TRUST MEDICAL SERVICES INC.
PATIENT INFORMATION

In order to properly bill your insurance and ensure our office is able to reach you if necessary, please print and fill in all the information requested below. Thank you.

Date ________________

Patient Name ____
Last First Middle

Home Phone ______________________ Cell Phone _______________

Street Address ____

City __________________ State ___________ Zip Code__________

Patient's Social Security Number ____________________

Sex ☐ Male ☐ Female Age _____ Date of Birth __________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow(ed)

Are you employed? ☐ Yes ☐ No ☐ Retire

Full Time ☐ Part Time ☐ Student ☐

If you answered Yes for the above, Please fill in below

Employer Name ____________________ Occupation__________

Address ____

Phone ____________________ Fax ______________

Primary Insurer____________________ Date of Birth __________

(Please fill in only if different from above)

Street Address /City/Zip ____

Social Security Number __________________ Tel: ______________

Emergency Contact Person ____________________ Relationship ______________

Street Address/City/Zip ____

Phone _____________________________ Cell _______________________

Responsible Person _______________________________ Relationship ____________

(Please fill in only if patient is under the age of 18)

Street Address ____

City ______________________ State ______ Zip Code ______________

Social Security Number ____________________

Sex ☐ Male ☐ Female Age _____ Date of Birth ____________

Were you referred by another Physician? ☐ Yes ☐ No If Yes, Please fill in below

Referring Physician _______________________ Phone ____________________

Reason for referring _________________________

Is your visit related to illness or injury? _______ Referrer Source if not referred __________

Do you have Medical Insurance? ☐ Yes ☐ No if yes, please fill in below

Primary Insurance

Name of policy holder _______________________ Relationship ______________

Name of insurance company ____

Claim Address ____

Policy Number _____________________ Group Number ______________________

Secondary Insurance

Name of policy holder _______________________ Relationship ______________

Name of insurance company ____

Claim a-Address ____

Policy Number ____________________ Group Number ________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician but usually not design to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by the insurance company, unless otherwise restricted by law or contractual agreement we might have with the insured.

IN ORDER TO HELP CONTROL THE COST OF BILLING.WE REQUEST payment of ALL CO-PAYMENTS, DEDUCTABLES AND NON- COVERED CHARGES BE MADE PRIO TO SERVICES BEING RENDERED.

I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, other carrier or commercial insurance company, any information needed for the processing of my medical claims. I permit a copy of this authorized to be used in place of the original, and request payment of medical insurance benefits made to TRUST MEDICAL SERVICES INC.

Signature __________________________ Date ______________

Payment Policy

Thank you for choosing Trust Medical Services is committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________________ ______________________

Signature of patient or responsible party Date

SAMPLE PATIENT RIGHTS AND RESPONSIBILITIES POLICY

The provider and office staff acknowledges and adheres to the following Patient Rights and Responsibilities as related to the patient's care:

PATIENT RIGHTS

- ☐ Patients have the right to quality services, appropriate to their care needs which are delivered in a timely manner.
- ☐ Patients have a right to appropriate Medically Necessary medical care.
- ☐ Patients have the right to reasonable access to medical care.
- ☐ Patients have the right to confidentiality in regard to medical and social history, individual medical records and medical information.
- ☐ Patients have the right to be treated with dignity, respect and consideration.
- ☐ Patients have the right to be informed about personal health as it concerns medical conditions, diagnostic tests and treatment plans.
- ☐ Patients have the right to change physicians/providers.
- ☐ Patients have the right to a second opinion.
- ☐ Patients have the right to involvement in decision-making concerning treatment.
- ☐ Patients have the right to refuse participation in research. Human experimentation affecting care or treatment shall be performed only with a patient's informed consent.
- ☐ Patients have the right to auditory and visual privacy during a visit.
- ☐ Patients have the right to approve or refuse the release of information except when the release is required by law.
- ☐ Patients have the right to refuse treatment or therapy. Such persons will be made aware of the consequences of their decision and it will be documented in their medical record.
- ☐ Patients have the right to create Advance Directives, which let providers, and others know the person's wishes concerning medical treatment.
- ☐ Patients have the right to assert complaints and grievances about the providers and the health care provided.
- ☐ Patients have the right to be informed about the role of medical students/supervised practitioners and the right to refuse such care.

PATIENT RESPONSIBILITIES

- ☐ To become informed about their insurance plan including benefits available.
- ☐ To become knowledgeable of the system to access medical care.
- ☐ To keep all scheduled appointments and to notify the provider when unable to keep scheduled appointment.
- ☐ To be on time for all scheduled appointments.
- ☐ To follow all medically appropriate physicians' orders and prescriptions.
- ☐ To treat all personnel with courtesy and respect.
- ☐ To provide complete health status information for accurate diagnosis and appropriate treatment.
- ☐ To always call your PCP before receiving urgent care and, when possible, emergency care.
- ☐ To notify your PCP when you receive emergency care within twenty-four (24) hours, or as soon as possible.

Trust Medical Services INC.

This notice describes how medical /protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully

By law, we are required to provide you with our notice of Privacy Practices (NPP).

This notice describes how your medical information may be used and disclosed by Trust Medical Services. It also tells how you can obtain access to this information.

As a patient, you have the following Rights.

The right to inspect and copy your information
The right to request corrections to your information
The right to request that your information be restricted
The right to request confidential communications
The right to report of disclosures of your information

The right to a copy of this notice

We want to assure you that your medical /protected health information is secure with Trust Medical Services. This notice contains information about how Trust Medical Services will insure that your information remains private.

Acknowledgement of notice of Privacy Rights

I hereby acknowledge that I have received a copy of Trust Medical Services Notice of Privacy Rights. I father understand that the practice will offer updates to this Notice of Privacy Rights should it be amended, modified, or changed in any way.

____

Patient or Representative Name (Print Please)

____

Patient or Representative Signature Date

○ Patient refused to sign

○ Patient unable to sign

Trust Medical Services Privacy Form

599 South Hamilton Road
Columbus, Ohio 43213

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) You have a right to request that communications concerning your personal health Information is made through confidential channels. TMS will not ask you why you are Making your request, and will try to accommodate all reasonable requests.

_______________________________(Print name) hereby requests the use of the following confidential Channels for the communication of information related to my personal health, treatment or payment For treatment. This request supercedes any prior request for confidential channel communications May have made.

Please select all that apply.

☐ **PHONE**

I want you to contact me by telephone at this primary number

☐ DO ☐ DO NOT Leave messages on my answering machine.

I want you to contact me by telephone at this secondary number:

☐ DO ☐ DO NOT Leave messages on my answering machine.

☐ DO ☐ DO NOT Leave messages with any other person.

☐ **MAIL**

I want you to contact me at the following address:

____

☐ **OTHER REQUESTS FOR CONFIDENTIAL COMMUNICATIONS (SPECIFY)**

____

____

Signature: _______________________________

Print Name: _______________________________

If not signed by the Patient or spouse, please indicate relationship:

☐ Parent or guardian of minor child
☐ Guardian or conservator of an incompetent individual
☐ Beneficiary or personal representative of deceased individual
☐ Other (specify)

Name of Patient _______________________________

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Patient History Form

Note: *This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.*

Name: ____________________ Date: __________ Date of Birth: __________ Age: ______

Chief Complaint/History of Present Illness

What is the reason for your visit? (Be specific as possible) ____________________

Past Medical History, Please List ____________________

____

Are you on any medications? Yes or No (If yes, list them all) ____________________

____

Do you have any allergies? Yes or No (If yes, list them all) ____________________

Social History

Do you smoke? Yes or No How much? __________ For how long? __________

Do you use Tobacco other than smoking? Yes or No. If yes please list: __________

Do you drink alcohol? Yes or No How much? __________ For how long? __________

Do you use any street drugs? Yes or No. If yes, please list: __________

Marital Status: Single/Married/Divorce/Separate Number of children: __________

Family History

Has any relative ever had some of the listed diseases? Yes or No

	Who		Who		Who
Inherited disease	______	Heart trouble	______	Mental illness	______
Cancer	______	Stroke	______	High blood pressure	______
Diabetes	______	Kidney trouble	______	Tuberculosis	______
Epilepsy	______	Sickle cell disease	______	Bleeding problems	______

Surgical History

Have you had any surgery? Yes or No (if yes please list): ____________________

Have you been hospitalized before? Yes or No if yes, what were the years and months: __________

____

Preferred pharmacy with street name ____________________