Browning MEDICAL GROUP

Jonathan Slothower, D.O.

Chad Francom, PA-C

Steffainy Hefley PA-C

Welcome!

Thank you for choosing Browning Medical Group for your health care needs. At this time, we would like to take a few minutes to explain our financial policy.

Insurance: Browning Medical Group belongs to PPO/HMO networks utilized by most of the major employers. It is your responsibility to call your insurance company prior to your first office visit to determine the status of your benefits with respect to the amount of your co-payment, deductible, or whether you need preauthorization, etc. Your insurance is a contract between you and your insurance company, but we will gladly bill your insurance if you supply us with your current insurance card and complete, accurate information regarding both the insured and the patient.

You will also be asked on each visit to verify your insurance information for us to maintain the most current information. *Once a year you will be asked to complete a new registration form*. It is your responsibility to notify our office immediately of any changes in your insurance (new insurance carrier, ID numbers, group numbers, etc.). **All charges are your responsibility including those billed to your insurance and not paid within 60 days from date of service**.

Self-Pay: For those of you who don't have insurance we ask for payment at the time of service. If you are unable to pay in full, we will set up payment arrangements, so you don't miss your appointment. If you are unable to pay for subsequent visits you will need to contact our billing office and arrange and payment plan prior to your appointment. Your previous credit history with us will be a factor in their decision.

Payment: We do require your co-payment to be paid at the time of service. You may be asked to reschedule your appointment if you are unable to pay. (If we are contracted with your insurance the contract requires us to collect at time of service.)

We accept cash, Visa, and MasterCard. Statements you receive showing balances owed are your responsibility and are due and payable upon receipt. If your account goes unpaid for 60 days, collection procedures may be started. If your account had been placed with our collection agency for lack of regular monthly payments or ignored attempts for collections one of the following will apply: You will be dismissed for the practice (doctor's decision), or all future office visits will have to be paid at 100% at the time of service. This same policy will apply to all accounts that have filed for bankruptcy.

IF you have questions regarding our financial policy, please contact our billing office at (775) 778-3437 ext. 109.

AGREEMENTS: By signing below you acknowledge that you have read and understand our financial policy.

_____ _____

Signature Date

07/11/23

Payment and Attendance Policy Agreement, Browning Medical Group

To ensure that Browning Medical Group receives fair compensation for medical care given to me and the community, I agree to the following:

1. My insurance is billed out of courtesy. I am responsible for all bills and charges associated with my visit to Browning Medical Group. If my insurance does not pay Browning Medical Group for the visit in a timely manner (within 60 calendar days from when the charges were submitted) I will be responsible for making sure the charges are paid. If I do not pay any outstanding charges within 30 days (90 calendar days from when charges were submitted), or set up a payment plan, I can be sent to collections.
2. If my account has been sent to collections and then my insurance pays for those charges, Browning Medical Group can refuse payment from my insurance company. Once my account has gone to collections, I understand that I, and my insurance company, will have to deal with the collections company.
3. Browning Medical Group has an agreement with my insurance in terms of discounts for procedures and visits. If my outstanding balance goes to collections, the charges will revert to their original amount, and the discount given to the insurance company will be revoked.
4. If I have a family balance of more than $250, and a payment plan is not set up, I will have to pay 50% of my outstanding balance and set up a payment plan before I can receive services from Browning Medical Group.
5. Copays are due at the time of the visit. If my copay is temporarily waived (on an individual case basis) I agree to pay it in full within 14 days.
6. Any discount given to me for a payment, or a payment plan is dependent on me meeting my payment plan obligations, should I violate that agreement, the discounts are null and void.
7. For Browning Medical Group to recoup costs associated with collections, I agree that if my account goes to collections, Browning Medical Group may charge me a service fee equal to 50% of the original balance that will be added to the original balance.
8. ***If I miss an appointment without notifying Browning Medical Group 24 hours in advance***, I will be charged a $50 no-show fee and agree to pay it within 30 days of receiving the bill for it. If I cancel appointments for any family member within 24 hours, I will be charged a $50- no show fee. If I cancel more than 3 times, or if I no-show more than 3 times, Browning Medical Group has the right to dismiss me from the practice***. If I am more than 5 minutes late to an appointment***, Browning Medical Group may require my appointment to be rescheduled. **_____ Patient Initials**

9. If I don't have my insurance card at the time of service, Browning Medical Group has the right to refuse service and I may need to go to the ER if it is an urgent care matter.

Signed: _____ Date: _____

Print Name: _____

07/11/23

Patient Information:

Name: _____ Date of Birth: _____

Record Requested From:

Facility Name: _____ Fax Number: _____ Phone

Number: _____ City/State: _____

Record to be Sent to:

Browning Medical Group **(**775) 778-3437 phone

1780 Browning Way (775) 778-3652 fax

Elko, NV 89801

Records Requested:

□ All Medical Records

□ Immunization Record

□ Behavioral Health Records

□ Lab Results

Purpose:

□ Personal Use

□ Coordination of Care

□ Legal

□ Transfer of Care

□ Disability

□ Other _____

Patient Signature:

I hereby certify that I am: 1. At least 16 years of age if requesting Behavioral Health and/or substance use disorder records, or at least 18 years of age if requesting medical records. 2. The parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age. I hereby authorize disclosure of health information for the above-mentioned patients(s). This authorization is valid for one year from the date of signature. I understand that I may cancel this request with written notification, but it will not have any effect on information released prior to notification of cancellation.

Authorized Signature: _____ Date: _____

Disclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

HIPPA Authorization Form

Patient Authorization for Use and Disclosure of Protected Heath Information

By signing I authorize Browning Medical Group and its employees, including Dr Jonathan Slothower and Chad Francom, to use and disclose certain protected health information (PHI) about me.

This authorization permits Browning Medical Group to access and/or disclose the individually identifiable heath information about me during medical care, as well as any information collected following medical care or consultation given to me in a hospital, emergency room or via telephone interaction with any employees of Browning Medical Group.

Disclosure of such information will be for the purpose of referral to a subspecialist or another general practitioner, after discussing and documenting the need for such a referral. The information may also be shared with a medical provider who, at the time the information is requested, is actively participating in the medical care of the patient represented by this form. The purpose(s) will be provided so that I can make an informed decision whether to allow release of the information.

Browning Medical Group will not receive payment from a third party in exchange for disclosing the PHI, except in the case where such information is requested by the insurance company or third-party payer that is financially responsible for part or all the medical expenses that I have accrued while being associated with Browning Medical Group.

By signing, I authorize Browning Medical Group to access my child's previous prescription medication history. With this consent, Browning Medical Group may telephone/e-mail my home, or other locations that I designate, any items that may assist the practice in carrying out treatment plan options, such as appointment reminder cards and patient statements.

I do not have to sign this authorization to receive treatment from Browning Medical Group. I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Written revocation must be submitted to:

Browning Medical Group
1780 Browning Way
Elko NV 89801

Signed by: _____
Signature of Patient

_____ _____
Print Patient's name Date

Patient Information

Name (Last/First/MI): _____DOB: _____

Sex: [ ] Male [ ] Female

Sexual orientation: [ ] Lesbian, gay or homosexual [ ] Straight or heterosexual [ ] Bisexual

[ ] Something else, please describe [ ]Don't know [ ]Choose not to disclose

Gender identity: [ ]Identifies as Male [ ]Identifies as Female [ ]Transgender Male/Female-to-Male (FTM)

[ ] Transgender Female/Male-to-Female(MTF) [ ] Gender non-confirming (neither exclusively male or female) [ ]Additional gender category/other, please specify

[ ]choose not to disclose

Assigned sex at birth: [ ]Male [ ]Female [ ]Choose not to disclose [ ]unknown

Pronouns: [ ]he/him [ ] she/her [ ] they/them

Marital Status: [ ]Married [ ]Divorced [ ]Separated [ ]Remarried [ ]Never Married

Street Address: _____City: _____ State: _____ Zip Code_____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email Address: _____

Occupation: _____

Race: [ ] American Indian/Alaskan Native [ ] Asian [ ] Native Hawaiian/Pacific Islander

[ ] Black/African American [ ] White [ ] Hispanic [ ] Other [ ] Declined

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Declined

Primary Language: [ ] English [ ] Spanish [ ]
Other: _____

Referred by: [ ] Hospital [ ] Insurance [ ] Family/Friend

[ ] Internet/Phone Book [ ] Promotional Ad [ ]Other:_____

Preferred Pharmacy: _____

Other family members seen here: _____

Previous Provider and their location: _____

We send out Announcements if we are Closed via Text, Email and Phone calls. Please choose your preferred method of communication.

Email _____ Phone _____ Text _____

Responsible Party Information

Name: _____Phone: _____

Street Address (If different from above): _____

City; _____ State: _____ Zip Code: _____

Employer's Name: _____ Employer's Phone: _____

Employer's Address: _____

Insurance Information

Insurance Name: _____

Member Id: _____ Group #: _____

Name of Primary Insurance Holder: _____

Policy Holder's Birth Date: _____

Insurance Name: _____

Member Id: _____ Group #: _____

Name of Primary Insurance Holder: _____

Policy Holder's Birth Date: _____

Emergency Contact Information

Name (Last/First): _____Relationship to Patient: _____

Home Phone Number: _____ Other Number: _____

Medical History:

List all your **medications**, including frequency and dosage (including over-the-counter medications, vitamins/supplements, and alternative therapies):

_____
_____
_____
_____
_____
_____
_____

Are you allergic to anything? _____

Please list any **medical problems, past or present**, that you have been treated for by a medical provider (examples: asthma, allergies, ADHD, congenital malformations, diabetes): _____

_____

Please list any surgeries and/or hospitalizations with approximate dates: _____

_____

Please list any **colonoscopies** with date and result: _____
_____

Please list any **mammograms** with date and result:_____

_____

Please list the date of your last **pap smear** with date and result:_____

Please check any illnesses, if known, pertaining to the relatives listed below:

	Deceased	Diabetes	High Blood Pressure	Heart Disease	Autoimmune Diseases	Psychiatric Problems	Congenital Disease	Asthma	Other (please list)	History Unknown
Mothers Family										
Fathers Family										

Social History:

Please list all people included in your household that you live with: _____

_____

Does anyone that lives in the home smoke? [ ] Yes [ ] No If yes, how much?

_____

_____

Are there pets in the home? [ ]Yes [ ]No If yes, what kinds and how many?_____

_____

Do you use alcohol? [ ] Yes [ ] No If yes, how much?_____

_____

Do you use tobacco? [ ]Yes [ ]No if yes, how much?_____

_____

Do you use Drugs? [ ]Yes No[ ] if yes, how much? _____

_____