



## FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider.

1. Each patient is responsible for their own bill.
2. Payment of all insurance co-payments and deductibles are required at the time medical services are rendered.
3. Patients who have no insurance are required to pay 100% of services rendered each visit. If this is impossible, you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks and Visa/Matcard.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, you will be responsible to pay.
6. If your insurance company has not paid your full account within 60 days, the outstanding balance must be paid by you without further delay.
7. Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1.75% per month (21% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of \$.50 per month. By signing below, you acknowledge receipt of this Financial Policy and Agreement. If collection is made by suit or otherwise, patient and /or responsible party agrees to pay interest until paid, collection costs of 50% of the remaining balance, all attorney fees and court cost.
8. A \$25.00 fee will be charged on all return checks.
9. Patients who fail to appear for their scheduled appointments may be charged a fee of \$25.00 unless the patient cancels the appointment at least 24 hours before the scheduled appointment time.

### USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

### AUTHORIZATION TO PAY BENEFITS

I further and direct said agency, attorney or insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that signing of this form does not prohibit customary monthly billings.

X \_\_\_\_\_ Date \_\_\_\_\_

# JORDAN LANDING CLINIC PATIENT HISTORY

Dr. Brent Pugh

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

What brings you here today?

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Medical Problems you are being treated for now or in the past:

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What surgeries have you had?


What have you been in the hospital for?

When?


What medications do you take?

Name:	Dose:	How Often:	When started:

What medications are you allergic to?

What happened?


Are you allergic to anything else?

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

**What medical problems run in your family?**

	Father	Mother	Siblings	Grandparents
Asthma				
Bleeding Disorder				
Cancer (which type?)				
Diabetes				
Heart Problems				
High Blood Pressure				
Kidney Disease				
Mental Illness				
Migraine Headaches				
Stroke				
Thyroid Disease				
Other				

**Social History**

Marital Status/Kids?	
Occupation?	
Education?	
Tobacco?	
Alcohol?	
Illicit Drugs?	
Exercise Regularly?	

**Have you recently been bothered by any of the following?**

	Yes	No		Yes	No		Yes	No
Fever or chills			Nausea			Skin Rashes		
Night sweats			Vomiting			Itching		
Weight change			Heartburn			Headaches		
Insomnia			Abdominal			Numbness		
Vision Changes			Diarrhea			Weakness		
Cold Symptoms			Constipation			Depression		
Nasal drainage			Black stools			Anxiety		
Chest pain			Blood in stools			Fatigue		
Palpitations			Pain with urination			Excessive thirst		
Swelling of legs			Urine incontinence			Heat/Cold intolerant		
Shortness of breath			Joint swelling			Swollen glands		
Cough			Joint Pain			Easy bruising		

**Females**

Last PAP Smear:	Last menstrual cycle:	Periods regular?
Last mammogram:	Vaginal discharge?	Other gyn problems?

**Males**

Poor urine stream?	Difficulty with erection?	Prostate problem?
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