



PATIENT REGISTRATION

NAME (FIRST, MIDDLE, LAST) _____

ADDRESS (INCL CITY AND ZIP) _____

DAY# _____ EVENING# _____ CELL# _____

DOB (MO/DAY/YR) _____ SS# _____ DL# _____

SEX _____ MARITAL STATUS _____

EMAIL ADDRESS _____

EMPLOYER (NAME/ADDRESS) _____

RESPONSIBLE/INSURED PARTY:

NAME (FIRST, MIDDLE, LAST) _____



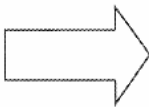
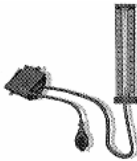


SS# _____ EMPLOYER NAME/ADDRESS _____

DOB _____ RELATION TO PATIENT _____

Insurance Name _____ Policy Number _____

Address(send claims address) _____ Phone#(provider) _____

How did you hear about us?

 FRIEND
  YELLOW PAGES
 
 SIGN
  REFERRAL
  OTHER

WE REQUIRE PAYMENT WHEN SERVICES ARE RENDERED.

METHOD OF PAYMENT:
(CIRCLE ONE)

 CASH
  CREDIT CARD
  CHECK

I authorize treatment by Primary Plus Organic Medicine, LLC. I agree to be responsible for my bill. I authorize disclosure of my medical records to any agency involved in payment for my treatment. I also will be responsible for any reasonable collection or attorney fees incurred in the collection of any amount due to Primary Plus Organic Medicine, LLC.

Signature: _____ Date: _____

PRIMARY PLUS ORGANIC MEDICINE, LLC FINANCIAL POLICY

Thank you for choosing Primary Plus Organic Medicine, LLC as your health care provider. We are committed to providing you with quality and affordable health care. Please read this, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we contract with, payment is expected in full at time of service. If you are insured by a plan we do business with, but don't have an up-to-date card, payment in full is required at visit until your insurance can be verified. Being educated upon your individual policy is your responsibility. We simply follow the guideline set forth by your insurance company. You basically are contracted with them and if you have any questions regarding coverage please contact the insurance carrier.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. We try to call and verify your coverage for you to collect accurately from you. We are not liable for false or outdated information that your insurance provides us with. Failure to collect co-pays and deductibles from patients can be constituted as Insurance Fraud. Please help us in upholding the law by paying your co-pay and deductible at time of visit. **We look at cases of financial distress on a case by case basis to determine if any type of financial forgiveness is applicable.**
3. **Non-covered services.** Please be aware that some -and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for these services at time of visit.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submissions.** We are not required to submit claims for you. This is a service we provide to you. We will submit your claims and assist you in any way within reason to help you get the claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. We also do not file **SECONDARY** insurance. You need to await your EOB from your primary insurance carrier to submit with a HCFA form (your ins co should provide you with this) to obtain payment. If you should have any questions regarding this we will be glad to assist you.
6. **Coverage change.** If your insurance company changes, please notify us before your next visit to make the appropriate changes to help you receive maximum benefits. If your insurance company does not pay your claim within 60 days, the balance is automatically billed to you. If you have not received any notification from them at this point you should call and investigate.

7. **Non-payment.** If your account is more than 45 days past due, you will receive a 7 day notification to pay your account balance in full. Partial payments will not be accepted unless otherwise negotiated. We reserve the right to charge 18% APR on all accounts that are past due. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by standard mail 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 emergent basis.
8. **Collections.** If you are submitted to a collection agency you will incur all collection costs. Upon submission to a collection agency no monies nor agreements can be negotiated from Primary Plus Organic Medicine, LLC. This account then becomes property of the agency and all arrangements should be discussed with them individually.
9. **Credit Card Policy.** Please read separate policy concerning credit card payments. We ask that you provide your credit card number for our files. When your insurance has paid it's portion and notified us of the amount of your share, we may call you to determine if we can charge your credit card on file. We will not charge your credit card without asking you first. By implementing this policy, we will cut down on the number of statements we have to mail and you have to mail back. Your credit card information will be held **SECURELY** at all times.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

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

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

PRIMARY PLUS ORGANIC MEDICINE, LLC CREDIT CARD POLICY

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout faster, easier and more more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time of check in or check out and this information is held securely until your insurances have paid their portion and notified us of your share. Any remaining balance owed by you MAY be charged to your credit card. This method is typically a safeguard for the office and will only be charged if necessary. There will always be an attempt to notify you of charges prior to doing so.

This is an advantage to you, since you will no longer have to write out checks and mail to us. It will be advantageous to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This is in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of visit will, of course, still be due at time of visit.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely yours,
Primary Plus Organic Medicine, LLC

I authorize Primary Plus Organic Medicine, LLC to charge outstanding balances on my account to the following credit card:

Visa Mastercard American Express Discover

Account number: _____ Expiration: _____

Name on card (please print) _____

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

I, _____ understand that my information is confidential and that I have reviewed my HIPAA privacy statement to ensure the standards the practice uses to safeguard my records.

Signature of patient or responsible party

Date

The 3 page copy of our Privacy Practice is available to you upon request. Most patients have been familiarized in the HIPAA act as they are affiliated with other entities that are guarded by these standards as well (pharmacies, other doctor offices, dentists, etc....).

Patient Medication History Form

"H Y'a YX]W]bYg'nci 'HU_YUfYdUfhcZnci f\ YUH 'jbZfa U]cb" Please fill out this form (or have your caregiver complete it) and discuss it with Dr. Koniver. If you need more space to list your medicines, please use the back side.

DU]YbhiBUa Y.": _____

■ '5''Yf[]Yg'

BUa YcZGi VghUbWY (drug or food)	HndY'cZF YUW]cb'

Do you react to latex or rubber (gloves, balloons, etc) with a rash, wheezing, etc.? Yes No

■ '7i ffYbhiA YX]WU]cbg'

DfYgW]dh]cb'8fi [g' (such as Atenolol, eye drops, creams)	GfYb[h ' (such as 50 mg)	8]fYW]cbg'' (such as 2 tablets in the a.m.) Check box if taken only as needed'	DfYgW]VYX'Vmi (such as J. Doe, MD)
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
< YfVgZJ]hUa]bgZA]bYfUgZ5 a]bc '5 W]XgZ YHW (such as 5HTP, Vitamin C, fish oil, multi-vitamins)	GfYb[h ' '	8]fYW]cbg''(such as one tablet each day)	

D\ Ufa UWriBUa Y.": _____ D\ cbY' .: _____

