**FAIR OAKS INTERNAL MEDICINE**

# Patient Registration

| Last Name: | First Name: | Middle Initial: | Date of Birth: |
|---|---|---|---|

| Home Address: | Apartment #: | Sex: ☐ Male ☐ Female |
|---|---|---|

| City: | State: | Zip Code: | Marital Status: (Circle One) Single / married / Widowed / Separated / Divorced |
|---|---|---|---|

| Home Phone #: ☐ Preferred | Cell Phone #: ☐ Preferred | Work Phone #: ☐ Preferred |
|---|---|---|

| Email: | Employer: |
|---|---|

| Race: ☐ Declined | Ethnicity: ☐Declined | Preferred Language: ☐ Declined |
|---|---|---|

## Primary Insurance Information

| Insurance Name: | Effective Date: |
|---|---|

| Policyholder/Subscriber Name: | ID #: | Group #: |
|---|---|---|

| Relationship to Patient: | Policyholder Birth Date: | Policyholder Daytime Phone #: |
|---|---|---|

## Secondary/Supplemental Insurance Information

| Insurance Name: | Effective Date: |
|---|---|

| Policyholder/Subscriber Name: | ID #: | Group #: |
|---|---|---|

| Relationship to Patient: | Policyholder Birth Date: | Policyholder Daytime Phone #: |
|---|---|---|

## Emergency Contact Information

| Name: | Relationship To Patient: | Cell Phone #: | Alternate Phone #: |
|---|---|---|---|

I authorize my insurance benefits to be paid directly to the physician and I agree to be financially responsible for all charges incurred. I hereby consent to the release and re-disclosure of my financial records to enable or facilitate the collection, verification, or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to Fair Oaks Internal Medicine, any of its affiliates or agents, or any third party services acting on behalf of Fair Oaks Internal Medicine or any of its affiliates.

I certify that I have insurance coverage with ____________________________ (Name of Insurance) and assign directly to Dr. ______________________ (Print Doctor Name) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**Patient Name (Print): ________________________________**

**Patient Signature: ____________________________________ Date: ______________**

MARC A. EISENBAUM, M.D.
3700 JOSEPH SIEWICK DR. #203
FAIRFAX, VA 22033
(703) 758-8200

**AUTHORIZATION TO RELEASE PATIENT INFORMATION**

I, ______________________________, hereby authorize Dr. Marc Eisenbaum and staff of this office to release any information pertaining to my health care, test results and billing information to the following person(s) or agencies:

Spouse: □ Name: ____________________________ Phone #:_____________________________

Children: □ Name: ____________________________ Phone #: _____________________________

Parent's: □ Name: ____________________________ Phone #: _____________________________

Other (please specify): ___________________________________________

I further authorize the doctor and staff to dispense results of my medical exam in one or more of the following, leaving a voicemail if I am unable to answer:

Home: ________________________ □ Preferred

Work: ________________________ □ Preferred

Cell: _________________________ □ Preferred

Other: _______________________ □ Preferred

I understand that this office will release any information to those persons whom I have listed above. In addition, I understand that this release relates to all medical as well as billing information. This will be actively enforced.

If you wish to change the status of this form you must do so in person, in writing and by signing and dating.

Patient Name (Please Print): _________________________________

Patient Signature: _____________________________________ Date: ____________________

# DR. EISENBAUM'S BILLING POLICY

**I, ____________________________, do hereby give permission for Dr. Marc Eisenbaum's office to charge the provided credit card any applicable charges incurred in this office. All services will first be submitted to my insurance(s) on file. I will receive an Explanation of Benefits from my insurance company stating my responsibilities for the visit. Once the office receives a response from the insurance company stating my responsibility this amount will automatically be charged. If there are any additional charges such as insurance denials that are over $100 the office will inform me, by either talking to me or leaving a message on the provided number, before any charges to my credit card are made.**
**Secure Phone # to leave detailed messages: ___________________**
**(If a phone number is not supplied, a phone call will not be made.)**

**Every transaction over $100 will result in having a detailed receipt sent to my home address on file.**

**Patient Name: ___________________________________________________**

**Credit Card / Flexible Spending Card:**

**VISA MASTERCARD AMER. EXP. DISCOVER**

**Card #: _________________________________________________________**

**Card Exp. Date: _______________________**

**Other Family in Practice to Add to Policy:**

______________________________________________________________________

**Authorized Signature: ____________________________________________**

**Today's Date: __________________**

# Important Practice Policy Information

Revised 2/26/13

To make it possible to provide you, and the rest of my patients, the best possible care, I have created the following policies:

1.) **Appointment Times:** You are asked to arrive a few minutes early to your appointment. This allows me to stay on schedule and prevents people scheduled after you from having to wait.

2.) **No Show/Cancellation Policy:** You will need to provide notice of one **full** business day (24 hours) for appointment time changes or cancellations. The current fee for no shows and cancellations made without proper notice is $50.00. The current fee is $100.00 if the appointment was a physical or stress test. Cancellation fee applies to same day/Emergency work in appointments if you do not notify us within 20 minutes of scheduling the appointment. This gives us the opportunity to offer the slot to another patient.

3.) **Insurance:** We will bill your insurance company for any services rendered here, whether we participate with your insurance or not. You are responsible for the following:

- **a.)** Paying your co-pay at the time of service, unless you have filled out our billing policy
- **b.)** Payment of any balances that your insurance does not cover that are designated as your responsibility by your insurance company
- **c.)** Providing this office with accurate insurance information
- **d.)** Calling your insurance company to provide them the necessary information to process your claim or resolve problems should they arise
- **e.)** Knowing what services are covered by your insurance company (although feel free to ask us for assistance if needed)

4.) **Self-Pay Patients:** Payment is expected at the time the service is rendered.

5.) **Balances Owed:** Payment is expected at the time you are notified of your balance. In the case of financial hardship this office will work with all patients, within reason, to create a payment plan for balances owed. Statements are mailed every 30 days. If we have not received payment or heard from you within 120 days your account will be turned over to a collections agency. All collections costs will be your responsibility.

**I, __________________________, have read and understand these policies:**

**Sign: ___________________________ Date: ______________**

## HIPAA & NOTICE OF PRIVACY PRACTICES

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. As a result, we have made some changes in our office management procedures to make sure we follow the Health Information Portability and Accountability Act (HIPAA). Passed into law in 1996, HIPAA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with. HIPAA gives you additional rights regarding control and use of your health information, meaning **you have more access and control than ever.** Please take a few minutes to review these new rights. We're happy to answer any questions you may have.

### Control over Your Health Information

All healthcare providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you choose them as your caregiver. We must, by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it. We must get your signature for non-routine uses and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs medical history, you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why. Authorizations of non-routine information are one-time-only, case by case, for the use defined by you.

### Access to Your Health Information

You can get copies of your medical records simply by asking for them. Healthcare providers are required to get you a copy of your records within 60 days of your request. There may be a cost for this service. Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you-no justification is needed. You can also amend your medical records. You cannot change the existing record, but you can add notes of comment on any procedures, treatments, payments or operations. The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side of the story about treatment and payment issues.

### Patient Recourse If Privacy Protections Are Violated

Every healthcare provider must also inform you of grievance procedures. If your privacy is violated, **report the incident to our Privacy Officer immediately.** You also have the right to report any violation to the Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201. If you decide to file a grievance either with us or with the Department of Health and Human Services, we are not allowed to discriminate or retaliate against you in any way. Aside from these new rights to access and control of your medical information under HIPAA, there are also clear limits on all healthcare providers regarding how they disclose medical information. Here are some of the key aspects of these boundaries. **Providers must ensure that health information is not used for non-health purposes.** Health information (covered by the privacy rules) generally may not be used for purposes not related to health care-such as disclosures to employers to make personnel decisions, or to financial institutions-without your explicit authorization. **There are clear, strong protections against using health information for marketing.** The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get you specific authorization before sending you any materials other than those related to treatment. **Use only the minimum amount of information necessary.** In general, uses or disclosures of information will be limited to the minimum necessary. This does not apply to discloser of records for treatment purposes, because physicians, specialists and other providers may need access to the full record to provide quality care.

### Exemptions:

There are situations where healthcare providers may not have to follow these privacy rules. They included: emergency circumstances; identification of a body, or the cause of death; public health needs; judicial and administrative proceedings' limited law enforcement activities; and activities related to national defense and security. We understand your right to have your medical information kept confidential. Our compliance with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on issues of patient's rights and privacy of information. We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.

Patient Name (PRINT): ______________________________

Patient Signature: ___________________________________ Date: ________________