

# The Family Practice Financial Policy

Thank you for choosing The Family Practice as your health care provider. We are committed to providing you with quality and affordable health care. This financial policy was developed to assist with questions you have or that may arise with regards to financial issues. We believe that stating our expectations with regards to financial issues helps us concentrate on our mission of providing excellent care.

**1. Insurance-** We participate in most insurance plans. If you are not insured by a plan we have a contract with or you are insured but do not have a copy of a current card, payment is due in full at time of service. We will bill your insurance company once we receive a copy of your current card, but payment will be your responsibility at time of service.

**2. Co-payments-** All copays and deductibles must be paid at the time of service. Copays that are not paid at the time of service will be billed a **\$25.00** administrative fee. This fee and your copay will need to be paid prior to future appointments.

**3. Deductibles-** Because more insurance companies are issuing policies with very high deductibles, we will need to collect deductibles that have not been met at time of service. It is your responsibility to call your insurance company prior to being seen to see if you have met your deductible. We have formulated a fee amount that we have tried to make as close as possible to the allowable amount that will be covered by your insurance company. Anything over paid or under paid will either be credited or billed to you accordingly. If you do not call your insurance company prior to being seen we will assume that you have not met your deductible and payment of the allowable amount is due at time of service.

**4. Non-covered services-** It is virtually impossible for us to have knowledge of what services each insurance plan covers. **Knowing your insurance benefits is your responsibility.** Any questions you may have regarding those benefits or dispute of any services not covered should be directed to your insurance company.

**5. No show appointments-** For any second no show appointment there will be a **\$25.00** fee. This amount will need to be paid prior to any future appointments. A no show appointment is defined as any appointment not cancelled 24 hours in advance.

**6. Statements/Bills-** After 90 days past due, you will receive a pre-collection letter stating you have 10 days to pay your balance. If we do not receive payment, you will then receive a collection letter stating you have 10 days to pay your balance or be turned over to a collection agency. **Once an account is turned over to collections, we will no longer see or treat anyone in the family, even after the balance is paid.** The Family Practice is not responsible for any disputes regarding your balance due. Any questions or problems need to be addressed directly to your insurance company.

**7. Non Sufficient Fund Check-** Any check that is returned to us will be assessed a **\$25.00** return check fee. The amount of the NSF check and the \$25.00 fee will need to be paid by cash or credit card within 10 days or it will be turned over to a collection agency at which time we will no longer be able to see or treat anyone in the family.

**8. Assignment of Benefits-** I, the undersigned, realize that all medical and surgical charges incurred are my responsibility and payable by me regardless of what my insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly to The Family Practice and Dr. Robert P. Vogt any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles and co-payments.

**I have read and understand the financial policy and agree to abide by it.**

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

*The Family Practice*

*Dr. Robert Vogt  
Dr. David Rogers  
Darragh Gott, FNP  
Keri Munyan, FNP  
Paul Safford, PA  
Erika Nichols, PA  
Dr. Christopher Phillips*

*Phone Message Consent Form*

**Notice of Privacy Practices – Patient Acknowledgement**

We, at the Family Practice, are committed to safeguarding the privacy and confidentiality of your medical records including the personal information that you with us. We comply with the Health Insurance Portability and accountability Act of 1996 (HIPAA).

From time to time it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

**Patient Name:** \_\_\_\_\_

**I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CIRCLE ALL THAT APPLY)**

**HOME PHONE:** \_\_\_\_\_

LEAVE A DETAILED VOICE MAIL MESSAGE?	YES	NO
LEAVE A MESSAGE WITH CALL BACK NUMBER?	YES	NO

**CELL PHONE:** \_\_\_\_\_

LEAVE A DETAILED VOICE MAIL MESSAGE?	YES	NO
LEAVE A MESSAGE WITH CALL BACK NUMBER?	YES	NO

**OTHER REQUESTS:** \_\_\_\_\_

**May we speak to someone else regarding your medical care? YES NO**

**Name of Person:**

**Relationship:**

_____	_____
_____	_____

**I understand that I may revoke this consent at any time.**

**Signature:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Acknowledgement of Receipt of Notice

Dr. Robert Vogt, The Family Practice, 6005 Delmonico Dr., Ste. 150

Dr. Robert Vogt, 719-266-5244

I hereby acknowledge that a copy of this medical practice's Notice of Privacy Practices with effective date of September 30, 2013 was posted and available to read in the reception area and I also acknowledge that it is available for me to read on this practice's website [www.thefamilypractice.org](http://www.thefamilypractice.org)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate your relationship to the patient:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_

---

### ***For Office Use Only:***

Signed form received by: \_\_\_\_\_

Acknowledgment refused:

Efforts to obtain:

\_\_\_\_\_  
\_\_\_\_\_

Reasons for refusal:

\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## Patient Health Questionnaire – PHQ-9

(Patient to answer questions)

<b>1. Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?</b>	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
a. Little interest or pleasure in doing things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2. If you checked off any problem on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
S	S	S	S
0	1	2	3

### To be filled out by Provider

Total # Symptoms: \_\_\_\_\_ Total Score: \_\_\_\_\_

Date of Visit: \_\_\_\_\_ Provider Signature: \_\_\_\_\_