rapha family wellness

comprehensive medicine with a healing touch

Financial Policy

Thank you for choosing Rapha Family Wellness, PLLC

It is our policy that all fees including co-pays, deductibles and non-covered services are due and payable on the date of service unless other payment arrangements have been made.

As a service to our patients, we will file a claim with your insurance company. The filing of insurance does NOT release the patient from responsibility for charges for services which have been provided. Please make sure we have a current copy of your insurance card. ***If we do not have a current insurance card on file, on date of service and your claim is denied, you are responsible for payment.*** It is your responsibility to verify if our office is in network with your plan.

Accounts that are not paid within a reasonable period of time, and for which no special arrangements have been made, will be subject to placement with collection agencies following due notice.

Having read and understood the above statements, I agree to the terms set forth.

1. I understand my co-pay, deductible or non- covered service fee is due and payable at my appointment or I will need to reschedule my appointment. _____
2. I understand that I am financially responsible for all charges, even if they are not covered by insurance. _____
3. If my insurance does not pay, I understand that I am responsible for those charges. _____
4. In the event that I do not pay in accordance with the above policy and my account is sent to a collection agency, I agree to pay all costs of collection, including attorney fees. _____
5. If my account is sent to collection, I understand I will be dismissed from the practice. _____
6. I understand if I fail to show up for a scheduled appointment, I will receive one courtesy notice. For a second no show appointment, I understand that I receive a bill for the missed appointment. I understand that a third missed appointment is grounds for dismissal from the practice. _____

I, the patient or guarantor/guardian, hereby authorize the release of all applicable medical information including without limitation, copies of all records and test results produced to the designated attending, referral and/or follow-up physicians and such other healthcare practitioners or organizations which will be providing subsequent monitoring, care or treatment in connection with care provided by Rapha Family Wellness, PLLC. I also authorize the release of information from my medical record in order to comply with applicable law, to facilitate the performance of utilization review and quality assurance activities and to facilitate third-party accreditation/certification activities. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service, unless other arrangements are made. I authorize physician and/or clinic to render medical treatment and to release information to process insurance claims and to determine Medicare benefits. I also authorize my insurance claim and/or authorized Medicare benefits to be paid directly to Rapha Family Wellness, PLLC. I further agree that a photocopy of this document is to be considered as valid as an original.

Signature of Responsible Party: _____ Date: _____

Printed Name _____ Relationship to patient _____

109 Hazel Path, Ste 7 Wren Building Hendersonville, TN 37075 P: 615-338-5750 F: 615-447-3827

Cancellation Policy/No Show Policy

Cancellation/No Show Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. When you do not call to cancel your appointment you may be preventing another patient form getting treatment.

If an appointment is not cancelled at least 24 hours in advance, you may be charged a $ 50 No Show Fee (which is not covered under your insurance).

Scheduled Appointments:

We ask that you call us to let us know if you will be running more than 15 minutes late. If we cannot get to your call, please leave a message, which will time stamp your call.

We will reserve the right to reschedule your appointment depending on how full our schedule is that day, if it is longer than 15 minutes. This will keep from delaying our schedule any further.

No Show Fees and Payment:

All No Show Fees will be due on your next visit, or we will send you a statement. Upon arrival to see the doctor we will ask that you pay your balance to zero prior to service.

Patients that have a balance over $100 will need to speak with the Office Manager to set up a payment plan to reduce your balance on your account. If you know you will have a problem paying your account in full, please ask to speak with Julie so we can work something out.

Print Patient Name: _____ Date: _____

Signature Patient/Guardian: _____

Name _____ Date of birth: _____

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

In order to maintain communication we may employ several services, including both email and text messaging to remind you of an appointment or even to provide general information regarding our office services, refills, etc. This is a consent that you would like to receive this information through these services.

_____ (Initials) I consent to receive text messages from Rapha Family Wellness on the cell phone number provided and to receive email communication at the email address provided. I understand that I am responsible for the cost of text messaging services should I incur them on my monthly cell phone bill. I will not receive a bill for these services from Rapha Family Wellness but standard text messaging rates may apply and I am aware to contact my carrier for pricing plans and details. I also understand that I can change this request, the phone number, the email address, or cancel this at any time.

I would like to receive text message communications at the following number: YES:____ NO:____

_____

I would like to receive email communications and access to my patient portal at the following email address: YES:____ NO:____

_____

Revocation (only to be used to remove my information from these services)
I hereby revoke my request for future communications via email and/or text

_____ **I hereby revoke my request to receive any further communications via text.**

_____ **I hereby revoke my request to receive any further communications via email.**

Consent to have another person pick up medications or prescriptions on my behalf:

We understand there may be times that a friend or family member will need to pick up your prescriptions or medication samples. We would like to have your permission to do this so we can be assured that we are releasing this information to the proper party.

_____ (Initials) I wish to designate the following person(s) to pick up this information on my behalf:

Name:_____ Date:_____

Name:_____ Date:_____

_____ (Initials) I do not want to designate anyone to pick up my prescriptions or samples.

Patient Signature:_____ Date:_____

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M. Dawn Linn, DO

109 Hazel Path, Ste 7, Hendersonville, TN 37075
Phone: 615-338-5750 | Fax: 615-447-3827 | www.raphafamilywellness.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: ___/___/_____

Other Name, if applicable: _____ Social Security #: ____-___-____

I request and authorize _____

to release healthcare information of the patient named above to:
RAPHA FAMILY WELLNESS, fax 615-447-3827

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

◉ All healthcare information ○ Other

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

◉ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

◉ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Guardian Signature: _____ Date signed:

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Rapha Family Wellness, PLLC

Patient Registration Form

First Name: _____ Last Name: _____

Middle Name: _____ Suffix: _____

Gender: Female _____ Male _____

Marital Status Single Married Widow Divorced Separated

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Preferred Communications:

Email: _____

Cell: _____

Home: _____

Text: _____

Race -- Please circle one:

American Indian Asian Native Hawaiian African American White Hispanic Other

Emergency Contact: _____
Emergency Contact Number: _____
Emergency Contact Relationship: _____

Primary Insurance Company: _____

Insurance/Subscriber ID: _____ Group #: _____

Insurance Plan: _____ Insurance Phone #: _____

Policy Holder Name if other than patient: _____

Policy Holder Social Security # (if known): _____

Relationship to Insured: _____

Insured Date of Birth: _____

Employer of Insured: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance Company: _____

Insurance/Subscriber ID: _____ Group #: _____

Insurance Plan: _____ Insurance Phone #: _____

Policy Holder Name if other than patient: _____

Policy Holder Social Security # (if known): _____

Relationship to Insured: _____

Insured Date of Birth: _____

Employer of Insured: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Student/Employment Status: Circle one: Employed Fulltime Student Not a student

I hereby authorize (a) payment of Insurance benefits otherwise due to me to be made directly to Rapha Family Wellness, PLLC (b) release of Information including protected health Information to insurance companies as needed to file payment for services incurred, (c) Rapha Family Wellness, PLLC to obtain records from other sources as may be necessary in the diagnosis or treatment, and (d) understand that I am financially responsible to Rapha Family Wellness, PLLC for charges related to services provided or incurred by me or my dependents.

Patient Signature: _____ Date: _____

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Please tell us the REASON FOR TODAY'S VISIT or any special concerns you would like to discuss with your doctor today:

Please list your CURRENT MEDICATIONS:

Name of Medication	Dosage (ie, milligrams)	How taken (ie, 1 tab daily)

Please list any ALLERGIES to medications:

Allergy	Type of Reaction (ie, rash, nausea)

Please provide your Immunization History

	Yes/No		Yes/No
Tetanus Diphtheria Booster		Hepatitis A Vaccine	
Influenza Vaccine (Flu shot)		Hepatitis B Vaccine	
Pneumococcal Vaccine		Human Papilloma Virus HPV	
Tuberculosis (TB) skin test		Varicella Vaccine	

Please provide your PAST MEDICAL HISTORY:

____ Allergies	____ Blood clots	____ Gallbladder disease	____ MI (heart attack)
____ Anemia	____ Cancer, type:	____ GERD (reflux)	____ Osteoarthritis
____ Angina (chest pain)	____ CVA (stroke)	____ Hepatitis C	____ Osteoporosis
____ Anxiety	____ COPD (emphysema)	____ High cholesterol	____ Peptic Ulcer disease
____ Arthritis	____ CAD (heart disease)	____ High blood pressure	____ Renal disease Kidneys
____ Asthma	____ Crohn's disease	____ Irritable bowel disease	____ Seizure disorder
____ Atrial Fibrillation	____ Depression	____ Liver disease	Thyroid disease
____ BPH (enlarged prostate)	____ Diabetes	____ Migraine headaches	

Please tell us about any SURGERIES you have had, you may indicate the date/year if known:

____ Angioplasty	____ Colon removal	____ Pace maker	Gender specific female
____ Angioplasty with stent	____ Colostomy	____ Small bowel ressection	____ Breast augmentation
____ Appendix	____ Gastric bypass	____ Thyroidectomy	____ Bilateral tubal ligation
____ Arthroscopy knee	____ Hernia repair	Tonsillectomy	____ Breast biopsy
____ Back surgery	____ Hip replacement		____ Cesarean section
____ CABG (open heart surg)	____ Knee replacement	Gender specific Male:	____ D & C
____ Carpal Tunnel release	____ LASIK	____ Prostatectomy	____ Hysterectomy
____ Cataract	____ Liver Biopsy	____ TURP	____ Mastectomy
____ Gallbladder	____ repair broken bone	____ Vasectomy	____ Breast reduction

Please list any ADDITIONAL PAST MEDICAL OR PAST SURGICAL HISTORY:

_____

Please provide your FAMILY HISTORY:

	Family Member:		Family Member:
ADD/ADHD	_____	Hearing deficiency	_____
Alcoholism	_____	High cholesterol	_____
Allergies	_____	High blood pressure	_____
Alzheimer's Disease	_____	Irritable bowel disease	_____
Asthma	_____	Learning disability	_____
Blood Disease	_____	Mental illness	_____
Coronary artery disease	_____	Migraines	_____
Premature heart disease	_____	Obesity	_____
Cancer type: _____	_____	Osteoarthritis	_____
CVA (stroke)	_____	Osteoporosis	_____
Depression	_____	Blood clots	_____
Developmental delay	_____	Renal (kidney) disease	_____
Diabetes	_____	Seizure disorder	_____
Eczema	_____	Other:	_____

FOR FEMALES Only:

Age at first period	_____	Are periods regular	Yes ___ No ___
Date of last period	_____	Do you have pain with your period? Yes __ No __	
Date of last mammogram	_____	If yes, explain: _____	
Date of last pap smear	_____	Number of pregnancies: _____	
Any history of abnormal Pap? Yes__ No __		Number of live children: _____	
If yes, When:	_____	Number of miscarriages: _____	

Have a durable power of attorney?

Yes _____ No _____

Name of durable power of attorney: _____

Have a living will?

Yes _____ No _____

Have a Do Not Resuscitate order?

Yes _____ No _____

Would you like access to our secure patient portal?

Email Address:_____

What is your preferred pharmacy and address location?

_____

Please provide your Social History:

Do you smoke? Yes __ No __ Former __

Packs per day: _____

Years smoked: _____

Year quit: _____

Have you tried to quit? Yes __ No__

Do you drink Alcohol? Yes __ No __ Former __

Type of alcohol: _____

Frequency: _____

Amount: _____

When was your last drink? _____

I hereby authorize Rapha Family Wellness, PLLC and any of its physicians and/or staff to treat my medical condition(s). The risks, benefits and alternatives will be explained at the time of service. I have the right to question and/or refuse treatment.

Patient Signature: _____ Date: _____

Rapha Family Wellness Policies

I have read and had all my questions answered regarding the office Privacy Policies. I have also been offered a copy of the same.

_____

The co-payment/co-deductible payment policy has been explained to me and I understand that I must pay prior to each visit.

_____

I agree that Rapha Family Wellness may obtain my prescription medication history.

_____

I have read and agreed to the form entitled "HIPAA Data Use Agreement."

_____

My personal medical information may be discussed with the following person/people. I agree that this information may be changed at any time upon written permission by me only.

Name and Relationship and phone number:

1. _____
2. _____
3. _____
4. _____
5. _____

Printed Signature: _____

Signature: _____

Date: _____