FAIC

FALLS AVENUE IMMEDIATE CARE

260 Falls Avenue, Suite C, Twin Falls, Idaho 83301 Office: (208) 733-6700 Fax: (208) 733-0803

Patient Information: (This section is for patient only)

Name _____ PCP _____

Physical Address _____ City/State/Zip _____

Mailing Address/ PO BOX if different from above _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth ____/____/____ Age ____ Sex ____ Ethnicity _____ Marital Status _____

Social Security # _____-_____-_____ Email Address _____
For billing purposes

Spouse _____ Primary Language _____

Employer _____ Company Work Number _____

Relationship to Responsible Party: Self Son Daughter Spouse Other _____

Responsible Party: (Primary Insurance Carrier)

Name _____

Address _____ City/State/Zip _____

Cell Phone _____ Work Phone _____ Date of Birth ____/____/____

***Emergency Contact:**

Name _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Insurance Information:

Primary Insurance _____ Policy ID # _____ Group # _____

Secondary Insurance _____ Policy ID # _____ Group # _____

Pharmacy Information:

MEDICATION TO ALLERGIES: _____

Primary Pharmacy _____ Phone # _____

Secondary Pharmacy _____ Phone # _____

Payment and Co-pays are due at the time of service unless other plans have been pre-arranged at check in
We are required to collect your insurance plan's co-payment at the time of service.

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General Information on Payment and Procedure

1. If after sixty (60) days insurance has not responded to the claim, the billing is expected to be paid in full by the responsible party. We do require payment within thirty (30) days of time of service.

2. Patients with health insurance should remember that services are rendered and charged to the patient. Any dispute over an insurance claim is a matter between the patient and insurance carrier. Should a dispute arise, we will make every effort to help resolve the claim.

3. Although we have lab and x-ray in our facility, at times other tests may need to be done outside FAIC. These are NOT included in our billing.

General Information on Payment and Procedure

1. **CONSENT TO TREATMENT*: I understand that medical treatment will be performed by independent physicians, their assistants, and employees of Falls Avenue Immediate Care between the hours of 8:00am and 7:00pm. Falls Avenue Immediate Care is NOT responsible for care between the hours of 8:00am and 7:00pm. I hereby give my authorization and consent to treatment and procedures and certify that no guarantee or assurance has been made as to the results of such treatment or procedures.

2. *ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION:* I request that payment of authorized benefits on my behalf, be made to Falls Avenue Immediate Care of Twin Falls, P.A., for services rendered to me. I authorize any holder of medical information about me to be released to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable to related services. I authorize FAIC to release any medical information to the patients treating physician.

3. **AGGREEMENT TO PAY FOR SERVICES*: For the care and treatment provided to the patient, I promise to pay Falls Avenue Immediate Care all charges for services rendered to or in behalf of the patient.

4. **RELEASE OF MEDICAL INFORMATION*: I hereby authorize **Falls Avenue Immediate Care** to release any medical information in connection with these services for health insurance purposes or to the patients treating physicians.

I HAVE READ AND UNDERSTAND THE ABOVE ACKNOWLEDGEMENTS AND AGREEMENTS.

Patients Signature _____ Date _____

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We are required to collect your insurance plan's co-payment at the time of service.

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Medicare ONLY - One-Time Authorization/ Medigap Assignment

One-Time Authorization

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Falls Avenue Immediate Care of Twin Falls, P.A., for services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature _____ Date _____

Medigap Authorization

I request that payment of authorized Medigap benefits be made to me or on my behalf to Falls Avenue Immediate Care of Twin Falls, P.A., for any services furnished to me by that provider. I authorize any holder of my medical information or other information to determine benefits payable for related services, to be released to _____.

Patient Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that the "Notice of Privacy Practices" has been made available to me

_____ _____

Signature of Patient Todays Date

_____ _____

Name or Signature of Legal Representative Relationship

_____

Document Reason for Refusal of Signature

Payment and Co-pays are due at the time of service unless other plans have been pre-arranged at check in
We are required to collect your insurance plan's co-payment at the time of service.