Saint Louis Medical Clinic
Patient Demographic Information

SLMC Account #_____

PLEASE PRINT LEGIBLY

Patient Name / Information		
First	Middle	Last
Date of Birth	Gender MALE / FEMALE	Ethnicity NON-HISPANIC / HISPANIC
Race AFRICAN AMERICAN / AMERICAN INDIAN / ASIAN / CAUCASIAN / OTHER RACE		

Contact Information		
Street Address		
City	State	Zip

Phone / E-mail / Pharmacy (Place a ✓ by PRIMARY phone number)		
☎Home	☎Cell	☎Alternate
✉E-mail Address		
Preferred Pharmacy	Pharmacy Location/City	

Employment	
Employer	Work Phone

Emergency Contact		
Name	Relationship to Patient	Phone

Insurance	
PRIMARY Insurance	Effective Date
Policy Holder Name	Relationship to Patient
Group#	ID#

SECONDARY Insurance	Effective Date
Policy Holder Name	Relationship to Patient
Group#	ID#

Signature of Patient or Representative Date

SLMC Account #_____

Financial Policy & Consent For Medical Treatment

Patient Name: DOB:

Account Responsibility

As the patient, or the patient's representative, registered with St Louis Medical Clinic (SLMC), you are agreeing to accept responsibility for all balances incurred on behalf of the named patient's medical care. Patient balances are due within 14 days of receipt of a statement. If you feel your statement is incorrect, have a concern regarding insurance, or are experiencing financial difficulties please contact our billing company ASAP at (866) 776-8150.

The individual (patient or representative) signing this Financial Policy will be responsible for any charges associated with the patient's account.

Co-Pays & Payment at the Time-Of-Service

If required by your insurance plan, you will be expected to pay your co-pay each time the patient is seen in our office.
SLMC accepts cash, checks, and all major credit cards.

Additionally, payment will be expected at the time of service when:

- SLMC is not contracted with the patient's insurance plan
- SLMC is not able to verify insurance eligibility
- The patient does not have insurance coverage
- The patient has new insurance coverage, but is unable to provide an insurance card

Professional Services Rendered & Fees

If the patient is seen for a scheduled preventive visit and another condition is treated at the same time, the provider will bill for each service performed in accordance with CPT coding/billing guidelines.

A $35.00 fee will be charged for any checks that are returned by the bank.

Past Due & Collection Accounts

Delinquent accounts may be placed with an outside collection agency. If placed with an agency, the account will be assessed a 25% collection fee. **Placement of an account with an agency will result in termination of the patient/provider relationship.**

- ■ I acknowledge that I have read and understand the policies stated above and agree to accept financial responsibility for the services rendered to the patient. I understand that SLMC may file a claim, on my behalf, with my insurance company and that any balance not paid by insurance is my responsibility (contractual write offs excepted). I understand that SLMC can only code and file a claim for medical services with a diagnosis that was encountered and documented in the medical record. Altering a diagnosis code in order to secure insurance payment may be inappropriate and possibly fraudulent. SLMC adheres to CPT coding guidelines.
- ■ I authorize the release of any medical information necessary to facilitate the processing of insurance claims.
- ■ I authorize and consent to the providers at St Louis Medical Clinic providing treatment for the patient.

Signature of Patient or Representative Print Name Date

SLMC Account #_____

Notice of Privacy Practices
Acknowledgement & Authorization Form

Patient Name: DOB:

Notice of Privacy Practices (NPP)

The Notice of Privacy Practices (NPP) explains how St Louis Medical Clinic (SLMC) may use and share your protected health information (PHI). It also describes your rights with respect to your PHI.

- SLMC will use and share your PHI to treat you and to bill for the services we provide.
- SLMC will use and share your PHI in the general course of operating our business.
- SLMC will use and share your PHI as required and allowed by law.

Pharmacy/Medication Consent

SLMC has the ability to obtain a list of your medications electronically when submitting your prescription to your pharmacy. However, we require your consent in order to obtain this information:

Please circle one below: I give my permission for my physician to obtain my prescription list from the pharmacy.
↳ YES / NO

Authorized Individuals

I give authorization to the doctors and staff of St Louis Medical Clinic to discuss my protected health information (PHI) and financial information with the following people.
The individual(s) named below will also be considered emergency contact(s) unless you specify otherwise.
If SLMC has a Durable Power of Attorney on file for a patient, PHI will be released to the authorized person.

	NAME	RELATIONSHIP
1		
2		
3		

- I understand that the NPP is available on the SLMC website (www.stlmedclinic.com) and at my physician's office.
- I acknowledge I was offered a copy of the SLMC Notice of Privacy Practices (NPP).
- I understand that it is my responsibility to inform SLMC of any desired changes to the list of authorized individuals.
- I hereby give permission to SLMC to: leave voice mail messages containing PHI and account information at my home or on my cell phone; to fax or e-mail PHI to me at my request; or contact me at my place of employment if I have provided a work phone number.

Signature of Patient or Representative Print Name Date