Thirlby Clinic, PLC Patient Financial Policy

Thank you for choosing Thirlby Clinic, PLC as your health care provider. We are committed to building a successful physician-patient relationship with you. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

Appointments

We value the time you have scheduled with us to treat you. It is important to understand that if you do not come to your appointment, it is time that could be spent treating other patients. Please provide at least a 24 hour notice if you are unable to keep an appointment. Help us to provide outstanding healthcare to all of our patients by keeping your scheduled appointments. Please be aware that three missed appointments may be grounds for discharge from our practice.

With the evolution of technology, we are now able to offer services to you virtually and sometimes via the telephone. While communicating with your physician regarding change in health status or specific questions related to your health you may be billed for an e-Visit or another type of virtual visit. These are reimbursable charges and are subject to copay and deductible similar to normal office visits.

Participating Insurances

- Aetna
- Blue Cross / Blue Shield (Traditional, PPO, FEP, out of state)
- Blue Care Network Advantage
- Blue Care Network
- Humana Choice PPO Commercial
- Humana Medicare
- Medicare
- Medicare Plus Blue
- Physician Care/ ASR/ HAP (PPO products)
- Priority Health
- Priority Health Medicare
- Railroad Medicare
- United Healthcare
- United Healthcare Medicare Advantage

If we are your primary care physician, be sure that your insurance company has Thirlby Clinic or one of our physician's names on file. If we are not listed as your "primary care physician", your insurance company may charge you a higher co-pay.

If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.

Co-payments

All co-payments and past due balances are due at the time of check-in unless prior arrangements have been made with our billing department. We accept cash, check or credit cards. We will not accept post-dated checks.

Insurance Claims

Insurance is a contract between you and your insurance company. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by your insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payments to us immediately.

Automobile/ Workman's Compensation Insurance

If you have an accident or injury that results in automobile or workman's compensation insurance needing to be billed it is your responsibility to let us know at the initial visit and provide the appropriate billing information including date and time of the accident, insurance company name, address, phone and claim number.

Self- pay Accounts (No insurance coverage)

We will extend a discount of 20% for patients who pay in full on the date that the service is rendered.

Returned Checks

We charge a $25.00 fee for checks returned unpaid. You will be billed for the check amount plus the service charge amount. Please make payment promptly with cash or credit card.

Delinquent Accounts

If you don't pay your bill, or make monthly payment arrangements with our office your account will become past due after 120 days,

Once your account is past due, Thirlby Clinic, PLC will take certain actions to resolve the debt.

These will include:

- The account being turned over to over to an outside collection's agency.
- The patient will be discharged from the practice.

Thirlby Clinic , PLC

Registration Form

Date:

Name:	Date of birth:	Phone:
Street:	City:	State/Zip
Preferred name:	E-mail:	
Last 4 of your social security number: xxx-xx-		Marital Status: o S o M o W o D
Employer:		Phone:
Insurance:		Contract Number:
Insured's name:		Insured's date of birth:
Relation to Insured: o self o spouse o dependent o other		

Sex at birth:	o Male	o Female
How would you like staff to refer to you? Pronoun: o He/Him o She/Her o They/Them		
Do you identify as trans, transgender, transsexual, or as having a trans history? o Yes o No		

Sexual Orientation:	How would you best describe your gender?	
o Straight/heterosexual	o Female/woman	
o Lesbian	o Male/man	o Other
o Gay	o Trans woman/transfeminine	
o Bisexual	o Trans man/transmale	
o Not sure	o Nonbinary, genderqueer, not exclusively male or female	

Race:	Ethnicity:	Preferred Language:
o White	o Hispanic	o English
o Hispanic	o Not hispanic	o Spanish
o African American	o Decline to specifiy	o Other
o Asian		
o Other		

Do you have an Advance Medical Directive? o Yes o No

Do you smoke? Or chew?	o Never	
o Current #pack/pouch per day?	o Quit what year?	Ready to quit? o Yes o No

IF, you are over 40:

Have you had a colon cancer screening?		o Yes o No
o Colonoscopy:	Date:	Result:
o Cologuard:	Date:	Result:
Have you had a mammogram?	o Yes o No	Date:

Name: _____ Date of Birth: _____ Today's Date_____

Pharmacy – Local_____**Phone number**_____

Mail order_____ **Phone**_____

Past or Present Medical Problems:

- ○ **High Blood Pressure**
- ○ **High Cholesterol**
- ○ **Stroke**
- ○ **Other (please list):**

_____

- ○ **Diabetes**
- ○ **Seizures**
- ○ **Ulcers**

- ○ **Heart Issues (please specify):** _____
- ○ **Cancer (please list):** _____
- ○ **Emphysema/COPD**

All Past Operations or Surgery (please list year):

1:	**6:**
2:	**7:**
3:	**8:**
4:	**9:**
5:	**10:**

Current Medications/Vitamins/Herbal Supplements: (please include strength) ○ **Taking no medications**

1:	**6:**
2:	**7:**
3:	**8:**
4:	**9:**
5:	**10:**

Allergies to Medications (please list reaction) ○ **No Known Allergies**

1:	**6:**
2:	**7:**
3:	**8:**
4:	**9:**
5:	**10:**

FAMILY HISTORY: ○ **ADOPTED**

	If Living:	If Deceased		□ Check box if any member has had:				Other:
	Age	Age	Cause	Diabetes	Heart Issues: (what age)	High Blood Pressure	Cancer: (what kind)	
Mother								
Father								
Brothers 1:								
2:								
3:								
Sisters 1:								
2:								
3:								

TC Thirlby Clinic

Medical Information (HIPAA) Release

Primary Care Provider:_____
*** Please return prior to appt ***

Patient Name:_____ DOB:_____/_____/_____

By listing the persons below, I am authorizing any employee of Thirlby Clinic, PC, to release information contained in my patient records, which may include alcohol and drug abuse records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any social services records, if any mental health records, including communications made by me to a social worker or mental health professional, if any and all information defined by statue and Michigan Department of Public Health Rules (Public Act 174, 1989) governing Human Immunodeficiency Virus (HIV) test, Acquired Immunodeficiency Syndrome (AIDS), and AIDS-related complex (ARC), if any, to the individuals listed below, only under the conditions listed below:

☐ Do not release any information to anyone.

☐ I authorize information to be released to:

Name:_____Relationship:_____Phone:(_____)_____-_____

Name:_____Relationship:_____Phone:(_____)_____-_____

Name:_____Relationship:_____Phone:(_____)_____-_____

☐ Emergency Contact: (this person will not be authorized access to any medical information unless indicated above)

Name:_____Relationship:_____Phone:(_____)_____-_____

Without expressed written revocation this authorization will remain in effect from the date of signature.

Messages from Thirlby Clinic, PC:
May include: appointment confirmation and new prescriptions or refills that have been sent to your pharmacy.

I would like to receive these messages via: (We will use the numbers listed in your chart)

Primary #: ☐ Home # ☐ Cell # ☐ Work #
Secondary #: ☐ Home # ☐ Cell # ☐ Work #

Do you prefer a detailed message or a brief message asking you to call back?

☐ Leave full message (if greeting doesn't verify whom we are calling only a call back may be left) ☐ call back only

The Patient Portal gives you online access to your information and allows you to communicate with your doctor. You may ask any employee to activate your portal. Your email address is needed: _____

I understand that my medical records may contain reports, test results and notes that only a physician can interpret.

I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent misunderstanding of the information that has been written in the record.

Signature:_____ Date:_____/_____/_____

Yearly Verification of Information: (I have reviewed the above information and it is still accurate)

Initials:_____Date:____/____/_____ Initials:_____Date:____/____/_____ Initials:_____Date:____/____/_____

Initials:_____Date:____/____/_____ Initials:_____Date:____/____/_____ Initials:_____Date:____/____/_____

Initials:_____Date:____/____/_____ Initials:_____Date:____/____/_____ Initials:_____Date:____/____/_____

Office Use: eMessenger:_____ HIPAA:_____ Contacts Entered:_____

THIRLBY CLINIC PLC
3537 West Front Street, Ste. 1
Traverse City, Michigan 49684
www.thirlbyclinic.com
(231) 935-8950

Please return form to clinic prior to visit

Authorization for USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Home Phone:** _____

D.O.B. _____/_____/_____ **Mailing Address:** _____

_____

Requesting records from:
Previous Physician or Facility Name: _____

Phone: _____ Fax: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Purpose of Disclosure: ☐ *Transfer of Care* ☐ *Continuation of Care*

Faxed records are preferred to Thirlby Clinic, PLC 231-935-8868

Information to be Released:
Colonoscopy, gynecologic cytology, lab tests, x-rays, consultation reports, problem lists, immunizations, bone density test, mammogram, office visit notes for the past year
Other Information: _____

All information regarding Alcohol and/or Drug Abuse or Behavioral Health will be released unless you restrict by initialing below:

_____ *Do not release Alcohol and/or Drug Abuse Information.*
_____ *Do not release Behavioral Health Information*

Acknowledgement of Understanding

- I understand the expiration date of this authorization is 180 days from the date signed.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand this consent for release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, as already acted in reliance on it.
- I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- I understand that, upon request, I will receive a copy of this form after I have signed it.
- I understand that in compliance with Michigan law, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.
- I understand that a photocopy or fax of this form is the same as the original.
- I understand, if applicable, that (1) my HIV test results may be released without my authorization to persons/organizations that have access under Michigan law, and that (2) a list of those persons/organizations is available upon request.

I authorize and request any and all of my medical information, as indicated above be released according to the terms outlined in this agreement.

Patient Signature: _____ Date: _____

Signature of Authorized Person _____ Relationship to Patient _____

Witness Signature: _____ Date: _____

This information may include any of the following, unless otherwise identified:
Alcohol or drug abuse, mental health treatment information protected under Title 42 of Code of Federal Regulations, Part II Serious communicable and infectious disease as defined by the Michigan Department of Community Health Code 1989, Act 174, Which includes Venereal Disease, Tuberculosis, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex (ARC) and Hepatitis. Revocation of this consent is available at any time, except to the extent that release of information has already occurred in reliance upon this consent. The duration of this consent without express revocation shall expire 180 days from the date signed.