OSTEOPATHIC HEALTHCARE OF MAINE

Patient Name_____________________________ Legal Guardian(s) _____________________________

DOB_____________ Phone (Home)________________________ (Cell)________________________

Mailing address____________________________Town__________________State_____ Zip_________

Email ______________________________________Occupation_________________________________

Primary Care Provider___________________________Who referred you_____________________________

Emergency Contact__________________________ Relationship_______________ Phone _______________

Please circle :

1. Do you have MaineCare? (YES / NO)
2. Are you dually eligible for Medicare and Medicaid/MaineCare? (YES / NO)

Please check one:

☐ I do not want any information about my healthcare communicated to family members/caregivers.

☐ I give permission to communicate to: (Please list names) ____

*Information that may be communicated: ☐ Prescription Request, ☐ Appointments, ☐ Billing, ☐ Mental health, ☐ Substance Abuse, ☐ HIV/AIDS, ☐ Other (specify):

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (**HIPAA**), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
-Conduct, plan, and direct my treatment.
-Follow-up among the multiple healthcare providers who may be involved in treatment directly & indirectly.
-Obtain payment from third-party payers.
-Conduct normal healthcare operations such as quality assessments and physician certifications.
I acknowledge that I have received Osteopathic Healthcare of Maine's Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that Osteopathic Healthcare of Maine has the right to change its Notice of Privacy Practices and that I may contact Osteopathic Healthcare of Maine at any time to obtain a current copy of the Notice of Privacy Practices. I may request in writing that Osteopathic Healthcare of Maine restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Osteopathic Healthcare of Maine is not required to agree to my requested restrictions, but if an agreement is reached, they are bound by such restrictions.

I have the right to revoke this authorization in writing at any time. Revocation will not cover information or material released before that date but will prevent further release of information.

Patient/Legal Guardian Signature ____Date: ______________________

Osteopathic Healthcare of Maine

The following information explains our office policies. **Please initial after each one.**
Remember to check in and check out at every appointment. Thank you.

Cancellations and Missed Appointments

If you need to reschedule or cancel an appointment, **we require at least two business days** to make the time available to another patient.

- If an appointment is missed or canceled without adequate notice, you will receive a letter explaining our policy.
- If you miss or cancel an appointment twice without adequate notice, you may be charged a $50.00 missed appointment fee.
- The third time an appointment is missed or canceled without adequate notice within 12 months, you may be charged a $150.00 missed appointment fee or discharged from the practice.

New patients who miss or cancel their initial appointment without adequate notice may be charged a $250.00 missed appointment fee at the providers' discretion. New patients who miss or cancel their appointment twice without adequate notification may not be eligible to establish care with OHM.

Initials ________

Prescription Refills

Please allow two business days to fill all prescription requests. If we have any questions, we will call you back. Otherwise, please contact your pharmacy in two business days to check the status of your refill.
Patients may request prescription refills using one of the following methods:

- Contact your pharmacy to fax a request to our office.
- Contact our Clinical Coordinator, *Meg Dehetre, at 207-835-2021 or 207-791-7900, option 3.*
- Speak with your provider at your next appointment. We will need the following information: Name, date of birth, medication name, dosage, frequency, quantity requested, and pharmacy location.

Initials ________

Reporting of Test Results

The length of time it takes for us to receive lab results varies for each lab. Once we receive your results, they will be attached to your next appointment to discuss with your provider. If you are not scheduled, we will contact you to schedule an appointment to discuss your results. **An appointment is needed with your provider to discuss your test results.** Please note that our office staff is not authorized or trained to interpret test results.

Initials ________

Supplement Purchasing

Payment for supplements is due at the time of purchase. **All sales are final. We are unable to accept returns on supplements.**

Initials ________

Minors

Children under 18 years old and not accompanied by a parent or guardian need verbal or written permission to be seen.

Initials ________

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), including Medicare, private health insurance, and any other health/medical plan, to issue payment directly to Osteopathic Healthcare of Maine, PA, for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for services not covered by my insurance. *

Initials _________

Financial Responsibility

You are expected to present your insurance card at each visit. **Copays are due at the time of service.** It is important to remember that health insurance coverage varies. It is your responsibility to understand which services your insurance will cover. You are responsible for the balance when your insurance carrier denies a service or makes a partial payment. Payments can be made through the patient portal, phone, or mail.

Initials _________

HMO Policies

Many insurance policies are changing to Health Maintenance Organizations (HMO), even without your knowledge. If you have an HMO policy, you must obtain a referral from your Primary Care Physician. **The PCP issuing your referral must match whom your insurance policy has listed, and you must have an active referral to schedule an appointment.**

Initials _________

Collection Policy

A balance will be considered past due 30 days from the date of the first statement. If you need help paying your balance in full within 30 days, please call 207-835-2030 to set up a payment plan. If your balance becomes 120 days past due without prior payment arrangements, your account will be transferred to the Thomas Collection Agency, and you will need to contact the Thomas Collection Agency (207-772-4659) for payment options.

Initials _________

Credit Card Processing Authorization

You can keep a credit card on file for future payments. You will be asked to sign a Credit Card Authorization form authorizing OHM to process payments using your card on file. We will not process payments without your verbal consent, **except for a missed appointment fee and prompt pay discounts.**

Initials _________

Prompt-Pay (Self-Pay) Accounts

We are contracted with most major insurance companies. If we are in-network with your health insurance, we are legally mandated to submit claims to that insurance. Prompt-pay (self-pay) accounts shall only exist if a patient has no insurance coverage or if we are not in the network. To qualify for the prompt-pay discounted rate, a credit card must be kept on file as **payment is *required* at the time of service and cannot be billed to the patient for later payment.**

Initials _________

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*Our doctors bill an office visit code covering evaluation and procedure codes for osteopathic treatment for most visits. We highly suggest that you check with your insurer if osteopathic manipulative therapy is covered under your policy. An example of typical coding is available on request.