WELCOME!

Dear Patient:

Welcome to Neighborhood Medical Center! All of us here at Neighborhood Medical Center –Doctors, nurses, front office staff, and administrators—will do our best to take care of your health care needs. But before we begin, we will need some information from you.

Please go through the rest of this packet and complete the forms as thoroughly as you can. If you have any questions, ask our staff.

When you are ready to register, we will need the following documents:

- **Proof of identification.** This can be a driver's license, passport, government-issued id, or another form of photo ID.
- **Proof of Residency**. For example: a current driver's license, utility bill, property tax statement, or a voter's registration card.
- **Proof of Income**. For example: a recent check stub or a letter from your employer. If you have no income, you can bring in a letter stating, from whoever is giving you assistance.

You must bring these items with you to your initial visit in order to continue to receive services.

Please be in the office at least 20 minutes prior to all appointments. Patients arriving more than 15 minutes late will be rescheduled. If you need to cancel or re-schedule your appointment, please call us at 850-224-2469 at least 24 hours in advance.

Let our office staffers know if there are any problems during your visit, and please take the time to fill out our Patient Survey to let us know how we are doing.

Thank you, and welcome to Neighborhood Medical Center!

NEIGHBORHOOD MEDICAL CENTER

ADULT

PATIENT INFORMATION

TRANSLATOR REQUIRED? YES_____ NO_____ PRIMARY LANGUAGE_____

PATIENT'S NAME_____
LAST FIRST MIDDLE INITIAL

SSN: _____ D.O.B _____ AGE _____ SEX _____ RACE_____

PHONE: _____ ALTERNATE: _____ MARTIAL STATUS: _____

HIGHEST GRADE COMPLETED: _____ EDUCATIONAL LEVEL: _____ EMAIL: _____

PATIENT'S ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

ALTERNATE ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

GUARANTOR INFORMATION: (IF DIFFERENT FROM PATIENT)

GUARANTOR'S NAME _____
LAST FIRST MIDDLE INITIAL

GUARANTOR'S D.O.B_____ GUARANTOR'S SSN _____

RELATIONSHIP TO PATIENT _____

EMPLOYMENT: PATIENT OR GUARANTOR (CIRCLE ONE)

EMPLOYER'S NAME _____

ADDRESS_____ PHONE_____

METHOD OF PAYMENT:

- ☐ CASH OR CHECK
- ☐ SLIDING FEE SCALE
- ☐ MEDICARE # _____
- ☐ MEDICAID # _____
- ☐ INSURANCE NAME AND ID # _____
- ☐ VISA/MASTERCARD/OTHER #
- ☐ OTHER

EMERGENCY CONTACT INFORMATION:

NAME_____ NAME:_____

PHONE#:_____ PHONE#:_____

ADDRESS: _____ ADDRESS: _____

RELATIONSHIP:_____ RELATIONSHIP:_____

NEIGHBORHOOD MEDICAL CENTER

Financial and Insurance Policies

PLEASE INITIAL BELOW indicating that you have read, understands, and agrees to all the policies contained on this page.

_____Full payment for all co-pays, deductible and non-covered services are due at the time of your appointment.

_____ I grant permission for myself or minor child to undergo all necessary tests, examinations, treatments, and other procedures required in the course of study, diagnosis, and treatment of illnesses by medical practitioners and other staff members of Neighborhood Medical Center.

_____I hereby authorize direct payment of medical benefits to Neighborhood Medical Center for services rendered by the physicians or the organization; I understand that I am responsible for any balances not covered by insurance claims not paid within a timely manner (60 days) by my insurance company, become fully my responsibility.

_____A returned check penalty fee of $25 will be charged to a patient's account for any check dishonored by the drawee bank. This fee will be waived if the check was returned in error, providing supporting documentation is submitted. The returned check and penalty fee must be paid by cash, credit card or money order. If a returned check was used to pay for more than one patient, each patient will be assessed the $25 returned check fee. Payments made by a returned check are reversed from the patient's account, leaving the balance due and payable immediately.

_____Concerns regarding denial of payment for ordered tests, procedures or visits to third party providers are to be directed to your insurance carrier.

_____ I consent to the release of medical information to the patient's insurer or to authorized institutions or agencies that accept the patients for medical treatment and I furthermore give permission to release data (medical and personal) to such government agencies as required by Neighborhood Medical Center.

_____I certify that the information given by me in the applying for payment under title XVII of the Social Security act is correct. I authorize any holder of medical or other information about myself to release to the social security administration or the intermediaries of carrier's any information needed for this or a related Medicare/Medicaid or other insurance claim. I hereby assign, transfer and set over to the physicians or organization furnishing the services all of my rights, title and interest of my medical reimbursement benefits under my insurance policy with any and all insurance companies, I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

CLIENT PARTICIPATION AGREEMENT

Applicant Name: _____ Social Security Number_____

This is to certify that the applicant listed may receive services from Neighborhood Medical Center from _____ until _____.

Neighborhood Medical Center offers the following services:

Medical

Physical Exams, Screenings, Prescription Medication , Nutritional Counseling, Health Education, Eye Care Screenings, Mental Health Services, Well and Sick Care, Medical follow-ups, Case Management Services, and Health & Hygiene Items.

Dental

Extractions, Cleanings, Fillings, Sealants, and Limited Emergency Services

These services have been explained to me. I certify that all information I have given regarding income and family size is true and correct to the best of my knowledge. I understand that although I or members of my family may be referred for specialty care, hospitalization, or other higher levels of care, there is no obligation for the provider to pay for these services. I understand that I am responsible for my dependents and myself. I will notify Neighborhood Medical Center when I cannot keep an appointment. Should I not utilize the services of Neighborhood Medical Center for a two year period; a letter will be sent advising me of the need to re-determine my eligibility. I understand that if I do not respond within two weeks, my name will be removed from the client list; this does not prevent me from re-enrolling as an active client in the future.

_____ _____

Patient's Signature Date

_____ _____

Witness's Signature Date

Use And Disclosure Of Protected Health Information To Family Members And Others Who May Be Involved In Your Care.

Patient Name: _____ DOB: _____

As a patient of Neighborhood Medical Center, you may wish to authorize the disclosure of information related to your care to family members or other individuals. To protect your privacy while facilitating this communication, we will require you to list the name(s) of those individuals who are authorized to communicate with our caregivers and staff about results, appointments, findings, treatments, referrals and other inquires. In order to verify that the caller has the right to this information, our staff may ask some questions to verify the identity. However, such persons may be contacted if needed based on the professional judgment of our caregivers and staff. If you decline this disclosure, Neighborhood Medical Center will not answer to any inquiries from family members or other individuals.

_____YES, I want my protected health information disclosed to the following family members or other individuals.

_____NO, I do not want my protected health information disclosed to any of my family members or other individuals.

Name	Relationship
1.	
2.	
3.	
4.	

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Witness's Signature Date

NOTICE OF PRIVACY PRACTICES
PATIENT RECEIPT

I agree and acknowledge that I have been provided a copy of Neighborhood Medical Center's Notice of Privacy Practices. I understand that the sole purpose for signing this receipt is to acknowledge that I received the Notice. I understand that I will not be denied treatment in the event that I do not sign this receipt, although Neighborhood Medical Center will note that I was provided the Notice.

_____ _____

Patient or Personal Representative Date

NOTICE FROM BILLING DEPARTMENT

As a patient of Neighborhood Medical Center we always try to provide complete and accurate insurance benefits according to your medical plan. In doing so there are times when we have either over collected or under collected copays, deposits or co-insurance amounts. In either situation as we receive an explanation of benefits from your insurance company, we will bill or refund appropriately. It is also extremely important to notify our staff of any other possible medical coverage including whether it is your own policy or whether you are listed as a child, dependent or spouse on any other insurance plans, as it may affect your medical claims and even possibly result in non-payment. At any time during the course of our regular billing cycle we are informed of other medical coverage that was not given to us at the time of service and we are unable to obtain payment from the insurance company you will be responsible for all applicable charges.

By signing below you are verifying that you have provided this office with any and all health coverage information. If you have any questions please do not hesitate to ask! Thank you for choosing Neighborhood Medical Center, Inc.

Thank You,
Neighborhood Medical Center, Inc. Billing Department

_____ _____

Patient Signature Date

_____ _____

NMC Staff Signature Date