FINANCIAL ADMISSION PACKET

ALL patients, no matter what insurance they have, must complete this FINANCIAL PACKET, inclusive of the following *mandatory forms*:

- **Patient Demographic sheet**
- **Paid To Patient Financial Responsibility Form - Signed & Witnessed**
- **Durable Power of Attorney - Signed, Dated, Notarized & Witnessed**
- **Coordination of Benefits - Signed & Dated**
- **Assignment of Benefits - Signed, Dated & Notarized**
- **Insurance Financial Agreement - Signed, Dated & Notarized**
- **Employment Verification Form for the patient** (to be completed upon admission & prior to discharge)

Optional Forms to be used at the Facility's discretion:
- **Promissory Note (Travel)**
- **Promissory Note (Cobra)**

Once completed, please send over to: dataentry@medprobill.com . This must be sent to MedPro within 48-72 hours of Patient's Admission as to not cause delays in claim submission & reimbursement.

Ref: ______

PATIENT INFORMATION

Patient Last Name	First Name	Middle Name	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital Status ☐ Single ☐ Sep ☐ Married ☐ Widow ☐ Divorced

Is this your Legal Name Yes ☐ No ☐	If not, what is your legal name?	Former Name	Date of Birth	Age	Gender M ☐ F ☐

Street Address	City	State	Zip Code	Social Security #	Home/Mobile Phone #

Employer	Occupation	Employer Phone #

Employer Fax #	Date of Admit:	Email Address

Chose Clinic Because /Referred by (Please check on box) ☐ Insurance Plan ☐ Hospital
☐ Family ☐ Friend ☐ Close to Home/Work ☐Internet/Website ☐ Dr. ___________ ☐ Other ________

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Date of Birth	Address	Home/Mobile Phone #
Social Security #	Employer	Employer Address	Employer Phone #

Is this patient covered by insurance Yes ☐ No ☐ Please Indicate Primary Insurance

Subscriber Name	Subscriber Social Security #	Date of Birth	Policy #	Group #	Co-Payment (If Applicable)

Patient Relationship to Subscriber (check applicable): ☐ Self ☐ Spouse ☐ Child ☐ Other _________________

Name of Secondary Insurance (If Applicable)	Subscriber Name	Policy #	Group #

Patient Relationship to Subscriber (check applicable): ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not living at the same address as Patient/Subscriber)	Relationship to Patient	Home Phone #	Work Phone #

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to ___________________________. I understand that I am financially responsible or any balance. I also authorize ______________________ or my insurance company to release any information required to process my claims.

X

Patient/Guardian Signature Date

Paid To Patient Financial Responsibility Form

****If the patient is not the primary policy holder (the Subscriber), then you MUST also have the policy holder complete this form because the check will be in the policy holder's name. This form for the policy holder is included in the Subscriber Paid to Patient Packet****

Date:____

Patient Name: ________________________________

Insurance Company:____________________________________

ID#:____

DOB:____

I ______________________________ , understand that my Insurance company will be billed for the services provided to me by **______________________.** My insurance company is ______________________ I acknowledge that pursuant to the terms of my insurance policy, ______________________ will issue payment directly to me for services provided by ______________________ based on insurance claims filed by ____________________ and that I am responsible for forwarding such checks as payment for services rendered directly to ____________________ under the terms of this Agreement. I hereby acknowledge and agree to forward any check or checks I receive from my insurance company for services rendered by ____________________ directly to the Facility, endorsed "Pay To The Order ____________________" with my signature so that my services are paid for. I further acknowledge and agree not to negotiate or otherwise cash or deposit any such checks in any other fashion other than as stated herein, and that doing so constitutes a material breach of this Agreement. In the event that I do not endorse and forward such checks to ____________________ endorsed as set forth above, I hereby understand and agree that ____________________ may take legal action against me to enforce the terms of this Agreement and will be entitled to recover any and all attorneys' fees and costs incurred in seeking enforcement of this Agreement, including pre-suit attorneys' fees and costs, attorneys' fees and costs at all level of litigation including trial and appellate levels, and during any proceedings to determine the amount and reasonableness of any fees awarded pursuant to this provision.

Patient Name (Print): __________________________________

Patient Signature: ____________________________________

Witness Name (Print):____

Witness Signature:____

DURABLE POWER OF ATTORNEY

LET IT BE KNOWN BY ALL MEN, that this power of attorney is intended to constitute a Durable Power of Attorney and THAT I _______________________________________(name of patient) (the "Principal"), having an address at _______________________________________with Insurance ID# _______________________________ hereby make, constitute and appoint each and all of: Melissa Zachariasz, Meredith Barry, and _________________________ (name of employee at _____________________) my true and lawful attorney-in-fact TO ACT SEVERALLY in my name, place and stead to do and perform all and every act and thing whatsoever requisite and necessary in any way which I could or might do, if personally present, with respect to obtaining payment and/ or reimbursement for hospital, medical, chemical dependency treatment and other health care services rendered to the Principal by ________________________ whose address is ____ and any of its affiliates, including, but not limited to obtaining insurance, making of claims against insurers, or other third-party payers, filing of appeals and grievances pursuant to the applicable benefit denial appeals process, instituting and prosecuting and/or defending litigation, arbitration and/or other dispute resolution proceedings, compromise and/or statement of claims and/or disputes, obtaining and/or releasing records, reports and statements including but not limited to any and all medical reports from prior treatment providers, subject to complying with federal confidentiality rules under 42 CFR Part 2, as well as all other acts which may be helpful and appropriate to the accomplishment of such purposes, for the ultimate objective of ______________________**'s** collection for such services. Such additional acts shall include, without limitation, endorsing any draft, check or other negotiable instrument, representing insurance or other third party benefits received by or on behalf of the Principals, updating information per the member's policy such as pre-existing conditions and/or coordination of benefits with respective insurance and /or third parties, updating and changing patient's address on file with the insurance and/or third parties, providing information and/or payment on behalf of the insured for COBRA, the filing of all documents and forms which may be necessary or appropriate to maintain continued or extended health care insurance, including but not limited to continuation of coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), 29 U.S.C. Section 1161. et. seq.

Each of my said attorneys shall have full and unqualified authority to delegate any or all of the foregoing powers to any person or persons whom my attorney(s)-in-fact-shall select, to the maximum extent not forbidden by law.

This Durable Power of Attorney shall not be affected by the subsequent disability, incapacity, or incompetence of the Principle except as provided in __________________________________ and other specifically applicable law.

To induce any third party to act hereunder, I agree that, as against third parties, I will not question the sufficiency of any other document executed by my attorney(s)-in-fact pursuant to this Power of Attorney. Any third party receiving a duly executed copy or facsimile of this Power of Attorney may act in reliance hereon, and that revocation or termination hereof shall be ineffective as to such third party unless and until receipt of actual notice of knowledge thereof, and I, for myself and my heirs, executors, legal representatives and assigns, agree to indemnify and hold such third party harmless from and against any and all claims that may arise by reason of reliance upon the Durable Power of Attorney. By signing this document I confirm that I have read and understand all terms if this document, which is being initiated without duress.

This Durable Power of Attorney shall automatically terminate on _________________________ (Fixed Date of Termination), or when all payments due and owing to ____________________________ with respect to payment and/or reimbursement for hospital, medical, chemical dependency treatment and other healthcare services rendered to the Principal by ___________________________have been made and ____________________________ has received payment in full for such services rendered, whichever occurs sooner.

SIGNATURE PAGE

I sign my name to this Durable Power of Attorney on _________ (date) at ____________, (city)

_______ (state). Patient/Guardian Signature: ____

[Note]

[YOU MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC AND IN THE PRESENCE OF TWO WITNESSES]

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY BOTH A NOTARY PUBLIC AND TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THE POWER OF ATTORNEY.)

STATE OF _____________________

COUNTY OF ___________________

ON _________________ before me,

____

(Print Name and title of the notary officer), personally appeared

____

Who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity (ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of ___________________ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

___________________________ (seal)

Notary Public Signature

State of ____________________

[AND]

STATEMENT OF WITNESS

(READ CAREFULLY BEFORE SIGNING. You can sign as a witness only if you personally know the principal or the identity of the principal is proved to you by convincing evidence. To have convincing evidence of the identity of the principal, you must be presented with and reasonably rely on any one or more of the following:

a. An identification card or driver's license issued by the state in which this document is being executed that is current or has been issued within five years
b. A passport issued by the Department of the State of the United States that is current or has been issued within five years.
c. Any of the following documents if the document is current or has been issued within five years and contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number.
    i. A passport issued by a foreign government that has been stamped by the United States Immigration and Naturalization Service.
    ii. An identification card or driver's license issued by a state other than the state where this document is being executed.
    iii. An identification card issued by any branch of the armed forces of the United States.
d. if the principal is a patient in a skilled nursing facility, a witness who is a patient advocate or ombudsman may rely upon the representations of the administrator or staff of the skilled nursing facility or of family members as convincing evidence of the identity of the principal if the patient advocate or ombudsman believes that the representations provide a reasonable basis for determining the identity of the principal.

I declare under penalty of perjury under the laws of the State of ____________________ that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as attorney in fact by this document.

Signature: ____

Print Name: ____

Residence Address: ____________________________________ Date: __________________

____

____

COORDINATION OF BENEFITS

TO:

FROM:____

PRINT PATIENT NAME

THIS WILL CONFIRM THAT UPON ADMISSION TO __________________ **located at** ____

- ☐ I am actively employed and have insurance provided through my employer listed below
- ☐ I am currently unemployed, but I have been employed within the past 18 months and have active COBRA insurance
- ☐ I have been employed for the past 18 months and do not have COBRA coverage
- ☐ I am currently unemployed but I have been employed within the past 18 months but do not have COBRA insurance
- ☐ I am presently employed with the company identified below, but do not have any hospital/ medical/addiction health insurance coverage.
- ☐ If a dependent the only benefits available to me during my stay at _______________ are through _________________________, enrolled as a dependent of

Insurance Company

______________________________ Who is my ___________________________.

Subscriber Name *Relationship*

EMPLOYERS NAME ____

EMPLOYERS ADDRESS ____

EMPLOYERS PHONE ____

_________________________________ _____________________

PATIENT SIGNATURE **DATE**

ASSIGNMENT OF BENEFITS AND HIPAA DISCLOSURE AUTHORIZATION PURSUANT TO 45 CFR 164.508

PATIENT NAME:

ASSIGNMENT OF BENEFITS

______________________________	______________________________
INSURANCE CO. #1	INSURANCE CO. #2
______________________________	______________________________
POLICY NUMBER	POLICY NUMBER
______________________________	______________________________
INSURANCE PHONE #1	INSURANCE PHONE #2

I hereby authorize and request that payment of authorized insurance company benefits, or any benefits to which I am entitled under any self-funded plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), be made on my behalf directly to ________________________________ for the amount due to me for any medical or psychological/psychiatric treatment or services that are rendered to me by _____________________________.

I further authorize my insurance company or self-funded plan governed under ERISA to pay and remit directly to ______________________________ all medical or psychological/psychiatric benefits for payment of services rendered by ________________________________. I also authorize ________________________________ to endorse any checks received on my behalf for payment of services rendered.

I hereby irrevocably assign to ___________________________ all benefits under any policy of insurance, self-funded plan governed by ERISA, indemnity agreement, or any collateral source as defined by statute for services provided. This assignment includes all rights to collect benefits directly from my insurance company or self-funded plan's plan administrator or claims administrator and all rights to proceed against my insurance company or self-funded plan governed by ERISA in any action, including legal suit, if for any reason my insurance company or self-funded plan fails to make payment of benefits due. This assignment also includes all rights to recover attorneys' fees and costs for such action brought by ____________________________ as my assignee.

HIPAA DISCLOSURE AUTHORIZATION

I hereby authorize the holder of medical or other information to release all protected medical information needed or related to claims for services rendered to me by ____________________________________ to any necessary government agent, including but not limited to the Social Security Administration, Health Care Financing Administration and to any insurance payor or provider. This authorization includes and authorizes _________________________ to disclose the following information to any covered entities under HIPAA:

- All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records reviewed by other physicians.
- All psychotherapy notes as defined under 45 C.F.R. § 164.501.
- All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- All radiology files, CT Scans, photographs, bona scans, pathology, cytology, histology, autopsy, immunohistochemistry specimens, cardiac catheterization videos, CDs, films, reels, and echocardiogram videos.
- All pharmacy/prescription records, including, but not limited to, NDC numbers and drug information handout/monographs.
- All billing records including, but not limited to, all statements, itemized bills, and insurance records.

Information about alcohol/substance abuse and HIV/AIDS may be disclosed as follows (check all that apply):

Disclose HIV/AIDS information? ___YES ____NO

Disclose alcohol/substance abuse information? ____YES ____NO

This acknowledges the right to revoke this authorization by writing to _________________________ at ______________________________. However, I understand that any actions already taken in reliance of this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and may no longer be protected under 45 CFR 164.508. I further understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.

Any facsimile, copy or photocopy of this authorization shall permit you to release the records herein.

This HIPPA Disclosure Authorization expires two (2) years from the below date, unless sooner revoked in writing.

IN WITNESS WHEREOF, I have executed this Assignment of Benefits and HIPAA Disclosure Authorization on this ________ day of ____________, 20____ in the presence of the notary public below.

______________________________________ ____________________________

PATIENT SIGNATURE **DATE**

STATE OF ___________________

COUNTY OF _________________

Sworn to (or affirmed) and subscribed before me, _____________________________ (name of notary) this _____________ day of ______________________, 20_______, by _______________________________________ (person making statement).

NOTARY SEAL

____

Signature of Notary Public – State of _________________

____

Name of Notary – Typed, Printed or Stamped

Personally Known _________ or Produced Identification ____________

Type of Identification Produced

____

INSURANCE FINANCIAL AGREEMENT

PATIENT NAME: ____

______________________ ___________________ ___________________
Insurance Co Name Policy No. Group Number

____
Patient Home Address

I, ________________________ (Name of Patient), state that my Social Security Number is, ________________________ hereby individually agree to guarantee the payment of for all services rendered by ________________. Any revisions to these rates or terms must be noted by a written attachment to this financial agreement.

I hereby make a deposit of $_________ to _____________________ (the "Assignee"), located at _________________________ which I, the patient understand that this deposit will be applied to my out of pocket expenses, including but not limited to, my deductible, co-insurance and/or out of pocket max.

I, the patient also understand that the Assignee will bill _____________________ (Insurance Company) for reimbursement for these health care services, and authorize and request that my insurance company pay directly to ______________________ the amount due me in any claim for Medical or Psychological/Psychiatric treatment or services rendered to me by ____________________ or the ancillary services provided.

I, the patient also understand that my insurance company will be billed the below charges. Additionally separate charges may be billed for Pharmacy and Diagnostic services rendered by the facility. I also understand in addition to the charges billed to my insurance company that I am responsible for my $__________ deductible, and $_____________ out of pocket. (Amounts to be taken off of the completed VOB)

DAILY PUBLISHED RATES PER DAY BILLED TO INSURANCE COMPANY

I do understand that by utilizing my insurance I am responsible for the facility’s daily published rates. I also understand that there are additional costs incurred for pre-certification and cost of billing my insurance. I the patient understand that by billing my insurance company, any monies paid by me and/or my insurance company goes towards my stay as per the facility’s daily published rates. ONLY in the event that my insurance does not cover any part of my stay, I the patient, will be responsible for the self-pay/scholarship rate of $___________________ per visit ☐ month ☐ day ☐other Explanation: ____

I understand that if this account is not paid according to the terms of this Insurance Financial Agreement, this account could be referred to a collection agency or legal actions pursuant to breach of this agreement be filed against me. I also understand that should any such collections or legal actions be initiated in reference to this Financial Agreement I will be fully responsible for any and all attorney fees and other reasonable collections costs associated with this account.

IN WITNESS WHEREOF, I have executed this Insurance Financial Agreement on this _____ day of ________, 20____ in the presence of the notary public by signing my signature below.

____

Patient Signature

STATE OF _____________

COUNTY OF __________________

Sworn to (or affirmed) and subscribed before me, ______________________ (name of notary) this ________ day of _________, 20____,by ____________________ (person making statement)

NOTARY SEAL

____

Signature of Notary Public-State of

____

Name of Notary Typed, Printed, or Stamped

Personally Known _____ OR Produced Identification ________________

Type of Identification Produced

____

EMPLOYMENT VERIFICATION

Employee Name: ____

Social Security Number: ____

Insurance: ____

Employer: ____

Employer Address: ____

____

Employer Contact: ____

Employer Phone: ____

I hereby authorize contact with my employer to verify my employment status. I authorize my Employer to release necessary information.

This authorization is valid for ninety (90) days from the date of signature. This authorization is subject to revocation at any time except to the extent the facility hand already acted in reliance on it.

I here release from any liability, which may arise as a result of the use of this information. I will presume that if such information is later used to my damage that it was obtained as a result of this authorization.

Employee Signature: ______________________________ Date: ___________

Witness Signature: ______________________________ Date: ___________

PROMISSORY NOTE (TRAVEL)

Borrower :____(individually and collectively the

"Borrower) Lender: _________________________________.

1. I, We_________________________ (Borrower) do hereby acknowledge on this the ____ day of ____________, 201___ that _____________________________________ (Lender) has paid the Principal amount of _______________________________________ ($ ___________) for any and all travel expenses to ___________________________ located at ____ on my, our behalf. I further acknowledge and understand that neither ____________________________ nor anyone associated with ______________________________ has made any contrary representation.
2. FOR VALUE RECEIVED, I, We _______________________________, the undersigned Borrower, jointly and severally promise to pay to ____________________________ the sum of ____ ($____________) Dollars.
3. This note will be repaid in
   - ☐ Full on the _______________
   - ☐ ____ consecutive monthly payments on the first day of each month in the amount of $_________ commencing on the ____ day of _________, 201___ and continuing until the _____ day of ___________, 201__ with the balance then owing under this Note being paid at the end its term.
   - ☐ ____ weekly installments on the first business day of each week in the amount of $_________ commencing on the ____ day of _________, 201___ and continuing until the _____ day of ___________, 201__ with the balance then owing under this Note being paid at the end its term.
4. Payments not made within_____days of due date shall be subject to a late charge of _____% of said payment.
5. This Note may be prepaid in whole or in part at any time without premium or penalty. All prepayments shall be applied first to interest, then to principal payments in the order of their maturity.
6. The undersigned agrees to pay all costs and expenses, including all reasonable attorneys' fees, for the collection of this Note upon default. All payments shall be made in lawful money of the United States to to ____________________________________ located at ____or at such other place as the holder hereof may from time to time designate in writing.

IN WITNESS WHEREOF, I have executed this Promissory Note on this _____ day of ________, 20____ by signing my signature below.

____

(Signature)

PROMISSORY NOTE (COBRA)

Borrower :____(individually and collectively the “Borrower)

Lender: ____________________________________.

1. I, We________________________ (Borrower) do hereby acknowledge on this the ____ day of ____________, 201___ that ____________________________ (Lender) has paid the Principal amount of _____________________________________ ($ ___________) for any and all expenses associated with COBRA (continuation of insurance) to _______________________, located at ____ on my, our behalf for the month of ____________, 201___. I further acknowledge and understand that neither _________________, nor anyone associated with ______________________ has made any contrary representation.
2. FOR VALUE RECEIVED, I, We ______________________________, the undersigned Borrower, jointly and severally promise to pay to ________________________ the sum of ____ ($____________) Dollars.
3. This note will be repaid in :
   - ☐ Full on the ________________
   - ☐ ____ consecutive monthly payments on the first day of each month in the amount of $__________ commencing on the ____ day of __________, 201___ and continuing until the _____ day of ____________, 201__ with the balance then owing under this Note being paid at the end its term.
   - ☐ ____ weekly installments on the first business day of each week in the amount of $__________ commencing on the ____ day of __________, 201___ and continuing until the _____ day of ____________, 201__ with the balance then owing under this Note being paid at the end its term.
4. Payments not made within_____days of due date shall be subject to a late charge of _____% of said payment.
5. This Note may be prepaid in whole or in part at any time without premium or penalty. All prepayments shall be applied first to interest, then to principal payments in the order of their maturity.
6. The undersigned agrees to pay all costs and expenses, including all reasonable attorneys' fees, for the collection of this Note upon default. All payments shall be made at ____________________________________ located at ______________________________ or at such other place as the holder hereof may from time to time designate in writing.

IN WITNESS WHEREOF, I have executed this Promissory Note (Cobra) on this _____ day of ________, 20___ by signing my signature below.

____

(Signature)

CLICK HERE TO SUBMIT