

**DR. ALBERT AND PATRICIA ALESSI'S**  
**FINANCIAL POLICY**

THANK YOU FOR CHOOSING DR'S ALBERT AND PATRICIA ALESSI AND ERIN BROUILLARD, PA AS YOUR HEALTHCARE PROVIDERS. WE ASK THAT YOU READ AND SIGN THE FOLLOWING FINANCIAL POLICY STATEMENT SO THAT WE HAVE A MUTUAL UNDERSTANDING ABOUT OUR BILLING PRACTICES. ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORMS BEFORE SEEING THE DOCTOR.

ON YOUR INITIAL VISIT, PLEASE BRING IN A LIST OF MEDICATIONS ALONG WITH YOUR INSURANCE CARD(S) AND PHOTO ID. WITHOUT YOUR INSURANCE CARD(S) WE ARE UNABLE TO PROCESS ANY MEDICAL CLAIMS. YOU NEED TO EITHER RESCHEDULE OR PAY FOR THE VISIT AT THE TIME OF SERVICE.

WE CANNOT GUARANTEE THAT WE ARE A PARTICIPATING PROVIDER WITH YOUR INSURANCE.

IT IS THE PATIENTS RESONSIBILITY TO KNOW THEIR INSURANCE POLICY. ALL PATIENTS WILL BE RESPONSIBLE FOR ANY OFFICE COPAYS, YEARLY DEDUCTIBLES AND ANY NON-COVERED BENEFITS AT THE TIME OF SERVICE. WE EXPECT THE SAME RESPONSIBILITY FROM OUR PATIENTS AS ANY OTHER SERVICE INDUSTRY, FOR OUR TIME AND EFFORT. WE ACCEPT VISA, CASH AND CHECKS.

NO SHOW POLICY: IT IS YOUR RESPONSIBILTY TO SHOW UP FOR YOUR APPOINTMENTS. APPOINTMENTS YOU BOOK ARE TIME WE SPECIFICALLY SET ASIDE FOR YOU. OTHER PATIENTS AND NEW PATIENTS SOMETIMES CANNOT GET IN TO BE SEEN BECAUSE NO APPOINTMENTS ARE AVAILABLE. WE WILL GIVE YOU AN APPOINTMENT REMINDER CARD IF YOU MAKE YOUR APPOINTMENT IN THE OFFICE. WE ALSO MAKE EVERY ATTEMPT TO CONFIRM YOUR APPOINTMENT 24 HOURS IN ADVANCE AS A COURTESY TO YOU. UNFORTUNATELY, WE CANNOT ALWAYS GET THROUGH FOR REASONS BEYOND OUR CONTROL. IF YOU DO NOT SHOW UP FOR YOUR APPOINTMENTS WITHOUT A 24 HOUR CANCELLATION NOTICE YOU WILL BE RESPONSIBLE FOR A NO SHOW FEE OF \$25.00.

I HAVE READ AND UNDERSTAND MY FINANCIAL RESPONSIBILITIES AS OUTLINED ABOVE.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

**PATIENT INFORMATION- PLEASE PRINT CLEARLY AND LEGIBLY**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI

Social Security # \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Martial Status \_\_\_\_\_

**Permanent Address (Main Residence/Physical)**

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Tele #( ) \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

**Extended Address (Other/ Mailing/ PO Box/ Local)**

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

**If Patient Is a Child**

Parents Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone # if different than listed above ( ) \_\_\_\_\_

**EMPLOYER INFORMATION:**

Employer Name \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF SERVICE. INSURANCE WILL BE BILLED AS A COURTESY. PLEASE PRESENT ANY INSURANCE INFORMATION ALONG WITH THIS FORM.**

**INSURANCE INFORMATION:**

Primary Insurance \_\_\_\_\_ Social Security # \_\_\_\_\_

Group # \_\_\_\_\_ Effective Date \_\_\_\_\_ Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Social Security # \_\_\_\_\_

Group # \_\_\_\_\_ Effective Date \_\_\_\_\_ Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Release of Information:**

I authorize the release of any medical or other information necessary in order of Alessi Family Care to process any insurance claims as result of treatment.

\_\_\_\_\_  
Date: \_\_\_\_\_  
Patient or Authorized Person's Signature

**Assignment of Benefits:**

I authorize payment of medical benefits to Alessi Family Care for any services provided while a patient at Alessi Family Care.

\_\_\_\_\_  
Date: \_\_\_\_\_  
Patient of Authorized Person's Signature

## ALESSI FAMILY CARE

Welcome to our office. Thank you for choosing us as your health care provider. Please contact our staff with any questions regarding our policies.

To avoid any misunderstanding regarding this policy, it is necessary for you to read and sign/ initial this financial policy before treatment. This policy also covers any laboratory and radiology testing at this facility.

- 1) **PAYMENT AT THE TIME OF SERVICE:** Payment is due in full at the time of service unless by Medicare or Insurance Company. \_\_\_\_\_
  
- 2) **MEDICARE PATIENTS:** We are participating physicians with Medicare. You will be responsible for 20% of the approved Medicare fee, the \$100.00 yearly deductible and full payment of any non-covered services. Non-covered services include but are not limited to complete annual physical exams, immunizations, screening diagnostic tests and any other service Medicare considers not medically necessary. As a courtesy, we will file your claim with a secondary insurance, although you will be responsible for any remaining balance if payment is not received. \_\_\_\_\_
  
- 3) **INSURANCE:** Patients will be asked to present their insurance cards upon check-in at our office when they are seen for medical services. We do require verification of insurance coverage prior to medical treatment. You will responsible at the time of service for the above mentioned non-covered services, co-payment, and deductible amounts. Any pre-certification of procedures or network referrals is ultimately your responsibility. Please let us know in advance if your insurance requires this. \_\_\_\_\_
  
- 4) **COLLECTIONS:** Please note if payment is not received from either you or your insurance company with in 90 days from the date of service, your account will be subject to referral with a collection agency. You will be responsible for their additional fees in addition to account balance. \_\_\_\_\_
  
- 5) **CANCELLATIONS:** We require a 24 hour notice for cancellations of your appointment. Patients will be billed a \$25.00 missed appointment fee if our office is not properly notified. This is in order to accommodate all of your patients needs. \_\_\_\_\_
  
- 6) **PHYSICAL:** We require a yearly physical to be file at our office on all patients. \_\_\_\_\_

### CONSENT FOR TREATMENT

The undersigned is presenting himself/ herself for medical services to Alessi Family Care and voluntarily consent to the rendering of such care including diagnostic procedures and medial treatment.

PATIENT SIGNATURE/DATE \_\_\_\_\_

GUARDIAN SIGNATURE (if patient is a minor) \_\_\_\_\_

I HAVE READ THE FINANCIAL POLICY AND CONSENT FOR TREATMENT.  
I UNDERSTAND AND AGREE TO THIS POLICY AND CONSENT.

**ALESSI FAMILY CARE  
PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Occupation \_\_\_\_\_  Retired  Male  Female  
 Marital Status \_\_\_\_\_ Contact in case of Emergency \_\_\_\_\_  
 Emergency Contact's Phone Number \_\_\_\_\_

Living Will: Y/N

Reason for visit today: \_\_\_\_\_

**FAMILY HEALTH HISTORY**

Please check if adopted

	Living	Deceased
Father medical illnesses _____	<input type="checkbox"/>	<input type="checkbox"/>
Mother medical illnesses _____	<input type="checkbox"/>	<input type="checkbox"/>
Brother / Sister illnesses _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
Children's medical illnesses _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

**IMMUNIZATIONS (include date)**

Pneumonia \_\_\_\_\_  
 Influenza (flu) \_\_\_\_\_  
 Tetanus \_\_\_\_\_

**HOSPITALIZATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATION (include aspirin, birth control)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATION ALLERGIES**

\_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY Y/N**

tobacco    
 alcohol    
 exercise    
 caffeine

**MEDICAL DATA (include date)**

Physical Exam \_\_\_\_\_  
 Chest X-Ray \_\_\_\_\_  
 Colonscopy/Sigmoidoscopy \_\_\_\_\_  
 EKG \_\_\_\_\_  
 Bone Density/ DEXA \_\_\_\_\_  
 PAP (females ) \_\_\_\_\_  
 Mammogram \_\_\_\_\_  
 Prostate Exam/PSA \_\_\_\_\_  
 Bloodwork \_\_\_\_\_

**SURGERIES**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL HISTORY**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> anemia             | <input type="checkbox"/> aneurysm            | <input type="checkbox"/> arthritis        | <input type="checkbox"/> blood transfusion        |
| <input type="checkbox"/> cancer, tumor      | <input type="checkbox"/> depression          | <input type="checkbox"/> diabetes         | <input type="checkbox"/> drug abuse               |
| <input type="checkbox"/> epilepsy, seizure  | <input type="checkbox"/> eye problems        | <input type="checkbox"/> heart attack, MI | <input type="checkbox"/> heart disease            |
| <input type="checkbox"/> hemorrhoids        | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> liver disease, hepatitis |
| <input type="checkbox"/> lung disease       | <input type="checkbox"/> night sweats        | <input type="checkbox"/> osteoporosis     | <input type="checkbox"/> rectal bleeding          |
| <input type="checkbox"/> seasonal allergies | <input type="checkbox"/> stroke,CVA,TIA      | <input type="checkbox"/> suicide          | <input type="checkbox"/> ulcer,reflux, GERD       |
| <input type="checkbox"/> venereal disease   | <input type="checkbox"/> weight change       | <input type="checkbox"/> other _____      |   |