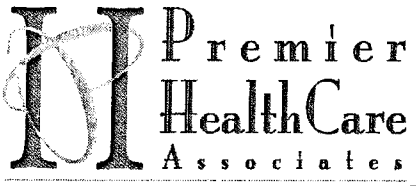

Appointment Information

Date: _____
Time: _____
Physician: _____

Please arrive 30 minutes prior to your appt. time

Patient Information

Name:
First _____ MI _____ Last _____

Street Address _____ Apt. or Post Office Box _____

City _____ State _____ Zip _____

Telephone Primary: (_____) _____ __ Home __ Work __ Cell

Work: (_____) _____ Cell: (_____) _____

Date of Birth _____/_____/_____ Social Security # _____-_____-_____

Marital Status (Please Circle) Married Single Divorced Widowed

Employer: _____ Occupation _____

Email address _____

Who referred you to our practice? _____

Primary Care Physician _____ PCP Phone _____

Preferred Pharmacy and Location: _____ Pharmacy Phone: _____

Emergency Contact Information

Contact #1:
Name
First _____ MI _____ Last _____

Street Address _____ Apt. or Post Office Box _____

City _____ State _____ Zip _____

Telephone:
Primary: (_____) _____ __ Home __ Work __ Cell
Secondary: (_____) _____ __ Home __ Work __ Cell

Relationship to Patient (Please Circle) Spouse Parent Child Friend Other

Contact #2:
Name
First _____ MI _____ Last _____

Street Address _____ Apt. or Post Office Box _____

City _____ State _____ Zip _____

Telephone:
Primary: (_____) _____ __ Home __ Work __ Cell
Secondary: (_____) _____ __ Home __ Work __ Cell

Relationship to Patient (Please Circle) Spouse Parent Child Friend Other

Insurance Company Information

Please fill out all information below. Refer to your insurance cards. Please be advised that Premier HealthCare Associates, Inc. will file **Primary** and **Secondary** Insurance claims for you. If you have another insurance carrier, you are responsible for filing to that carrier.

Primary Insurance Company _____ Effective Date _____

ID #: _____ Employer /Group # _____

Subscriber: First _____ MI ____ Last _____

Subscriber Date of Birth ____/____/____ Social Security # ____-____-____

Patient Relationship to Subscriber (Please Circle) Self Spouse Child Other

Subscriber Address (if different from the patient)

Street Address _____ Apt. or Post Office Box _____

City _____ State _____ Zip _____

Secondary Insurance Company _____ Effective Date _____

Subscriber ID # _____ Employer/Group # _____

Subscriber: First _____ MI ____ Last _____

Subscriber Date of Birth ____/____/____ Social Security # ____-____-____

Patient Relationship to Subscriber (Please Circle) Self Spouse Child Other

Subscriber Address (if different from the patient)

Street Address _____ Apt. or Post Office Box _____

City _____ State _____ Zip _____

Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____ have received a copy of the Premier HealthCare Associates' Notice of Privacy Practices dated September 23, 2013.

I understand that I may ask questions to the Privacy Officer if I do not understand any information contained in the Notice of Privacy Practices.

_____
Patient Signature

_____
Date

_____
Authorized Representative of Patient

_____
Relationship to Patient

_____
Date

Premier HealthCare Associates

Authorization to Disclose Patient Information

Patient Name: _____

Date of Birth: _____ SSN: _____

Your Premier HealthCare Associates Physican(s) **(Please circle)** Dr. Crognale, Dr. Moroianu, Dr. Mueller, Dr. Spring, Dr. Strachan

I authorize the Physicians and staff of **Premier HealthCare Associates** to discuss (as indicated) with the below listed individuals.

Please enter full name and date of birth and relationship to the patient for each individual.

Full Name	Date of Birth	Relationship to Patient	Contact Telephone Number	Healthcare, treatment, Billing Issues Please circle all that apply.
				Healthcare Treatment Billing
				Healthcare Treatment Billing
				Healthcare Treatment Billing
				Healthcare Treatment Billing

I request that Premier HealthCare Associates, Inc. **not** discuss my ☐ healthcare ☐ treatment and/or ☐ billing issues with:

_____

*** Please note - This authorization is optional and **does not** grant access to the patient's medical records. All requests for medical records must be authorized by the patient in writing. This allows our staff to speak to these individuals regarding your current healthcare, treatment or billing issues.

Please note that this authorization revokes previous authorizations.

I understand this authorization may be revoked by me at any time and must be done so in writing.

Signature of Patient: _____ Date:_____

Patient Representative: _____ Date:_____ Relationship: _____

Updated: 06/23/15

Premier HealthCare Associates

Financial Policy

Thank you for choosing Premier HealthCare Associates as your health care provider. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays/High-Deductibles/Account Balances/Returned Checks
All co-payments, patient responsibility of deductibles not met, and account balances are due at time of check-in unless previous arrangements have been made prior to your appointment with a Patient Account Representative. Upon arrival for an appointment and you are unable to pay your co-payment, you will be asked to reschedule your appointment for a later date. For your convenience, we accept cash, check, VISA, MasterCard or Discover. Post-dated checks are not accepted.

I understand that if I have a high deductible insurance plan and if the deductible is not met, I will be required to pay a $150.00 deposit at the time of service. Once my insurance has been billed and the claim adjudicated, any balance will be my responsibility.

A service fee of $25 will be charged to your account for all returned checks which is payable by cash or credit card. This fee is applied to your account in addition to the original check amount. You are placed on a cash or credit only basis following any returned check.

Insurance Claims
There is no doubt that health insurance benefits are confusing. Most plans do not provide 100% coverage for medical expenses. Each plan has its own set of rules, exclusions and benefit structures. **It is your responsibility to be familiar with your insurance policy's requirements.** If you are unsure of your coverage as it relates to services rendered at our office, you should call the customer service telephone number on your insurance card before receiving services.

Insurance is a contract between you and your insurance company. We will submit a claim to your insurance company as a courtesy to you. In order to properly file a claim with your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information at the time of each visit. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

In the event your claim is denied for a date of service, by your insurance company, due to non-payment of health insurance premiums, you will be responsible for payment in full for the services rendered. Proof of premium payment for Exchange products will be requested at time of appointments.

Participating Insurances

- Aetna
- AARP
- Anthem Blue Cross Blue Shield (WellPoint)
- Blue Cross Blue Shield Association
- Cigna
- Coventry Healthcare of VA
- Golden Rule
- Humana
- Medicare (Part B)
- Medicare Advantage (Part C)
- Medicare Supplemental Plans (Medigap)
- MultiPlan
- Optima Health
- Optima Family Plan (for established patient's only)
- Principal Financial Group
- PHCS
- Tricare (Prime, Standard & Tricare for Life)
- United Healthcare
- Virginia Health Network

We accept regular Medicaid and Optima Family Plan Medicaid for our **established** patients only.

Referrals
If you have an HMO or POS plan with which we participate, you may need a referral from your Primary Care Physician (PCP) to see a Specialist. Check your insurance card or call your insurance carrier to determine if your plan requires you to have a referral to see a Specialist. We must have the referral in the office before you are seen by the Specialist. We will ask you to reschedule your

Over →

appointment in the event that your referral is not received at the time of your appointment. For this reason, it is important that you make sure that your Primary Care Physician has sent the referral and that we have received it before you come in to the office. Another option is to bring the referral with you at the time of your appointment.

Self-pay Patients

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient is considered self-pay. Self-pay new patients are required to bring $200 at the initial appointment and are billed for the remaining balance due after the visit is complete. For all subsequent visits, payment is due in full at time of service. Established patients are eligible to receive a same day 40% cash discount for services rendered if they pay in cash. Patients paying with check or credit card are required to pay for services rendered in full; no discount will apply. Please ask to speak with a Patient Account Representative to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Missed Appointments

Premier HealthCare Associates requires 24-hour notice of appointment cancellation. Any appointments not canceled are subject to a "No Show" fee of $60. Any infusion center appointments not canceled are subject to a "No Show" fee of $100.

Outstanding Balance Policy

It is our office policy that all account balances be sent two statements. If payment is not made on this account, a notice of collections is sent asking you to contact our business office to pay your account in full or make payment arrangements. If no resolution can be made, the account is sent to the collection agency, or attorney, in which you are responsible for all fees incurred. You may also be subject to possible discharge from the practice.

Payment plans are available for account balances in excess of $50 in the event of a financial hardship. Payment terms are as follows: 50% of the total balance must be paid at inception of the payment plan agreement. The remaining balance is due within 6 months. A bill is sent to your mailing address each month for the amount agreed upon. If you are delinquent on a payment, your account is turned over to the collection agency where you will incur collection agency fees. All charges incurred after the inception of the payment plan are due with 30 days of receipt of the statement. Please note you may receive two separate bills from our office, one for your payment plan and one for other services rendered outside the terms of your payment plan.

Failure to comply with these payment terms may result in a dismissal from the practice.

Should the account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of 33 1/3%, interest at 18% per annum from the last date of payment and any and all applicable court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact *Pamela West,* our Business Office Manager, Monday through Friday, 8:30 am to 5:00 pm. Please call 804-288-7901, extension 398.

Authorization

Authorization to Release Information:

I authorize Premier HealthCare Associates, Inc. (PHA) to release information to my healthcare insurer, the Center for Medicare and Medicaid Services (CMS), or any other entity necessary to determine benefits and process claims related to medical services that have been provided to me. An electronic copy of this authorization will be deemed as valid as the original.

Assignment of Benefits:

I authorize payment of insurance benefits, including CMS benefits, for medical services provided to me directly to Premier HealthCare Associates, Inc. An electronic copy of this authorization will be deemed as valid as the original.

Financial Responsibility:

I have read the Premier HealthCare Associates Inc. Financial Policy and understand that I am responsible for all fees for medical services rendered to me by the physicians and nurses of PHA. Any fees deemed patient responsibility or are not covered by my insurance company will be due on the day of service or upon resolution of my insurance claim. PHA reserves the right to request payment of these fees before my insurance company has completed the processing of my claim (s) or if my claims are denied. It is my responsibility to notify PHA of any changes in my health care coverage before services are rendered. I understand that by signing this form that I am accepting financial responsibility as explained above for payment for medical services rendered to me. An electronic copy of this authorization will be deemed as valid as the original.

Patient Signature: _____ Date:_____

Please print your name: _____

Reviewed 8/8/2017