UP-NORTH MEDICAL CENTERS PATIENT PROFILE

REFERRING/PRIMARY PHYSICIAN_____

Patient Information:

_____, _____
Last Name First Name Middle Name

☐ Single ☐ Married

_____ ☐ Male ☐ Female _____ ☐ Widowed ☐ Divorced
Date of Birth Gender Social Security Number Marital Status

_____ _____
Home Phone Cell Phone

_____
Address City State Zip

I authorize Up North Medical Center permission to send text messages, reminders, or emails to the information provided below.

☐ **yes** ☐ **No**

Phone number: _____ Email Address _____

*If you choose no above, you will not receive a reminder for your appointment

_____ _____ _____
Emergency Contact Relationship to Patient Phone

_____ _____ _____
Person to whom we may release medical information Relationship to patient Phone

Insurance Information:
(If patient is not responsible party)

_____
Insurance Company Policy Holder's Name Date of Birth

_____
SSN of Policy Holder Relationship of Policy Holder to Patient

_____ _____ _____
Responsible party (Guarantor) Date of birth Phone

Patient Consent for Treatment & Use and Disclosure of Protected Health Information

I understand that as part of my healthcare, Up North Medical Center uses health information and medical records describing all aspects of my care. It is used for:

- Planning my care and treatment
- Communicating with health professionals involved in my care
- A source of information for billing
- A means by which any payer can verify that services billed were provided, and assist with our providers being paid for services and care provided to me
- A tool used for routine healthcare operations to measure the quality of my care

- I acknowledge that:
    - If I am a first time patient, I can receive a copy of privacy practice laws at www.hhs.gov/orc/privacy/hipaa. .
    - If I am not a new patient to Up North Medical Centers, I was notified at a previous visit that I can receive a copy of the notice of privacy practice at www.hhs.gov/orc/privacy/hipaa.
- I understand that Up North Medical Centers reserves the right to change this notice and will post notifications that there have been changes in the waiting rooms and examination rooms.

Signed by:

_____ _____

Signature of Patient / Legal Guardian | Relationship to Patient, if applicable

_____ _____ _____

Print Name of Patient / Legal Guardian | Date of Birth of Patient | Date

Cancellation and No-Show Policy

We understand that situations arise in which you mut cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours' notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made with less than 24 hours' notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a **$25.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as **NO SHOW.**

Patients who No-Show three (3) or more times in a 12-month period, may be dismissed from the practice and thus they will be denied any future appointments. Patients may also be subject to a **$50.00 fee for office appointment No-Shows.**

The cancellation and No-Show fees are the sole responsibility of the patient and must be **paid in full** before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived at our discretion.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department at 989-732-3284.

Please sign that you have read, understand, and agree to the cancellation and no-show policy.

Signature: _____ Date:_____

Payment Policy

As a courtesy, Up North Medical Centers, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will still pay according to policy provisions regardless of what we were quoted.

It is the policy of Up North Medical Centers that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. At the conclusion of your visit, you may be also be asked to pay outstanding balances. If there is a credit, you will be provided a refund promptly.

If you are covered by health insurance with Dermatology and Family Medicine benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff.

Accepting your insurance does not guarantee payment. You will be held accountable for any unpaid balances.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and verify your coverage for Dermatology and Family Medicine. Please do not assume that you will not owe anything if you have more than one insurance policy.

Questions or concerns should be directed to: Billing at 989-732-6395

Patient Signature:_____Date:_____