Family Medical Specialties
516 W 14th Ave, Ste 100
Holdrege, NE 68949
308-995-4431

Patient Account Number/Name: ______________________________________ DOB: _________________

PATIENT AGREEMENT

Family Medical Specialties

Authorization for Medical Treatment

I Do Hereby Voluntarily Consent To Such Diagnostic Procedures, Hospital Care, & Medical/Surgical Treatment by Family Medical Specialties Medical Providers As Is Necessary In His/Her Judgment. I Acknowledge That No Guarantees Have Been Made To Me As To The Result Of Treatment Or Examination In This Facility. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

Assignment of Insurance Benefits and Financial Responsibility

I Hereby Authorize Family Medical Specialties To Furnish Information To My Insurance Carriers Or Other Payors Concerning My Illness &Treatments & I Hereby Assign To Family Medical Specialties - All Payments For Medical Services Rendered To My Dependents Or Myself. I Understand That I Am Responsible For Any Amount Not Covered By Insurance & That This Assignment Will Remain In Effect Until Revoked By Me In Writing. A Photocopy Of This Assignment Is To Be Considered As Valid As The Original. See back for more detail.

Precertification Policy

I understand that Family Medical Specialties will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

Family Medical Specialties does not discriminate against any person on the basis of race, color, national origin, disability, age, sex, sexual orientation, or gender identity in admission, treatment, or participation in its programs, services, and activities or in employment or on the basis of sex in its health programs and activities.
For further information about this policy contact: Sharon Jensen, Section 504 Coordinator, 308-995-2847, TDD/State Relay: 1.800.833.7352

IN CASE OF BILLING ERRORS

The Federal Truth Lending Act requires prompt correction of billing mistakes.

1. If you wish to preserve your rights under this Act, you must do the following to correct any billing errors.
   a. Do not write on your bill. On a separate sheet of paper write the following.
      i. Your name and address.
      ii. A description of the error and explain why you believe it is in error. If you are just requesting more information, explain the item you are unsure about, ask for evidence of the charge.
      iii. The dollar amount of the suspected error.
   b. Send your billing error notice to the creditor as soon as you can, early enough to reach the creditor within 60 days after the bill was mailed to you.

2. The creditor must acknowledge all letters pointing out possible billing errors within 30 days of receipt of the letter unless dispute can be corrected within that 30-day period. Within 90 days of receiving your letter, the creditor must correct the error or explain why they believe the charge is not in error. Once the creditor has explained the bill, the creditor is under no further obligation to you even though you still believe that there is an error.

3. After the creditor has been notified, neither the creditor or the attorney nor a collection agency may send you a collection letter or take further action with respect to the disputed amount until the dispute is rectified, however, statements may be sent and the disputed amount can be applied toward your credit limit. You cannot be threatened with damaging credit information or credit rating or sued for the amount of the dispute, nor can that amount be reported to a credit-reporting agency. You are required to pay any amount not in the dispute.

4. If it is determined that an error has occurred, the creditor will remove any finance charges reflected for the amount. If no error occurred, you would be required to pay finance charges related to the disputed amount and pay any missed payments as a result of the amount dispute. The creditor must send you written notification, unless you have agreed that there was no error of the balance of the account. If an error in billing is determined, you will then be given the standard time to pay the balance of the account, which would normally be given for new charges (30 days) before any additional finance charges can be charged as a result of the disputed amount.

5. If the creditor's explanation of the amount is not satisfactory and you notify the creditor in writing within 10 days of their notice of explanation, you may still refuse to pay the disputed amount. The creditor has the right at that time to continue any attempt to collect the full amount due including using outside resources such as an attorney and/or a collection agency.

6. If the creditor does not follow these rules, the creditor is not allowed to collect the first $50.00 of the disputed amount including finance charges even if there was an error.

I (WE) AGREE AND UNDERSTAND:

1. That each purchase I incur and consent to be charges to my account is to be recorded on a sales ticket or similar form as seller may use, and if accepted by the seller it is referable to this agreement.

2. A statement will be sent detailing all charges, payments and credits entered on my account during the month prior to the statement closing. A total amount owing will be noted at the time indicated as new or current charges.

3. I may pay the balance in full within 30 days of the closing date and there will be no finance charges. If payment in full is not made within 30 days of the closing date, I will pay the amount due according to the payment schedule in effect at the time.

4. Finance Charges will be calculated each month on the amount of unpaid charges, referred to as previous or past due balance, after deducting payments or credits and before adding new purchases.

5. If monthly payments become past due, I agree to pay the total amount owing upon demand and to pay reasonable collection cost, attorneys fee and court cost permitted by law.

6. I have retained a copy of this agreement and disclosure relating to the Equal Credit Opportunity Act and Fair Credit Billing Act.

7. I understand delivery of this disclosure statement does not indicate the account (we) are applying for has been approved and that I (we) will be informed of this decision separately.

FAMILY MEDICAL SPECIALTIES WILL ADD A 1.5% FINANCE CHARGE TO ANY BALANCE OVER 120 DAYS LATE.

Medicare Beneficiaries Only

1. I hereby authorize Family Medical Specialties (“Provider”) and other medical professionals or staff members that the Provider has designated to access and use the Phamily services on its behalf, to communicate with me, and the Caregivers identified, if any, about my medical conditions and treatment using unencrypted text messages, if I have provided a mobile phone number, and/or unencrypted email, if I have provided an email address, including those that may be considered marketing messages (e.g. flu shot reminders, etc.). I acknowledge that text messages are inherently unsecure and may be able to be accessed by third parties.

2. I understand that the Phamily service should only be used for routine and non-urgent matters. If you are experiencing a medical emergency or life-threatening symptoms, please go to the hospital or contact 911 emergency services.

Acknowledgement of Notice of Privacy Practices

A complete description of how your medical information will be used and disclosed by this Clinic is in our NOTICE OF PRIVACY PRACTICES, which you have received. A copy is posted in this Clinic.

I have received a copy of Notice of Privacy Practices.

Release of Protected Health Information/Emergency Contact Information

The following individuals may be contacted regarding your care/treatment and information may be released to: (Parent/Guardian may include School Athletic Director or Nurse):

______________________ ____________________ ____________________
Name Relationship Phone Number

______________________ ____________________ ____________________
Name Relationship Phone Number

Certification

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original agreement.

Patient or Legal Representative Printed Name: ______________________________ Date of Birth: ______________

Patient or Legal Representative: ____________________________________ Date:________________

Relationship to Minor: ____

_____ Patient/Parent/Legal Guardian declined, stating they have already received the Notice of Privacy Rights and Practices.

Witness:____