Family First

Eatontown office email: INFO-EATONTOWN@FAMILYFIRST-URGENTCARE.COM
Oakhurst office email: INFO@FAMILYFIRST-URGENTCARE.COM
Toms River office email: INFOTR@FAMILYFIRST-URGENTCARE.COM

Patient Legal Name (first, middle, last):		**Date of Birth:** / /
Patient Preferred Name:	**Social Security #:** - -	
Mailing Address:		**APT#:**
City:	**State:**	**Zip Code:**
For Minors: Please indicate responsible Parent/Guardian		
Email:		
Home Phone #: ( ) -	**Cell Phone #:** ( ) -	**Work Phone #:** ( ) -
Sex: (CIRCLE ANSWER) Male Female Other (Please specify) _____	**Marital Status:** (CIRCLE ANSWER) Single Married Partnered Divorced Widowed	
Pharmacy Name & Address:		
Emergency Contact Name:	**Emergency Contact Phone #:** ( ) -	**Relationship to Patient:**
Primary Physician Name:		
Primary Physician Address:	**Primary Physician Phone #:** ( ) -	

PRIMARY INSURANCE INFORMATION

Insurance Company:	**ID #:**	
Insurance Company Address:	**Policy Holder Date of Birth:** / /	
Policy Holder Name:	**Policy Holder SS #:** - -	**Relationship to Patient:**
Policy Holder Address:		

SECONDARY INSURANCE INFORMATION

Insurance Company:	**ID #:**
Insurance Company Address:	

FINANCIAL POLICY

Patient Name: _____ Patient Date of Birth: ____/____/____

Thank you for choosing us as your healthcare provider. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to your treatment.

Individual's Financial Responsibility:

- I understand that I am financially responsible for any co-pay, co-insurance, deductible, or the cost of any non-covered service. **Please be aware that some services provided may not be covered and/or considered reasonable and necessary under the Medicare program and/or other medical insurances.* _____ ***(initials)***
- Should you have any outstanding balance you will receive a statement via text, email, or mail from Collectly. All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. _____ ***(initials)***
- I understand that payment in FULL is due at the time services are rendered. I understand that if my insurance requires a referral, I must obtain it prior to my visit. _____ ***(initials)***
- I authorize the insurance company to forward payment directly to the physicians. Should payment be sent directly to me, I understand it is my responsibility to forward payment directly to MVP Medical Associates, d.b.a. Family First Urgent Care _____ ***(initials)***
- I authorize the release of any information necessary to process the health claims for my care. _____ ***(initials)***

Financially Responsible Party Information (Complete Only if Patient is Not the Responsible Party):

Last Name:		Date of Birth: / /
First Name:		Relation to Patient:
Mailing Address:		APT#:
City:	State:	Zip Code:
Home #:	Cell #:	Email:

COMPLETION OF FORMS: $25.00 to complete physical/pre-employment/sports physicals/insurance request forms/work notes if not provided at time of service. *Please allow **48 hours** for completion.*

COLLECTIONS: Any fees or surcharges imposed by a collection agency will be your responsibility, along with the full outstanding balance from your visit.

MEDICAL RECORDS: Request for medical records must be made in writing. Please allow ***72 hours*** for completion.

_____ _____/_____/_____

Patient/Responsible Party Signature **Date**

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Thank you for choosing us as your healthcare provider. Family First Urgent Care is committed to maintaining integrity of your protected health information and complies with all applicable state and federal regulations. I understand that in accordance with the Health Insurance Portability and Accountability Act (also known by its acronym, "HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly as needed, obtain payment from third-party payers, as well as conduct normal healthcare operations such as quality assessments. By signing the form below, I certify that I have read the Notice of Privacy Practices which is available on our website www.familyfirst-urgentcare.com and posted at the practice office. A copy is available upon request.

PLEASE CHECK ALL THAT APPLY

I authorize my physician/clinical staff to disclose my protected health information to:

- ☐ Myself only
- ☐ My spouse or significant other (specify full names) _____
- ☐ My parent(s) (specify full names) _____
- ☐ Others (please specify relationship & full name) _____

I would like to be contacted in the following manner:

Home Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Cellular Telephone

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Written Communication

- ☐ OK to email through our patient portal
- ☐ OK to mail to my home address

I grant Family First Urgent Care permission to obtain information from external sources (Pharmacy) regarding medications that have been prescribed to me. *If you **DO NOT** consent for external prescription history check box* ☐

PLEASE PRINT AND SIGN BELOW.
FOR ANY PATIENTS THAT ARE MINORS OR HAVE A LEGAL GUARDIAN - PLEASE SIGN AT RESPONSIBLE PARTY

_____	_____	____/____/____
Patient Name Printed	**Patient Signature**	**Date**

_____	_____	_____	____/____/____
Responsible Party Name Printed	**Responsible Party Signature**	**Relationship to Patient**	**Date**

PERSONAL MEDICAL HISTORY

Patient Name: _____ Patient Date of Birth: ____/____/____

Please to the best of your ability fill out the sections below. If not applicable to you, write "N/A" or "none".

CURRENT MEDICATIONS (prescription and over the counter)	**DOSAGE**	**FREQUENCY**

PAST MEDICAL HISTORY (Please ***CIRCLE*** all that apply to you)			
Alcohol/Drug Abuse	COPD/Emphysema	Heart Murmur	Liver Disease
Allergies	Coronary Artery Disease	Hepatitis	Pacemaker
Anemia	Congestive Heart Failure	High Blood Pressure	Psychiatric Problems
Atrial Fibrillation	Depression	High Cholesterol	Seizure
Asthma	Diabetes	Hypo/hyperthyroidism	Stroke
Cancer	Heart Attack	Kidney Disease	Vascular Disease

ALLERGIES	**REACTION** (hives, anaphylaxis, etc.)
PAST SURGERIES/HOSPITALIZATIONS	**DATE**

Please list any ***additional medical diagnoses*** that you have that are not mentioned above:

_____

Please list any ***significant family medical history*** (Ex. heart disease, cancer, diabetes, etc.):

_____

Smoking History (Please circle): Nonsmoker/Former/Current (including vaping or marijuana use)

Did you receive a COVID-19 Vaccine? (Please circle) Yes or No

If ***yes***, please list

Date of last dose received: _____

Vaccine type: _____

Did you receive a Flu Vaccine? (Please circle) Yes or No

If ***yes***, please list the date received: _____

Credit Card on File Agreement

Family First Urgent Care & Family First Primary Physicians has a convenient method of payment for past due balances with your card or debit card on file. The credit/debit card authorization allows the charge to be applied to the card for any balances not paid by your insurance for that visit only.

I authorize *First Urgent Care & Family First Primary Physicians* to charge my credit/debit card up to $200 for any outstanding patient responsibility balance that remains after insurance reimbursements have been applied for authorized medical services received at *First Urgent Care and/or Family First Primary Physicians.*

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give *First Urgent Care & Family First Primary Physicians* a new, valid credit card which I will allow them to charge over the telephone. Even though *First Urgent Care & Family First Primary Physicians* is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented. I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. The authorization will remain in effect until you cancel this authorization. To cancel you must give 60-day notice to *First Urgent Care & Family First Primary Physicians* in writing and the account must be in good standing

You will receive an email with the notice for any charge or refund if you have provided us your email address. If the visit has a $0 balance, then there will be no further charge or refund.

If you have any questions about our policy, please read the FAQ on the back and do not hesitate to ask.

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS

Patient Name (Print): _____ DOB: ____/____/_____

Name on Card (Print): _____

Credit Card # _____ Exp Date: _____/_____ Security Code: _____

Zip Code _____ Phone: _____

Cardholder/Representative Authorizing Signature: _____Date: _____

Cardholder/Representative Printed Name: _____

Email Address for Notice: _____

Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy, and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in patient deductibles. The amount of time and effort to collect payments that will be saved will allow our office to focus more on patient care. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The insurance companies on average take approximately 2-3 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. It simply depends on your individual policy what you may owe. Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our PCI and HIPAA compliant practice management system. This system stores the card information for future transactions using the same sort of technology that any online retailer would. We can't see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than us storing the information. The extra time the staff has can now be spent on directly helping the patients, either over the phone, with insurance claims or in person.

I always pay my bills on time.
Why do I have to do this? The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up costing a lot of money. Reducing unnecessary costs are essential to allowing us to continue to be your provider. Nothing is changing about how much you end up paying.

What if there is a payment discrepancy or I have other payment questions?
Please contact our office directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or questions your insurance company's explanation of benefits.

Will I still receive a receipt/invoice bill by mail?
Yes. You will receive a paid receipt/invoice for each transaction by mail or email based on your preference.