



HIPAA Consent Form

Terms and Conditions

Consent for Release of Information: I authorize Southwest Family Physicians to use and disclose my health information in order to make decisions about and plan for my care and treatment; refer to consult with, coordinate among and manage along with other health care providers; determine my eligibility for health plan or insurance coverage and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and perform various office, administrative, and business functions that support my doctor’s efforts to provide, arrange, and be reimbursed for my care.

I understand and consent that health information received or created in the course of the delivery of health care at Southwest Family Physicians will be used in accordance with the Southwest Family Physicians Notice of Privacy Practices, which is posted in the waiting/reception area. A copy of the Notice of Privacy Practices is available upon request for my review.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the matter described in the Notice of Privacy Practices, and I understand that Southwest Family Physicians is not required by law to agree to such requests.

To support accurate and efficient documentation, some of the healthcare providers use secure virtual assistants or AI-powered scribing tools during visits. All information is handled in accordance with HIPAA regulations and privacy standards. By signing this form, I acknowledge and consent to the use of such technologies as part of my care.

Credit Policy

Statement of Financial Responsibility: I understand that insurance billing is done as a courtesy and that I am ultimately responsible for my account. I agree to pay each provider of service, in accordance with their regular rates and terms, for the services rendered. I hereby authorize my insurance benefits to be paid directly to the physicians and know that I am financially responsible for non-covered services. I also understand that it is my responsibility to determine my insurance coverage, including whether there is an existing contractual relationship between my insurance company and Southwest Family Physicians and if my insurance covers naturopathic services which are provided here at this clinic.

I agree to pay all amounts due within thirty (30) days of receiving a statement. I agree to pay a \$40 fee for any check returned due to insufficient funds. Paper statements printed and mailed after the second billing cycle will incur a \$10 fee. I understand that if payment is not received within ninety (90) days, my account may be referred to a collection agency for collections. I understand I will also be liable for attorney fees.

Southwest Family Physicians is able to offer payment plans to patients who have a financial hardship on a case by case basis. I understand that in order to apply for this consideration, I must make arrangements through the billing department.

Patient Full Name

Date of Birth

Insurance Carrier

Member ID

Group Number

Insurance Subscriber Full Name (if not self)

Subscriber Date of Birth (if not self)

Signature

Today’s Date



Our Financial Alliance

(It is ESSENTIAL that you carefully read the following)

We strive to eliminate surprises by creating an easy-to-understand partnership in the settlement of your account!

It's important to us that the quality of our business services matches the quality of our medical care. We want the handling of your account, from your initial copay to final payments, to be an extension of the care we provide you and your family.

Your Role as Our Patient

As with any partnership, both parties have a role to play. Our role is to provide you with quality care and service. In turn, your role is to pay for your care in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an arrangement made, our joint follow-through will result in a win for everyone.

Don't hesitate to ask: We will always try to work with you to plan for your present and future care and financial needs.

We ask all patients to complete the information and insurance lines at the top of Page 1 before seeing the doctor. This information helps us get the best result based on your insurance coverage. We are happy to file all insurance claims for you. *Please understand that you remain responsible for paying all balances due after your insurance company has paid the covered charges.*

Co-pays

We are required by your insurance company to collect copayments prior to offering care. Please come prepared to pay your copay prior to seeing your doctor.

What is your preferred method of paying your copay? Cash Check Debit/Credit Card *(Please Circle One)*

If you have questions concerning your co-pay amount, please call our office 24 hours prior to your appointment.

Paying Remaining Balances After Treatment

Option 1: Our practice requires that you place a credit or debit card on file to resolve any remaining balances after treatment. You will receive detailed statements about your treatment, and we will use your card-on-file information for payment of those invoices.

Option 2: If the balance of your account exceeds what you can pay in one payment, we will work with you to set up automatic payments you can afford. These plans are offered on a case-by-case basis and are subject to our practice policies and can be arranged with our billing staff.

Agreement (Please read carefully and sign below)

I agree to pay each provider of service, in accordance with their regular rates and terms, for the services rendered. I hereby authorize my insurance benefits to be paid directly to the physicians and know that I am financially responsible for non-covered services. I also understand that it is my responsibility to determine my insurance coverage, including whether there is an existing contractual relationship between my insurance company and Southwest Family Physicians.

I agree to allow Southwest Family Physicians to use my card-on-file to resolve my outstanding balances, unless I pay by cash, check, or debit/credit card prior to my account reaching the 30-day mark. I agree to pay a \$40 fee for any check returned due to insufficient funds. Paper statements printed and mailed after the second billing cycle will incur a \$10 fee. I understand that if payment is not received within ninety (90) days, my account may be referred to a collection agency for collections. I understand I will also be liable for attorney fees.

Southwest Family Physicians can offer payment plans to patients who have a financial hardship on a case-by-case basis. I understand that in order to apply for this consideration, I must make arrangements through the billing department.

Patient Full Name

Date of Birth

Signature

Today's Date