Mahon Family Medicine

Office Policy

To Our Patients and Patient Guest:

Mahon Family Medicine is pleased to accept patients who have requested our services. We would like our patients to know that we respect their need for a safe, friendly and caring environment in which to receive care. Our providers and office staff will take the steps, when necessary, to ensure that all visitors to our practice are prevented from experiencing any abusive or offensive behavior while visiting our office. We expect everyone at our practice (our providers, staff, patients, and any other visitors) to behave in a civil, courteous and respectful manner.

We do reserve the right to discontinue services to patients who are not compatible with our providers or members of our staff. Our office considers the following behaviors to be incompatible with our practice:

- Unwilling to follow medical recommendations or treatment plans
- Unwilling to schedule recommended follow up visits or tests as prescribed by our providers
- Repeatedly missing scheduled appointments, without proper notice of cancellation
- Vulgar or abusive speech toward our providers, staff or other guest at our office
- Abuse of our facility, equipment or supplies
- Threatening behavior of any kind toward our providers, staff or other guest at our office
- Wandering the clinical areas unescorted or otherwise violating patients' privacy rights as outlined under HIPPA
- Disrespect for the needs of other patients visiting our office

Our office does require the following notice for cancellation of appointments:

Wellness appointments (physicals, pap, well child)- If we are not notified at least 2 business days prior to your appointment that you are not coming in, a **$50 charge** will be added to your account balance and no future appointments will be scheduled until that balance is paid in full.

All other appointment types- If we are not notified at least 1 business day (24 hours) prior to your appointment that you are not coming in, a **$25 charge** will be added to your account balance and no future appointments will be scheduled until that balance is paid in full.

While the great majority of our patients and guests do not fall into any of these categories, we are required to advise all our patients of our office policies. Our provider feels that to provide our patients with the best medical care, it takes active participation from both the provider as well as the patient. Once again, we would like to thank you for choosing us as your primary care provider.

Sincerely,

I have read and understand this Office Policy: Date: _____

_____ _____

Printed Name Patient Signature

Mahon Family Medicine

info@mahonfamilymedicine.com

Name:_____ Age: _____ Birth Date: _____
Last First MI

Preferred Name: _____ Occupation:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Email:_____ Work Phone: _____

Local pharmacy:_____ Mail order pharmacy:_____

Marital Status (circle one): Single Married Divorced Widowed -- Who referred you here:_____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name:_____ Relationship:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone: _____ Work phone: _____

INSURANCE INFORMATION

Primary Insurance Co. Name:_____ID#_____

Group # _____

Address:_____City:_____State:_____Zip:_____

Policy Holder's Name:_____ Social Security Number: _____

Date of birth: _____ Relation to Patient (circle one): Self Spouse Parent Other

Secondary Insurance Co. Name:_____ ID #_____ Group_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder's Name: _____ Social Security Number: _____

Date of Birth: _____ Relation to patient: (circle one) Self Spouse Parent Other

I authorize the release of any medical information necessary to process insurance claims. My signature also authorizes payment of medical benefits to the named provider for professional services rendered. I understand that I am financially responsible for all services rendered, that there is a $50 returned check fee and that 30% will be added to my balance if any account must be referred to an agency for collection.

_____ _____
(Patient's Signature or parent if minor) (Date)

OFFICE POLICY ON MANAGED CARE INSURERS

In order to accommodate the needs and requests of our patients, we are enrolled in numerous managed care insurance programs.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to know all the individual requirements of the plans. Each one has different stipulations regarding how often services may be performed.

Even with the same insurance company, the plans may differ depending upon what type of contract your employer has negotiated. Therefore, you will need to provide your insurance card at each visit with either listed as the PCP or No PCP listed on the card. If another PCP is listed on your insurance card, you will need to contact your insurance provider to change the PCP and may be financially responsible for that visit if insurance refuses payment for incorrect PCP listed.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work, EKG, etc., that are not covered at the selected facility, we will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Also, any services not covered by your insurance or any claims that are denied by your insurance will be your responsibility. Copayments are due at time of service. Upon receiving an explanation of benefits from your insurance company for your date of service, we will forward any remaining patient balance to you.

If services are provided and your coverage is not in effect on that day, the fees submitted and denied by your carrier will become your responsibility. Furthermore, if current insurance card is not available at time of visit and we submit to insurance and that claim is denied then the fees associated with that visit will become patient responsibility. The patient can then work with insurance to get that claim paid.

With your cooperation and help, you should be able to receive all of the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

I have read and understand the office policy stated above and agree to accept responsibility as described.

_____ _____

Patient Signature and/or Insured Date

_____

Printed Name

Mahon Family Medicine

1786 Oak Road
Suite B
Snellville, GA 30078
(770-925-2526)

PATIENT'S CONFIDENTIALITY INSTRUCTIONS

Patient Name _____ Birth Date: _____

It is important for us to honor the confidentiality between patient and physician.
PLEASE CHECK YOUR PREFERENCE BELOW.

_____ You may discuss my medical information ONLY with me.

_____ I give my permission to discuss my medical information with the following people.

_____Relationship_____

_____Relationship_____

_____Relationship_____

Yes or No (circle ONE) **You may leave medical information (test results) on my voice mail at:**

Cell # _____

Home #_____

Email_____

Signed_____ Date_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully

Effective Date: February 21, 2017

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new or revised Notice in our office
- If requested, making copies of the new Notice available in our office or by mail.

Uses and Disclosures of Protected Health Information

We May use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time to time with another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with, but is not limited to, the following: billing companies, Insurance companies, Health plans, Government agencies in order to assist with qualification of benefits and/or Collection agencies.

Example: You are seen at our practice for a procedure. We will need to provide a listing of services, such as x-rays, to your insurance company so that we can get paid for the procedure.

We may use or disclose, as needed, your PHI in order to support the business activities of this practice which are called health care operations.

Examples: Training students, other health care providers, or auxiliary staff such as billing personnel to help them learn or improve their skills.

Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.

Mahon Family Medicine

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip:_____

I have received a copy of the Notice Of Privacy Practices for the above named practice.

_____ _____

Signature Date

_____

FOR OFFICE USE ONLY

_____

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- An Emergency existed and a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

  _____

- Other: _____

  _____

  Prepared by: _____

  Signature: _____

  Date: _____