient Signature/ Authorized Representative Date

______________________________ ______________

If authorized Representative; please print name Relationship to patient