Fairbanks Ultrasound, LLC

Patient Information:

Name: _____ DOB: ____/____/_____ Sex: Male Female

Social Security #: _____ Marital Status: Married Single Widowed Divorced

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Home #: _____ Work #: _____ Cell #: _____

Employer Name: _____ Email: _____

Emergency Contact Name: _____ Contact #: _____

If patient is a Minor, Responsible Party:

Primary Insurance:

Insurance Name: _____

_____

Insurance Address: _____

_____

ID#: _____

Group#: _____

Policy Holder: _____

Relationship to Policy Holder (circle one):

Self Spouse Child

Policy Holders Date of Birth: _____

Policy Holders SS#: _____

Secondary Insurance:

Insurance Name: _____

_____

Insurance Address: _____

_____

ID#: _____

Group#: _____

Policy Holder: _____

Relationship to Policy Holder (circle one):

Self Spouse Child

Policy Holders Date of Birth: _____

Policy Holders SS#: _____

By signing below, you agree to the use and disclosure of our protected health information by Fairbanks Ultrasound, LLC, Jeffrey Zuckerman, M.D., our staff and other business associates for treatment, payment and healthcare operations. Your healthcare information will not be release to any other party without consent from you prior. For a more detailed description of uses and disclosures for these purposes, please review our NOTICE OF PRIVACY PRACTICES. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice simply by contacting our office. I hereby authorize Fairbanks Ultrasound, LLC to provide me with diagnostic imaging services as requested by my health care provider. I have read, understood, and agree that I am ultimately responsible for all professional and/or technical fees. I hereby assign payment for all medical benefits including major medical benefits to which I am entitled from private insurance and any other health plans to Fairbanks Ultrasound, LLC. This assignment will remain in effect until revoked by me in writing. I authorize assignee to release all information necessary to secure payment for services.

Patient Signature (or guardian if minor): _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Medical Record No._____

Address: _____

Facility Name: FAIRBANKS ULTRASOUND, LLC

I have been given a copy of Fairbanks Ultrasound, LLC *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that Fairbanks Ultrasound, LLC has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official, or by visiting the Fairbanks Ultrasound, LLC web site at www.fairbanksultrasound.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name

_____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by:

_____ _____

Signature of Facility Representative Date

_____

Print Name

FILE ORIGINAL IN RESIDENT'S BUSINESS OFFICE RECORD

Payment Policy — Fairbanks Ultrasound, LLC

We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. 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. By executing this Payment Policy you are agreeing to pay for all services that you receive.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at time of service. If you are insured by a plan we do business with but don't have an up-to -date insurance card, payment in full is required at time of service and for all future services until we can verify your coverage. Although we may estimate what your insurance will cover, your insurance company makes the final decision on your eligibility and you will be responsible to pay for any portion of charges not covered by your insurance. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

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. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-pay or deductible at the time of service.

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 must pay for these services in full at the time of service.

4. **Proof of insurance.** All patients must complete our patient information form before seeing our medical professionals. We must obtain a copy of your driver's license or photo ID and current valid insurance card 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 submission.** As a courtesy to our patients we will submit your claims and assist you in any way we reasonably can to help get your claim 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. You insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

7. **Statements.** If you have a balance on your account you will receive a monthly statement. All balances are due in full upon receipt of the statement. Payments not received within 30 days of the statement date are considered past due and all outstanding balances will be assessed interest at the rate of 4%.

8. **Returned Check/Non-Sufficient Funds (NSF) Fee.** Checks are not accepted as payment at the Fairbanks Ultrasound office. However, there will be a fee of $20 per check for any check returned by the bank to our third-party billing company. If a returned check is received on your account you will also be responsible for any and all fees associated with that check.

9. **Nonpayment.** If your account is over 90 days past due, you will receive a final statement that you have 10 days to make acceptable payment arrangements of your account balance. Please be aware that if a balance remains unpaid, we will take steps necessary to collect this debt, which may include referring your account to a collection agency or filing a lawsuit. By signing below you agree to pay all actual costs and expenses, including attorneys fees, incurred in collecting the debt.

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** _____