

**PATIENT / ACCOUNT INFORMATION
THE TOLEDO CLINIC**

DATE	CHART NUMBER
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DOCTOR	PRIMARY CARE PHYSICIAN & CITY
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A. PATIENT INFORMATION

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER
MAIDEN NAME	ADDRESS	CITY	STATE	ZIP CODE		
HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS	MARITAL STATUS	SPOUSES NAME		
EMERGENCY CONTACT	RELATIONSHIP	PHONE	EXT	CELLULAR PHONE		
ADDITIONAL CONTACT	RELATIONSHIP	PHONE	EXT	CELLULAR PHONE		
PREFERRED METHOD OF CONTACT <input type="checkbox"/> CELLPHONE <input type="checkbox"/> HOME PHONE <input type="checkbox"/> E-MAIL <input type="checkbox"/> TEXT	RACE <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> HAWAIIAN OR PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINED	ETHNICITY <input type="checkbox"/> HISPANIC OR LATINO <input type="checkbox"/> NOT HISPANIC OR LATINO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINED	LANGUAGE <input type="checkbox"/> ARABIC <input type="checkbox"/> CHINESE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH <input type="checkbox"/> JAPANESE <input type="checkbox"/> SPANISH <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINED			

B. PERSON RESPONSIBLE FOR PAYMENT - IF PATIENT IS A CHILD, THE PERSON WHO HAS CUSTODY

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER
ADDRESS	CITY	STATE	ZIP CODE		
HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS			

C. INSURANCE INFORMATION

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER			
ADDRESS	CITY	STATE	ZIP CODE		
NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT		
INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT			

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER			
ADDRESS	CITY	STATE	ZIP CODE		
NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT		
INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT			

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT.

SIGNATURE _____

DATE _____



The Toledo Clinic, Inc.
4235 Secor Road
Toledo, Ohio 43623

Financial Policy

We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; however, payment in full is expected at the time of service.
- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility, and payment in full is due at the time of visit.
- Payment for professional services can be made with cash, check, or credit card.
- Patients who do not have insurance are expected to pay for professional services at the time of service.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring his/her insurance card to each visit. If claims are rejected by insurance company due to untimely filing limits, and the delay is a result of the patient not providing insurance information timely, the patient will be responsible for all charges.
- Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. The telephone number is printed on the insurance card.
- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash, or check at the time of service has been verified. Statements indicating any patient responsible balance will be mailed monthly. Payment in full is due within 30 days .
- Patient balances over 30 days will be subject to a late payment charge equal to 1.25% (15% annual percentage rate) of the balance as of the end of each month.
- Patients will be asked to pay all patient responsible balances in full when they are seen in the office at their next visit.
- Patients with outstanding balances may not be seen by the physician absent medical necessity and are subject to discharge from the practice.
- In the unanticipated event you are unable to pay your bill when due, please contact us as informal arrangements may be worked out.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the Business Services department at 419-479-5398. We are happy to help you.

I hereby authorize The Toledo Clinic to submit to my insurance plan all covered services rendered by the physician(s) and to furnish complete information (including Medical Records, if necessary) to my plan regarding services rendered. I understand that in signing this form, The Clinic will not release to anyone, including those processing my Clinic claim, any information that the law specifically protects and for which a special consent is required. For those records to be released, I will need to sign a separate consent. I authorize and direct my insurance carrier to issue payment check(s) directly to the physician(s) rendering covered services unless otherwise notified.

AUTHORIZED SIGNATURE

I have read this form or had it read to me. I understand it.

Signature of Patient/Authorized Representative

Relationship (if other than patient)

Patient Name _____

Date _____

Chart # _____

ACKNOWLEDGMENT OF RECEIPT OF TOLEDO CLINIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Toledo Clinic's Notice of Privacy Practices effective April 14, 2003

Staff Use Only
PATIENT CHART NUMBER _____

Signature of Patient

Printed Name of Patient

Date of Birth

Signature of Parent/Guardian of Minor

Date

Staff use only
<u>Good Faith Effort to Obtain Acknowledgment</u>
The above named patient refused to sign the acknowledgment after being requested to do so.
_____ Staff Member Signature
Date: _____

PERSONS THAT ARE ALLOWED TO GIVE/RECEIVE MY PRIVATE HEALTH INFORMATION

METHOD OF ALLOWED RELEASE: _____ VERBAL _____ WRITTEN

Name	Relationship	Phone#
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Name	Relationship	Phone#
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Name	Relationship	Phone#
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