Cooper Family Medical, PLLC

5123 4th Avenue Circle East
Bradenton, Florida 34208
P:(941)744-5510
F:(941)744-5166

Patient ID:

Physician ID:

All patients must complete our Patient Payment Registration form prior to seeing our medical providers.

Payment Policy

Thank you for choosing Cooper Family Medical, PLLC as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided upon request.

All Payments Due at Time of Service

Initial This office maintains a pay at time of service policy. You will need to know your insurance policy in advance in order to be aware of the portion of your visit for which you will be responsible. If you accrue a credit balance, we will maintain that credit balance on your account and apply it to any future balance that may accumulate. If a credit balances exceeds $30.00, we will refund the credit by check to the address on your account. These policies are designed to comply with the Fair Debt Collection Practices Act and any applicable state laws. If your account goes to collections we will no longer provide medical services to you, at which that time you will then be discharged from Cooper Family Medical.

Regarding Insurance

Initial Regarding insurance plans where we are a participating provider, all payments are due including but not limited to deductibles from previous visits, copay, and/or non- covered services, and will be collected upon your arrival. Your insurance policy is a contract between you and your insurance company - we are NOT party to that contract. We cannot bill your insurance unless you provide timely clear and accurate insurance information. **If you have new insurance, or a change in insurance plans, you must provide us with clear and accurate insurance information within 30 days of your visit for your insurance to be billed**. If you are unable to provide this information within 30 days you will be responsible for any visits that may have occurred.

Statements & Claim Submission

Initial We will submit your claims and assist you in any way reasonable we can help to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. We will send you a statement should you have a balance with our office. If no payment is received within 30 days, an additional statement may be mailed. When you receive your explanation of benefits from your insurance company showing any patient responsibility, you have received your first statement. There will be a $35 charge for check denied by your bank and returned to the office for any reason. If your account is over 90 days past due for nonpayment, you will receive a letter stating you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware if your account remains unpaid, we may refer your account to the three major credit bureaus which may adversely effect your credit.

Minor Patients

Initial The adult accompanying a minor and the parents(or guardian) of the minor are responsible for full payment. If a balance accrues at any time, it is your financial responsibility to arrange ahead of time to transfer copayments, coinsurance amounts, and deductibles to the parent or guardian who brings the child to the office visit.

Divorced Parents/ Legal Custody issues

Initial The adult accompanying their child to our office for an appointment is responsible for payment. Arrangements for court orders or any legal payment arrangements amongst parents must be worked out BEFORE your child's appointment. If a separate parent is responsible for payment, we are not party to this arrangement. Payment is due in full at the time of service, and we will prepare a receipt of payment verification purposes.

Appointment Reminders and Missed Appointments

Initial Your signature authorizes us to attempt to contact you 24 hours prior to your appointment with our office. We are not able to guarantee a reminder call for each visit, but we will certainly try.

Unless canceled **AT LEAST 24 HOURS IN ADVANCE**, our policy is to charge the person who is scheduled for the appointment a missed appointment fee at the rate of $50.00. Please help us serve our entire patient population best by keeping scheduled appointments. **Patients who miss three or more appointments without notice may be dismissed and may no longer receive medical treatment at our medical practice**.

Cooper Family Medical, PLLC is committed to providing the best treatment to our patients. Our prices are a representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Printed Name of Patient/Responsible Party	**Signature of Patient/Responsible Party**	**Date**

Cooper Family Medical

Patient Information - 2023 Annual Update

*****Please Present Insurance Card and Photo I.D. Upon Checking In*****

Date: _____

Name: _____ **Date Of Birth:** _____

Address: _____

City/State: _____ **Zip:** _____

How would you like to receive your appointment reminder? ☐**Home Phone** ☐**Text Reminder (Cell)**

Phone: _____ **Cell:** _____

Work: _____ **E-Mail:** _____

(Please note you may communicate directly with our office through your patient portal. If you have not yet logged in using your e-mail address please see our front office for your temporary password)

Preferred Pharmacy: _____ **Phone #** _____

(Please include Address)

Insurance Information

Primary Insurance: _____

Subscriber's Name: _____ **DOB:** _____

(If not self)

Cooper Family Medical

Name: _____ **Date Of Birth:** _____

HIPAA

Do We Have Permission to:

Mail medical information to your home? Yes_____ No_____

Leave a detailed message on your home/cell answering machine for:

Appointment Information? Yes_____ No_____
Billing Information? Yes_____ No_____
Other Medical Information? Yes_____ No_____

Leave a detailed message on your work answering machine for:

Appointment Information? Yes_____ No_____
Billing Information? Yes_____ No_____
Other Medical Information? Yes_____ No_____

I give permission to share information with the following person(s):

Appointment Information : _____ Relation/Phone #:

Billing Information _____ Relation/Phone #:

Medical Info (Including biopsy & Lab results): _____ Relation/Phone #:

Emergency Contact: _____ Relation/Phone #:

With my consent, Cooper Family Medical may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Cooper Family Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. By signing this form, I am consenting to Cooper Family Medical use and disclosure of information according to the Notice of Privacy Practices, and acknowledge receiving a copy of Notice of Privacy Practices.

I authorize release of any medical information necessary to all my insurance companies to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment direct to Cooper Family Medical. I understand that I am responsible for all co-pays, deductibles, and uncovered services. I authorize use of this form for all my insurance submissions. I authorize Cooper Family Medical to release information concerning my treatment to any of my other physicians. I authorize my signature to be placed "on file" for purposes of Medicare and insurance claim for submission. Under penalty of perjury, I declare that I have read the forgoing and the facts alleged are true, to the best of my knowledge and belief.

Patient Signature:_____ **Date:**_____

Witness Signature(CFM Employee):_____ **Date:**_____