MANSFIELD
F·A·M·I·L·Y
PRACTICE

A LIMITED LIABILITY COMPANY

Welcome to Mansfield Family Practice. We are honored that you have chosen us to be a part of your healthcare team. We believe the best healthcare outcomes are based on mutual trust between patient and physician. We believe patients and families are partners in ensuring that the best possible care is provided in a healthy, safe environment. In this package you will find information regarding healthcare compliance as well as important information we feel you should know.

Help Us Care for You:
To the best of your knowledge, provide accurate and complete information about your present symptoms, past illnesses, allergies, hospitalizations, medications and other matters relating to your health.

Your Appointments:
Please arrive 10 minutes before your appointment to ensure you are seen on time.
To help us serve you, please keep our scheduled appointments or call to reschedule. When you do not keep a scheduled appointment, and do not cancel, we are unable to care for another patient that needs us. We have a no-show fee that your provider may charge if you no-show more than once.

Understanding Your Insurance:
Insurance coverage and requirements vary greatly. Although we try, we cannot keep up on all of the changes. Ultimately it is your responsibility to know what your insurance requires. If you have any questions, we urge you to contact your insurance company. There should be a phone number on the back of your card. If you need a referral from us to a specialist; it is your responsibility to request one. Co-pays are due at the time of your appointment.
If you have a different insurance for your prescriptions, it is important that we have that information as well.

Healthcare Insurance Portability and Accountability Act (HIPAA):
In this package you will find 3 HIPAA forms.
We take our responsibility for your care and your privacy seriously. At the end of this packet, you will be asked to sign acknowledging that you have received our NOPP.

1) Your copy of our Notice of Privacy Policy (NOPP). This outlines how we use your information and your rights to privacy.
2) Right to Access form. Complete this form with the information of any individuals you are giving us permission to speak with concerning your care, your insurance, your appointments, etc.
3) Release of Medical Records. This is used for coordination of care. If you have medical records at another provider that would assist our physicians in your care, we ask that you please have them sent to us. You can send this form directly to your other provider or to us and we will request them for you.

Pediatric Care:
Please note the additional areas to complete if the patient is under the age of 18.

Prescription Refills:
We will fill or refill prescriptions within twenty-four (24) hours. Refill requests made off hours will be processed the following work day.

Returning Phone Calls/Correspondence:
We will make every effort to return your communications during normal business hours within a timely manner. Please understand; *you may need to be seen in our office to properly diagnose and treat.* We can only truly treat all medical problems in person.

If you have a life-threatening situation, call 911 or go to the nearest emergency room.

MANSFIELD FAMILY PRACTICE

Authorization for Access to Your Information

(Who do you give us permission to speak with on your behalf?)

I,_____, direct the health care providers at Mansfield Family Practice to disclose and release my (patients name) protected health information to the follow individuals:

Name: _____ *Relationship:* _____

Contact information: _____

Name: _____ *Relationship:* _____

Contact information:

The above-named individual(s) have my permission to request information on my behalf including appointment dates/times, insurance/billing and the following concerning my healthcare:

Health Information to be disclosed upon the request of the person(s) named above --(Check either A or B):

- □ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions)
  OR
- □ B. **Disclose** my health record, as above, **BUT do not disclose** the following(check as appropriate):
  - □ Mental health records
  - □ Communicable diseases (including HIV and AIDS)
  - □ Alcohol/drug abuse treatment
  - □ Other (please specify): _____

This authorization shall be effective until (Check one):

- □ All past, present, and future periods, OR
- □ Date or event:_____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying us in writing.)

_____
Print Name of Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

_____ _____
Name of patient if minor Date of Birth

_____
Relationship to patient if patient is a minor

MANSFIELD FAMILY PRACTICE

AUTHORIZATION FOR RELEASE OF RECORDS
TO MANSFIELD FAMILY PRACTICE

I,_____, (Please Print) Date of Birth _____ authorize:

Name of Healthcare Facility: _____

Address: _____

Phone Number: _____

To Release medical records to:

Mansfield Family Practice
34 Professional Park Road
Storrs, CT 06268
Fax: 860-429-1663
Phone: 860-487-0002

Health Information to be released upon the request of the person named above --(Check either A or B):

- □ A. Release my complete health record (including but not limited to diagnoses,lab tests, prognosis, treatment, and billing, for all conditions)
  OR
- □ B. Release my health record, as above, **BUT do not disclose** the following(check as appropriate):
  - □ Mental health records
  - □ Communicable diseases (including HIV and AIDS)
  - □ Alcohol/drug abuse treatment
  - □ Other (please specify): _____

This authorization shall be effective until (Check one):

- □ All past, present, and future periods, OR
- □ Date or event:_____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying us in writing.)

_____
Print Name of Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

_____ _____
Name of patient if minor Date of Birth

_____
Relationship to patient if patient is a minor

FINANCIAL POLICY

Insurance. If you do not have an updated insurance card with you, payment will be due at the time of our visit. Once we receive your insurance information and payment is received, we will refund you any balance on your account. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Insurances We Do Not Participate: If you are not insured by a plan we participate with, payment is expected at each visit. We do not participate with BCBS Prime or Aetna Whole Health. We do not participate with any SHARED plans such as; AVMED, Healthshare Ministries, or Altua Healthshare. You can submit to your Shared plan for reimbursement. *We suggest you check with our office or your insurance company to confirm our participation.

Parents/Guardians:
I understand I am responsible for any monies due for the services/treatments provided to the child/children in which I am the guardian.

Co-payments & Non-Covered Services. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Your physician will provide you with notice of the potential costs associated with known non-covered services.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. For some insurances we may need your social security number. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment. If your account is past due, you will receive a letter stating that your account may be heading to collections. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail.

Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. A $25.00 fee will be your responsibility and billed directly to you. You will need to pay this amount prior to scheduling your next appointment. Excessive missed appointments may lead to discharge from the practice.

Form Completion Fee. We will complete the forms you may need for school/camp physicals, disability, FMLA, etc. within 7 days. A form completion fee may apply of $25.

Making Payments. Payment may be made on our website: MFPStorrs.com.

Mansfield Family Practice

Please Select Your Primary Care Provider: Dardick Madraswalla Winakor Hughes

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS IF DIFFERENT THAN ABOVE: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: ( )_____ CELL #: ( )_____ WORK #: ( )_____

EMAIL: _____

PREFFERRED CONTACT NUMBER? □HOME □CELL □WORK Okay to leave a detailed message? □YES □NO

Sign up for the patient portal? □YES □ NO

DATE OF BIRTH: ____/_____/_____ MARTIAL STATUS □M □ S □ D □ W □O

BIRTH GENDER ____ Male ____ Female **IDENTIFIED GENDER: _____**

RACE: □American Indian/Alaska Native □ Native American/Pacific Islander □ Black/African American

□ Asian □ White □ Other **ETHNICITY:** □ Hispanic/Latino □ Not Hispanic/Latino

□ I DECLINE TO ANSWER RACE/ETHNICITY

EMERGENCY CONTACT NAME: _____ NUMBER: _____

RELATIONSHIP: _____

PREFFERED PHARMACY_____ ADDRESS: _____

INSURANCE

PRIMARY INSURANCE: _____ INSURANCE ID #: _____

GROUP #: _____

SUBSCRIBER'S SOCIAL SECURITY NUMBER_____

SUBSCRIBER NAME: _____ SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER EMPLOYER: _____

SECONDARY INSURANCE: _____ INSURANCE ID #: _____

GROUP #: _____

SUBSCRIBER'S SOCIAL SECURITY NUMBER: _____

SUBSCRIBER NAME: _____ SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER ADDRESS: _____

SUBSCRIBER EMPLOYER: _____

Please list any family members who are also a part of the practice

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Mansfield Family Practice

Permission to Treat a Minor

There may situations that arise when parents/guardians cannot be available to bring their child/children to our office for care. When your child is in the care of someone else, we must have the information below to treat your child.

In presenting my child/children for diagnosis and treatment, and when accompanied by the below listed individual(s), I hereby consent to the rendering of such care. This includes medical treatment from the providers of Mansfield Family Practice, as may in their professional judgement be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's conditions

I authorize the below designated individual(s) to arrange for routine or emergency medical treatment, if necessary, to preserve the health of our/my child. I acknowledge that I am responsible for all charges in connection with the care and treatment rendered.

I understand it is my responsibility to inform this office of any change in my child's medical status. I understand if I fail to complete this form, Mansfield Family Practice will not treat my child, unless accompanied by anyone other than the registered parent/guardian as listed on the Patient Registration Form.

I/We have read this form and understand its contents. I/We hereby give consent to:

Name: _____

Relationship to patient: _____

Name: _____

Relationship to patient: _____

Parent/Guardian Printed Name: _____

Signature: _____ Date: _____

Assignment of Benefits. I authorize Mansfield Family Practice (MFP) to submit claims to my insurance company on my behalf directly. This means that MFP will collect payment for services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

I have read and understand the information provided to me. I agree to abide by the financial policy and the practice guidelines. I have received a copy of the Notice of Privacy Policy (NOPP) and I understand I may request a copy of this package for my own records.

_____

Print Name of Individual Giving this Authorization

_____ _____

Signature of the Individual Giving this Authorization Date

_____ _____

Name of patient if minor Date of Birth

_____

Relationship to patient if patient is a minor