Springer Medical Associates

16615 Highway 104 North Suite B.
Lexington, TN 38351
Alicia G. Springer, NP-C
Robert Pomphrey, MD

Name_____ Sex: FEMALE OR MALE

Social Security number_____ Date of Birth_____ Age_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell phone_____

Marital Status: SINGLE, MARRIED, DIVORCED, WIDOWED, Spouse_____

Employer_____ Occupation_____ Phone_____

Address_____City_____ State_____ Zip_____

Spouse Information

Spouse name_____ _____ _____Social Security Number_____

Address_____ Date of Birth_____

Spouse employer_____ Occupation_____

Emergency Contact

Name_____ Phone_____

Address_____ Relation_____

Information of the Insurance Policy Holder

Mother_____ DOB_____ Father_____ DOB_____

Mother's employer_____ Father's employer_____

Mother's SS#_____ Father's SS#_____

Mother's Address_____ Father's Address_____

NOTE: PLEASEPRESENT INSURANCE CARD(S) TO THE RECEPTIONIST FOR MAKING COPIES:
I understand and agree that regardless of my insurance status, I am ultimately responsible for payment for any professional services I receive from Springer Medical Associates. I have read the above-listed data and have responded to all the data requested that is applicable to my personal and insurance date. I certify that the above listed information I have provided to be true and correct to the best of my knowledge, Furthermore, I will advise you of any changes that may occur with regards to my personal or insurance data

Signature_____ Date_____

Parent/Guardian(if minor)_____ Date_____

Springer Medical Associates
Patient Authorization Form
Advance Directive

Patient Authorization

1. I consent to treatment necessary for the care of the below named patient.
2. I authorize the release of all the medical records to the referring and family physicians and to my insurance company, if applicable.
3. I allow fax transmittal of my medical records, if necessary.
4. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
5. In the event that the charges are not paid-in-full when due and collection action is instituted, whether by collection agency, or attorney, or both; I agree to be responsible for and to pay in addition to the charges for services and treatment receive all cost associated with such collection activity including, but not limited to, reasonable collection agency fees, attorney fees, and court cost.
6. I further authorize and request that insurance payments be made directly to the provider.
7. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information, and insurance authorization policies stated above.
8. I agree with all of the above with the exception of number _____.
9. I acknowledge full financial responsibility for services rendered by Springer Medical Associates.

Patient Signature:_____Date:_____
Witness:_____Date:_____

Advanced Directives

Do you have a living will or durable power of attorney? _____ Yes _____ No
If you do have a durable power of attorney, please identify:_____

Patient Signature:_____Date:_____
Witness:_____Date:_____

Patient Record of Disclosures

In general, the HIPPA privacy rule gives the individuals the right to request a restriction on the use and disclosures of an individual's personal health information (PHI). The individual is also provided the right to request confidential communication about his/her PHI be received by alternative means, such as sending correspondence to the individual's office address or to be contacted by cell phone, etcetera.

O Home Phone O It is ok to leave message with detailed Information O Leave message with call-back number only	O Cellular Phone O It is ok to leave message with detailed Information O Leave message with call-back number only
O Written Communication O It is ok to mail to my home address O It is ok to mail to my work address O It is ok to fax to number	O Other _____ _____

Patient Signature:_____Date:_____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependent, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____

(Name of Insured) (Name of Insurance)

to pay and hereby assign directly to Alicia G. Springer, NP-C, all benefits, if any, otherwise payable to me for her services as described on the attached form. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Alicia G. Springer, NP-C, or Springer Medical Associates will be credited to my account.

_____ _____

Authorized Signature of Subscriber Date

Medicare Authorization

IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on behalf to Alicia G. Springer, NP-C/Springer Medical Associates for any services furnished to me by SMA. I authorize any holder of medical information about me to be released to the Center for Medicare and Medical Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand that my signature requests the payment be made and authorized released of medical information necessary to pay my claims. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the user or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date

Consent for Treatment

I (or my parent/legal guarding), authorize Springer Medical Associates to provide medical care reasonable by today's standards.

_____ _____

Signature Date

Springer Medical Associates
Financial Policy
Notice to our patients regarding our guidelines

The following is to inform patients of Springer Medical Associates guidelines.

Your time and health is valuable to us and when a patient does not show up for their appointment, they take the time that could be used to help the health of another fellow patient. If you are unable to make your appointment, please call the office at least 24 hours in advance to cancel or reschedule your appointment. **If you do not call and do not show up for your appointment, you will be charged a $25 fee.**

Your health is extremely important to us, but if patients do not pay for their services they receive from Springer Medical Associates, we will be unable to keep the clinic opened to serve your health needs. Therefore, if you do not have health insurance, payment of the office visit fee is expected in full before you are seen. Any remainder balance for services deemed necessary by your healthcare provider will be expected to be paid in full before you leave the clinic.

If you do have health insurance, payment of your co-pay is expected in full before you are seen. Springer Medical Associates will not be responsible for any labs or any other institutions bill that your health insurance does or do no cover. We file your insurance as a courtesy to you it does not mean the services will be covered. You as the patient will be responsible to call your insurance company and to find out the reason why your insurance didn't' cover the services indicated by your healthcare provider. If by any reason your health insurance denied to cover services provided by Springer Medical Associates, you will be responsible for payment of your balance, including but not limited to any and all collection cost, attorney fees, and/or court cost incurred it he process of debt collection.

We are honored that you have chosen Springer Medical Associates for your healthcare needs. We are committed to make your time with us as pleasant as possible and to give you the ultimate in care. If for any reason, there is something that you feel we can do better to serve you, please do not hesitate to let us know. Thank you for choosing us for your healthcare needs.

By signing below, you agree that you have read and understand the guideline for Springer Medical Associates as stated above.

Patient (Responsible party) Name Printed:_____

Patient (Responsible party) Name Signature:_____

Springer Medical Associates
Authorization to Release Medical Records and/or Information

Physician/Clinic records are being requested from _____

Please FAX or MAIL this request _____

Requesting Clinic: Springer Medical Associates
16615 Highway 104 North Suite B
Lexington, TN 38351
Phone: (731) 968-0660 Fax: (731) 968-0007

Release these Records: **Patient Initials**

1. Only medical records by this facility (not including records received from other sources _____
2. Only some portion of records maintained at facility (date of treatment, etc. specified) _____
3. All medical records at the facility _____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED, OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the **EXCEPTION** of the following:

Patient Initials

_____ Substance Abuse, if any

_____ Psychological or psychiatric conditions, if any

_____ HIV/AIDS, if any

_____ Other, Please specify: _____

Expiration or revocation of the authorization: I understand that I may revoke tis authorization at any time and that unless an earlier date is specified; it will automatically expire 12 months after the date below. Use of copies: a copy of this authorization may be utilized with the same effectiveness as the original.

Patient name: _____

Printed name of person authorized to sign for patient: _____

Patient signature: _____

Signed name of person authorized to sign for patient: _____

Date (for patient): _____ Date: (for authorized signee):_____

Witness/Date: _____