CHISOVEREIGN

P: (703)-246-0011

F: (703)-246-0012

www.ChiSovereign.com

PATIENT UPDATE FORM

Dear Patient:

Please complete the attached form for any demographic changes to your account: example: change in home, work or cell numbers, change of address, CHANGE IN INSURANCE COVERAGE, pharmacy change.

Once the form is completed you can email, fax or mail it to us:

Email: admin@chisovereign.com

Subject: Patient update

Fax to 703-246-0012 Attn: Patient Registration

Mail it back to Chisovereign

3975 Fair Ridge Drive, Suite 150N, Fairfax, VA 22033

IF REPORTING AN INSURANCE CHANGE – PLEASE MAKE SURE ALL THE SUBSCRIBER INFORMATION IS COMPLETE IN THE INSURANCE SECTION AND MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE

IT IS ESSENTIAL FOR US TO HAVE A COPY OF THE CARD AND FOR YOU TO FILL OUT THE INSURANCE SECTION OF THE FORM BECAUSE THE PATIENT IS NOT ALWAYS THE SUBSCRIBER ON THE INSURANCE POLICY.

Any questions, please call front desk for assistance at 703-246-0011 ext. 10

Thank you for your cooperation.

Chisovereign, PLLC

PATIENT INFORMATION UPDATE

(If you have not been seen in the last 9 months or any information has changed, please fill out))

Date_____ (Please Print)

PATIENT INFORMATION

Name_____ Soc. Sec # _____
Last Name First Name Initial

Address_____

City_____ State_____ Zip_____

Email_____

Sex M / F (circle one) Age_____ Birthdate_____ Single Married Widowed Separated Divorced (circle one)

Race:_____ Ethnicity: Non-Hispanic or Hispanic (circle one)

Preferred Pharmacy Name/Address/Phone _____

Home #_____ Work #_____ Cell #_____

PRIMARY INSURANCE NAME: _____ Effect Date_____

Policyholder Name:_____ DOB:_____ SSN_____

Address (if different from patient) _____

ID# _____ GROUP#_____

Relationship to Insured: SELF SPOUSE CHILD OTHER _____

SECONDARY INSURANCE NAME: _____ Effect Date_____

Policyholder Name: _____ DOB:_____ SSN_____

Address (if different from patient) _____

ID# _____ GROUP#_____

Relationship to Insured: SELF SPOUSE CHILD OTHER _____

Authorization for Assignment of Benefits/ Release of Information/ Financial Agreement

I authorize **Chisovereign, PLLC (Chisovereign)** to apply for benefits from my insurance carrier and further authorize payment directly to Chisovereign for the medical and/or mental health benefits, if any, otherwise payable to me for services rendered by Chisovereign. I understand that this service is available for health plans that Chisovereign participates and will only be submitted for the primary insurance plan unless my primary plan is Medicare.

I further authorize the release of medical/mental health information required by my insurance carrier or its designated review agent, required for payment, or (if applicable) my employer's worker's compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of Chisovereign. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or by the insurance carrier at any time in writing. I hereby assume financial responsibility for and agree to make payment in full to Chisovereign for all charges for services provided to the above-named patient not otherwise authorized or paid by my insurance carrier.

Payment is to be made within fourteen (14) days as statements are presented with settlement in full, or payment arrangements to be made with Chisovereign. I certify that the information given is true, accurate, and complete to the best of my knowledge, and further authorize Chisovereign to investigate any and all information given concerning this or related claims.

Policies and Procedures

PRESCRIPTION REFILLS: Refills not made during scheduled visits may be requested via email, fax, or phone. If you choose to utilize our prescription refill service, you will be charged an administrative fee of $25 that will not be billed to or reimbursed by your insurance carrier.

LATE CANCELLATIONS/MISSED APPOINTMENTS POLICY: We understand there are times when you must miss an appointment due to emergencies or obligations to work and family. If an appointment is not cancelled at least 24 hours in advance, you personally will be charged a **$60.00** cancellation fee, (you, not your insurance company). If you fail to show or call, you will be charged an **$80.00** no show fee. Should you cancel less than 24 hours prior to, or fail to show up for your scheduled initial evaluation, you will be held responsible for evaluation fee

FEES: At the time of your visit, we will be glad to discuss our fee structure for specific diagnostic or treatment procedures. You will be expected to pay your deductible and/or co-payment at the time of each visit. We will bill your primary insurance carrier if you have signed the authorization section below and if we participate with your health plan.

INSURANCE COVERAGE: Insurance companies and employer plans vary significantly in how they administer mental health benefits. We strongly urge you to know what deductibles, co-payments, visit and/or benefit limitations, authorization requirements, and exclusions your plan may include. If we have submitted a claim to your carrier, we will receive an Explanation of Benefits (EOB) from the plan. Chisovereign will use this information to determine your responsibility for full payment. You should review the EOB that is sent to you by the plan carefully. If you feel that they have made an error in administering your benefits, please call them directly to have it corrected. We will use the EOB as a final determination of benefits available.

NOTIFICATION OF CHANGES
We ask that you notify our office immediately of changes in the following information:
~ Name, address, or phone number changes
~ Change in Insurance Carrier
~ Change in Primary Care Physician
~ Change in marital status

RETURNED CHECKS: There is a $25 (Twenty-five) charge for any returned check from your bank.

I understand and agree to abide by the above policies and procedures:

Responsible Party Signature_____ Date of Signature___/___/___