280 Sierra College Dr, Grass Valley, Ca 95945

Acknowledgement of Receipt of Notice of Privacy Practices

I have received and understand Bouchier-Pritchett Family Medicine Notice of Privacy Practices. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made by BPFM and its affiliated physicians and health care providers, my individual rights, how I may exercise these rights, and BPFM's legal duties with respect to my medical information. I understand that BPFM reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at or controlled by BPFM.

With my consent, Bouchier Pritchett Family Medicine may mail to my home or other designated location any items that assist in my treatment, payment and healthcare operations, such as appointment reminders and patient billing statements.

Patient Printed Name: ______________________________ Date of Birth: ____________

Patient (Guardian) Signature: ______________________________ Date: ________

280 Sierra College Drive, Ste 207, Grass Valley, Ca 95945 p.530-477-7390 f. 530-477-7389

Authorization to Release Protected Health Information (PHI) to Family Members or Designated Individuals

HIPAA Laws prevent us from discussing or disclosing your protected health information to family members, friends or other designated individuals unless you provide Bouchier & Pritchett Family Practice with authorization to release this information. We are required to have a completed authorization form on file prior to releasing your protected health information. Should a change be required, it is the patients' responsibility to notify the office of such changes. The most recently dated form will be considered current and will negate any previous versions.

I, ______________________________ Date of birth__________________
authorize Bouchier & Pritchett Family Practice to disclose my protected health information to the individual(s) listed below:

____
Name Phone# Relationship

____
Name Phone# Relationship

____
Name Phone# Relationship

Health information to be disclosed (Check all that applies):

☐ **My Complete Health Record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing for all conditions) or**

My complete health record, as above, **with the exception of the follow information:** (Check as appropriate)

☐ Mental Health Records
☐ Communicable diseases (including HIV & AIDS)
☐ Alcohol/drug abuse treatment
☐ Other (please specify):__________________________________

The health information may be used to enable the persons I authorize to know and understand my condition and my treatment options, for treatment or consultation, for claims payment purposes or related reasons. I understand that this Authorization is voluntary and I may revoke my authorization in writing at any time.

Signature: ______________________________________ Date:______________

Printed Name of Legally Authorized Representative (if applicable):______________________________

Relationship: ☐ Parent or legal guardian ☐ Power of Attorney ☐ Other:__________________

Bouchier & Pritchett Family Medicine

Financial Agreement and Office Policies

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

Patients Information Responsibilities:

- Change of Information: It is the patient's responsibility to inform the office of any address, phone number or insurance changes prior to appointment. Failure to do so may cause your account to be in delinquent status.
- Proof of insurance: All patients must complete our patient information form before seeing the provider. 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 will be responsible for the balance of a claim.

Patient (Guardian) Initial: ___________

Insurance Billing & Collections Policy:

- Insurance. We participate in most insurance plans, including Medicare. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required at time of visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- Cash Pay. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you do not have insurance, payment in full is required at the end of your visit. Failure to stay current on your account may require us to refer your account to a collections agency and will result in dismissal from our practice.
- 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.
- 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. In this event you will be responsible for payment.
- 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.
- Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days 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 a collection agency and you and your immediate family members may be discharged from this practice with notification via certified mail.
- Returned Payment. All returned payments will incur a $25 service fee in addition to returned payment amount. All returned payments must be paid in full prior to future appointments.

Patient (Guardian) Initial: ___________

No Show, Cancelled and Late Appointment Policy:

- Missed appointments. We are a busy practice and respect all of our patient's time. To help stay on time we adhere to a strict 5 minute reschedule policy. We also require 24 hours' notice for any cancelations or reschedules. Failure to do so will result in your appointment being considered a "no-show" and a $50 fee billed directly to you. Consistent tardiness and or three (3) no show's will result in discharge from our practice, notified via certified mail.

Patient (Guardian) Initial: ___________

Our practice is committed to providing the best treatment to all our patients. Thank you for understanding our policy so we may be able to serve every patient in the best possible way.

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

_______________________________ _______________

Signature of patient or responsible party Date

_______________________________ _______________

Patient Name Date of Birth