PATIENT NAME ______________________________ ***DOB*** ________________

please print

CONSENT TO MEDICATION HISTORY

All prescription medications are registered by your pharmacy in a secure and confidential electronic database. With your consent, MVFP can access this database and improve your medical care by:

- Coordinating care between physicians (specialists, ER, urgent care, etc.)
- Verifying that you are not receiving dupicate medications
- Reducing the risk of interactions between medications

By signing below, you give consent to Mountain View Family Physicians to access your complete medication history.

PATIENT SIGNATURE ______________________________ ***DATE*** ________________
Or Guardian

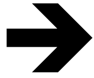
RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been provided with Mountain View Family Physicians' ("MVFP") Notice of Privacy Practices ("Notice"):

- It tells me how MVFP will use my health information for the purpose of my treatment, payment for my treatment, and MVFP's health care operations
- The Notice explains in more detail how MVFP may use and share my health information for reasons other than treatment, payment, and health care operations
- MVFP will also use and share my health information as required/permitted by law

PATIENT SIGNATURE ______________________________ ***DATE*** ________________
Or Guardian

DESCRIPTION OF GUARDIAN'S AUTHORITY: ______________________________

 Name ________________________

Mountain View Family Physicians Financial Policy

Thank you for choosing Mountain View Family Physicians for your health care. We strive to provide the best services and quality care for you and your family. This guide will serve to assist in getting your services paid. Please be knowledgeable about your insurance coverage. Your insurance plan is a contract between you, your employer and the insurance company. Our relationship is with you, our patient, not with your insurance company.

Please bring the following to each office visit:

- A current insurance card
- Your co-payment. If you have a large deductible that has not been met, we will require $75.00 to be paid at the time of service in addition to your copayment.
- Any past due balance will also be collected at check-in.

We are contracted with the majority of large payers. As a convenience to you, we will file claims with those plans. Eligibility is based on the information on your insurance card and is confirmed at each visit.

Updated Information

Your current information is critical for billing and for our office to contact you with test results. Our preferred method of communication is through our secure Patient Portal. This feature allows you to receive your test results, request an appointment and send messages to your doctor. Please keep our office current on any changes in email address, physical address, cell and home phone numbers and any insurance coverage updates. You will be asked to review your information and acknowledge that you have given us the current information by signing a form before each appointment.

Co-Payments, Patient Responsibility Balances

Your co-pay is always due at the time of service and will be collected prior to seeing the physician. Failure to pay co-payments at the time of service is a violation of your insurance contract. Any past balances are due at each visit. If you have a high deductible that has not been met, you will be expected to pay an additional $75.00 at the time of service.

Copy of Records

Fees for record requests can be discussed with the Medical Records staff and are on file at the office.

Missed Appointment

We provide a system to remind you of your appointment 48 hours in advance. For your convenience, we also provide a 24 hour cancellation message line if you call after hours. That number is (602) 224-9218 x 106. We require you notify us 24 hours in advance of your appointment so that other patients can be scheduled. Failure to cancel may result in a "No Show" fee, which is not covered by your insurance plan and is therefore patient responsibility. We reserve the right to discharge a patient after the third documented "No Show." Appointments cancelled less than 25 hours in advance may also result in a "Late Cancel" charge.

Non-Covered Services

Please be aware that some, and perhaps all, of the service and tests recommended by your physician may not be covered by your insurance company. Your physician will make recommendations for your health with your best interests in mind. Please familiarize yourself with your insurance coverage and benefits. Ultimately, you are responsible for any charges your insurance company decides not to pay.

Collection Agency Policy

Failure to pay balances can result in the account going to an outside collection agency. Patients are also discharged for the practice at this time. Please contact our billing department and one of our representatives will work with you, should you need to establish a payment plan. Any fees incurred from the collection agency will be assessed to your account.

Billing Department

You can reach our billing department by calling out main number at (602) 224-9218 and pressing 5. When you receive your monthly statement, please review for accuracy. If there is a portion due from the patient, please remit payment or contact our billing department to discuss arrangements.

Fee Schedules

Our prices are dictated by the insurance contracts and are competitive for our area. It is a violation of our contractual agreement to discount or waive any fees.

Forms

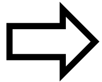
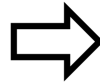
Please allow 5-7 business days for the completion of any forms, prior authorizations, or letters. Please be aware that any form brought by to be completed may require an office visit. There is a standard fee for any form completion, including FMLA. This amount is dependent on the number of pages and the

complexity of the form. This amount is due at the time the forms are submitted to our office. We do not charge for prior authorizations.

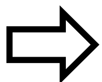
Acceptable Forms of Payment

For your convenience, we accept cash, checks (with an Arizona ID), Visa, MasterCard and American Express.

If you have any questions or concerns about the information contained in this packet, please feel free to contact our Practice Administrator.

 ______________________________  _________________

Patient Signature Date

 ______________________________

Patient Name (printed)

HIPAA CONSENT

PATIENT NAME ______________________ ***DOB*** ______________

Please Print

CHECK ✓ ONE:

OR

☐ I authorize MVFP to disclose my medical information to the following people:

☐ I do NOT authorize MVFP to disclose my medical information to anyone, other than to comply with the privacy practices.

name	
relationship to patient	
phone #	

name	
relationship to patient	
phone #	

This consent is valid for one year from the date of this consent form.

PATIENT SIGNATURE ______________________ ***DATE*** ______________
Or Guardian

PATIENT NAME ______________________
Or Guardian

Please Print