HEALTH PARADIGM, L.L.C

DR. HERBERT F. VANDENBERG

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Patient Name: _____ **Visit Date:**_____

DOB:_____ **SSN (Required):**_____

Address:_____ **Apartment No.** _____ **City:** _____

State:_____ **Zip:**_____ **Phone: Home**_____ **Cell**_____

Work _____

Sex: M_____ **F**_____ **Marital Status: (circle one) M S D W**

Student Status: (circle one) Full time Part time Non-student

EMERGENCY CONTACT:

Name:_____**Relationship:**_____

Phone Number:_____

REFERRING PHYSICIAN:_____

PRIMARY INSURANCE INFORMATION:

Medicaid #: _____

Medicare #: _____

Name of **Private Insurance:**_____

Name of Policy Holder's Name:_____

Policy Holder=s SSN: _____

Policy Holder=s DOB: _____Work:_____

Policy #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION:

Medicaid #: _____

Medicare #: _____

Name of **Private Insurance:** _____

Name of Policy Holder: _____

Policy Holder=s SSN: _____

Policy Holder=s DOB: _____**Work:**_____

Policy #: _____ Group #: _____

I authorize Health Paradigm to release my health information to my insurance company for reimbursement purposes.

Patient Signature:_____**Date:**_____

Medicaid Primary Care Provider _____ Referral # _____

If lab needed, you are responsible to tell them to send copies to Dr. Vandenberg's office.

List all medications you are on _____

OFFICE FINANCIAL POLICY

Basic Policy: Payment for service is due in full upon receipt of service.

Patients with Insurance: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance company is a private one, we do not routinely research why and insurance company has not paid or why it paid less than anticipated for services rendered. If an insurance company has not paid within 60 DAYS of billing, **services fees are due and payable in full from you.**

For Medicare Patients: We will bill Medicare for you. If you have signed a tertiary payer agreement with other insurance (Arcadian, Humana, PPO, Value Options) you need to give us ALL THE INFORMATION before services are rendered. Your

co-payment, coinsurance or deductible is due when service is rendered. If Medicare Company has not paid within 60 DAYS of billing, **services fees are due and payable in full from you.** There are some services that Medicare do not covered, those are payable when service is provided.

Non-covered Services: Any care NOT PAID by your existing insurance will require payment in full at the time services are provided or upon notice of insurance claim denial. **This includes denials for exceeding your 12 visits per year with MEDICAID.**

Worker's Compensation: If your injury is work-related, we will need the CASE Number and Name of PAYER, prior to your visit in order to bill the worker's compensation company.

Medicare Patients: Signature on File. I request payment of authorized Medicare benefits be made either to me or on my behalf to Health Paradigm, LLC. For services furnished to me by Herbert F. Vandenberg, M.D. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 on the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determined of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services.

Patient Name (please print): _____

Patient's Signature: _____

Patient's Medicare No. _____

Assignment of Insurance Benefits: Patients with Insurance please read and sign below.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and my other health plans, to Health Paradigm, L.L.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

I have read, understand, and agreed to the above financial policy for payment for professional fees. The PATIENT is ultimately responsible for all financial payments. Also, with my signature I acknowledge receipt of Privacy Practice and was explained to me. I understand that I have the right to object to any release of Protected Health Information not covered in this paperwork.

Signature of Parent/Guardian or Staff Member: _____ Date: _____