UB|MD PRIMARY CARE

UBMD Primary Care

Jennifer S. Abeles, DO
Michael Aronica, MD
Andrew Baumgartner, MD
Roseanne Berger, MD
Scott Darling, MD
Frederick Michael Elliott, MD
Steven Foulis, MD
Deepa Gosine, MD
Kevin Hughes, MD
Marlon Koenigsberg, PhD
Peter Kowalski, MD
Michelle Lombardo, MD
Robert Macek, MD
Andrea Manyon, MD
Shirley Mazourek, LCSWR
Ashley McCorkle, MD
Daniel Morelli, MD
David Newberger, MD
Sangrok Oh, DO
Christina L. Padgett, DO
Gregory Schenk, MD
Andrew Symons, MD, MS
David Thomas, MD
Diana Wilkins, MD
Kimberly Wilkins, MD
Sarah Adams, PA
Ashley Coe, PA
Katherine Duman, PA
Lauren Merkle, PA
Julie Schmidt, PA

For more:

ubmd.com
ubmdprimarycare.com

A MEMBER OF

UB|MD PHYSICIANS' GROUP

Welcome to UBMD Primary Care!

Thank you for selecting your Primary Care Physician with UBMD Primary Care. An appointment has been reserved for you on:

_____ with Dr. _____.

Before your first visit:

- Call your health insurance company and list Dr. _____ as your new Primary Care Physician (PCP). Some insurance companies require this.
- A medical record release has been enclosed for your convenience, or, if you prefer, you may contact your current primary care physician's office directly to request that your records be transferred to our office.
- Please complete the enclosed New Patient Health History and sign the enclosed Financial Policy. Please return the enclosed forms to us no later than _____ (by mail, fax or drop off).

Please Note: Failure to return the completed patient information forms by the above date will result in the automatic cancellation of your new patient appointment. We thank you in advance for your cooperation regarding this policy.

On your first visit, please bring:

1. Your current insurance card
2. Your co-pay/co-insurance or deposit (if applicable). We accept cash, check, Visa, MasterCard, Discover, and American Express.
3. Government-issued photo ID
4. All medication bottles

Please arrive 20 minutes prior to your scheduled appointment time. If you need to cancel your appointment for any reason, please allow a minimum of 24 hours' notice.

WELCOME!

Amherst Office
850 Hopkins Road
Williamsville, NY 14221
Phone: 716.688.9641
Fax: 716.932.7465

Conventus Office
1001 Main Street, 4th Floor
Buffalo, New York 14203
Phone: 716.550.8361
Fax: 716.323.0585

Sheridan Office
2465 Sheridan Drive
Tonawanda, NY 14150
Phone: 716.835.9800
Fax: 716.835.9876

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Our Policy

Follow-Up Appointments:

- If you are more than 15 minutes late for your scheduled appointment, we reserve the right to reschedule your appointment to another day. If you are excessively late for 3 scheduled appointments, or NO SHOW for 2 appointments, we reserve the right to discharge you from our practice.
- All co-payments and co-insurances are due in full at the time of your visit.
- Same day appointments are available for urgent issues.
- We provide equal appointment availability for all of our established patients regardless of insurance status or type of insurance.

Prescriptions:

- NO prescriptions (new or refills) can be written for new patients until you have been in our office to establish care.
- Future refill requests for routine/maintenance medication should be requested through your pharmacy. Your pharmacy will contact us electronically if a prescription is needed.
- Refills are authorized by your provider (or covering provider) within 1-2 business days.
- Prescriptions for controlled substances may not be filled at your first new patient appointment. This will be done at the discretion of the Provider.

If you have any questions, please feel free to contact the office.

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UB|MD PRIMARY CARE

NEW PATIENT HEALTH HISTORY

Please **take time** to provide the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs. **Please address every section**.

PATIENT NAME:	DATE OF BIRTH: / /	PREFERRED PRONOUNS: ☐ he/him ☐ she/her ☐ they/them

MEDICAL HISTORY

*Please fill in date of onset for any conditions you have had in the past, and **check box for any conditions that you still have**.*

Condition	Date of Onset	Condition	Date of Onset	Condition	Date of Onset
☐ NONE		☐ Hiatal hernia	_____	☐ Arthritis	_____
☐ Migraine headaches	_____	☐ Chronic heartburn	_____	☐ Gout	_____
☐ Seizures or convulsions	_____	☐ Stomach ulcer	_____	☐ Broken bones (Type: _____)	
☐ Stroke	_____	☐ Duodenal ulcer	_____		_____
☐ Glaucoma	_____	☐ Hepatitis	_____	☐ Varicose veins	_____
☐ Cataracts:	_____	☐ Cirrhosis	_____	☐ Phlebitis or blood clots	_____
Circle: Left Right Both		☐ Gall stones	_____	☐ Bleeding problems	_____
☐ Recurrent ear infections	_____	☐ Colon or bowel trouble	_____	☐ Sickle cell	_____
☐ Hay fever/allergic nose	_____	☐ Dysentery or severe diarrhea		Circle: Trait Disease	
☐ Chronic sinusitis	_____		_____	☐ Anemia	_____
☐ Asthma	_____	☐ Rectal trouble	_____	☐ Cancer (Type: _____)	
☐ Chronic bronchitis	_____	☐ Chicken pox	_____		_____
☐ Emphysema	_____	☐ Mumps	_____	☐ HIV infection/AIDS	_____
☐ Tuberculosis	_____	☐ Measles	_____	☐ Gonorrhea	_____
☐ Overactive thyroid	_____	☐ Polio	_____	☐ Syphilis	_____
☐ Underactive thyroid	_____	☐ Diabetes	_____	☐ Genital herpes infection	_____
☐ Goiter	_____	☐ Breast lump(s)	_____	☐ Anxiety	_____
☐ Heart murmur	_____	☐ Skin problems	_____	☐ Depression	_____
☐ Heart attack	_____	☐ Hemorrhoids	_____	☐ Emotional problems	_____
☐ Angina	_____	☐ Urinary Incontinence	_____	☐ Nervous breakdown	_____
☐ Enlarged heart	_____	☐ Recurrent urinary infections		Women:	
☐ Rheumatic fever	_____		_____	☐ Menstrual difficulties	_____
☐ High blood pressure	_____	☐ Kidney stones	_____	☐ Abnormal PAP	_____
Men:		☐ Other kidney disease	_____	☐ Ovarian cyst(s)	_____
☐ Prostate trouble	_____	☐ Other: _____		☐ Gestational diabetes	_____
☐ Erectile Dysfunction	_____	☐ Other: _____		# of pregnancies:	_____
				# of births:	_____

PAST MEDICAL HISTORY *Please list any Surgeries, Procedures, Hospitalizations **NOT ALREADY NOTED ABOVE**.*

Procedure/Reason/Diagnosis	Date	Procedure/Reason/Diagnosis	Date
☐ **NONE**		5.	
1.		6.	
2.		7.	
3.		8.	
4.		Please use a separate sheet of paper to list any others.	

PATIENT NAME:	DATE OF BIRTH:

IMMEDIATE FAMILY HISTORY *Please complete the following on your biological ("blood") relatives.*

Please write in family member's name and check box if also a patient at this practice.	Living	Deceased	Age	Sex	Chronic Condition(s) - If deceased, Cause of Death
Father: ☐	☐	☐		--	
Mother: ☐	☐	☐		--	
Brothers or Sisters: ☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
Children: ☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	
☐	☐	☐		M F	

FAMILY HISTORY

Please complete the following on your biological relatives NOT COVERED ABOVE. Please note which relatives are affected; if extended family, such as aunt/cousin/grandparent, please note whether on maternal (mother's) or paternal (father's) side.

Condition	Relation	Condition	Relation	Condition	Relation
☐ Stroke	_____	☐ Bleeding problems	_____	☐ Diabetes	_____
☐ Heart trouble	_____	(Type: _____)		☐ Birth defects	_____
(Type: _____)		☐ Clotting disorders	_____	(Type: _____)	
☐ Early heart disease	_____	☐ Cancer, including leukemia	_____	Other: Condition	Relation
(males under 55, females under 65)		(Type: _____)		☐ _____	_____
				☐ _____	_____

YOUR CARE TEAM *Please list any specialists or other health care providers involved in your care, including OB/GYN, oxygen companies, visiting nurse agencies, etc.*

☐ **NONE**

Location seen at:

Location seen at:

Location seen at:

Location seen at:

Location seen at:

PATIENT NAME:	DATE OF BIRTH:

SOCIAL/PERSONAL HISTORY *Please complete the following information about yourself.*

Current Employment Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Student ☐ Stay-at-home

Current Occupation: _____

Have you ever worked in a job where you were exposed to hazardous environment or chemicals? Y / N

If Yes, when and what: _____

Highest Education Completed:

☐ Grade: _____ ☐ High School ☐ College: _____ years; Degree/Major: _____

☐ Post-graduate: _____

Marital Status: ☐ Single ☐ Married (Date: _____) ☐ Separated (Date: _____)

☐ Divorced (Date: _____) ☐ Widowed (Date: _____) Married: _____ time(s)

Personal Habits: *(check all that apply)*

☐ Never used nicotine

☐ Currently nicotine use: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco ☐ e-Cigarettes

Amount/Day: _____ Years: _____

☐ Former nicotine use: Type/Amount/Day: _____ Years: _____ Quit Date: _____

☐ Exposed to second-hand smoke/nicotine: Amount/Day: _____ Years: _____

Consume alcohol: Y / N Type: _____ Amount/Day: _____

Use recreational drugs or any problems misusing prescription medications: Y / N

If Yes, type: _____ Frequency: _____

Consume caffeine: Y / N If Yes, beverage type: _____

Amount/Day: _____

Exercise regularly: Y / N If Yes, activity type(s): _____

Frequency: _____

Do you wear a seatbelt? Always / Occasionally / Never

Do you eat 5 or more servings of fruit and vegetables most days? Y / N

Do you talk/text on phone while driving? Y / N

Do you have a smoke detector? Y / N

Do you have a carbon monoxide detector? Y / N

Do you have any unsecured guns in the home? Y / N

Sexual orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Would you like to be screened for HIV or sexually transmitted diseases? Y / N

Please describe your comfort level in understanding concepts and care requirements related to managing your health: ☐ No concerns ☐ Occasional difficulty, with guidance/direction feel comfortable ☐ Frequent difficulty, require extra assistance

Living Situation/Circumstances:

Do you live alone? Y / N If No, with whom do you live? _____

Do you have a caregiver? Y / N If Yes, whom: _____

Are you a caregiver for an adult? Y / N If Yes, for whom: _____

Do you have any pets? Y / N If Yes, type/how many: _____

Do you have a good support network of family/friends? Y / N If No, please explain:

_____

PATIENT NAME:	DATE OF BIRTH:

Do you have concerns about meeting basic needs for shelter, food, medication or clothing? Y / N If Yes, would you like information on resources that may be of assistance to you? Y / N

Do you have any communication needs due to hearing, seeing or other issues such as memory or difficulty understanding or reading? Y / N If Yes, please explain: _____

Do you have any cultural, spiritual or personal beliefs that affect your health care needs? Y / N If Yes, please explain:

_____

Do you have a health care proxy? Y / N / Not Sure If Yes, please ensure this practice has a copy for your records.

Do you have advanced care directives? Y / N / Not Sure If Yes, please ensure this practice has a copy for your records.

Would you like to discuss planning Advance Directives at your visit? Y / N

GOAL SETTING *Please complete the following information about yourself.*

What are your healthcare goals for this year? (Examples include: exercise 3 days per week; be able to kneel down and play with my grandchildren) _____

_____

How do you plan to accomplish these goals? _____

What are the barriers, if any? (Examples include lack of healthy food, knowledge, lack of outside exercise or play time, no safe outside environment, family distractions, genetics)

_____

_____

IMMUNIZATIONS & PREVENTIVE SERVICES *Check all that you have had and **PROVIDE DATE** done.*

PLEASE NOTE: All patients under 18 must have vaccine records either attached or transferred by previous provider

	DATE/YEAR
☐ Flu vaccine	_____
☐ HPV/Gardasil	_____
☐ Tetanus	_____
☐ Tdap	_____
☐ Pneumonia vaccine	_____
☐ Prevnar	_____
☐ Zoster Vaccine	_____
☐ Hep B series	_____
☐ Hep A	_____
☐ MMR	_____
☐ Other: _____	

	DATE/YEAR
☐ Dental exam	_____
☐ Eye exam	_____
☐ GC/Chlamydia screen	_____
☐ Hearing test	_____
☐ HIV testing	_____
☐ TB skin test	_____
☐ Other _____	
☐ Last Physical/Annual Exam:	
_____	

*If you are not certain of date, please contact your insurer. If you have already had a physical/annual exam this year, your insurance may not cover a second well visit and this could leave you responsible for payment.

	DATE/YEAR
☐ PAP smear	_____
☐ Mammogram	_____
Where: _____	
☐ Bone density test	_____
☐ PSA	_____
☐ Colonoscopy	_____
Where: _____	
☐ Abdominal Aortic Aneurysm Screening	
_____	
Where: _____	
☐ Other: _____	
☐ NONE	

PATIENT NAME:	DATE OF BIRTH:

ALLERGIES *Include drugs, foods, chemicals, insects, etc. IF NO KNOWN ALLERGIES, PLEASE CHECK "NONE".*

ITEM	TYPE OF REACTION
☐ NONE	

MEDICATIONS

Include all current medications including prescription and over-the-counter herbal/vitamins/supplements. IF NOT ON ANY MEDICATIONS, PLEASE CHECK "NONE".

NAME OF MEDICATION	DOSAGE	HOW OFTEN IS IT TAKEN?	REASON FOR MEDICATION	PROVIDER PRESCRIBING THIS MEDICATION
Example: Aspirin	**81 MG**	**Daily, Twice, Bedtime, etc.**	**Stroke Prevention**	**Dr. John Doe**
☐ NONE				

PATIENT NAME:	DATE OF BIRTH:

PATIENT DEMOGRAPHICS

Street Address:		
City:	State:	Zip:
Social Security #:		
Preferred Phone #:	Alternate Phone #:	
Email Address:		
Primary Language:	If primary language is not English: Do you speak English? Y / N	
Previous Primary Physician:		

RACE	ETHNICITY	SEX	GENDER IDENTIFICATION
☐ Black or African American ☐ American Indian/Eskimo ☐ Asian ☐ Caucasian ☐ American Indian, Alaska Native ☐ Native Hawaiian/Other Pacific Islander	☐ Hispanic or Latino ☐ Not Hispanic nor Latino	☐ Male ☐ Female ☐ Male-to-Female Transgender ☐ Female-to-Male Transgender	☐ Male ☐ Female ☐ Non-Binary ☐ Prefer not to say

EMERGENCY CONTACT Note: If under 18, name of Responsible Parent/Guardian.

Name:	Relationship to you:
Primary Phone #:	Secondary Phone #:

INSURANCE

Primary Insurance Name: _____

Policy Holder: _____ Relationship to Patient: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Member ID: _____ Group #: _____

Secondary Insurance Name: _____

Policy Holder: _____ Relationship to Patient: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Member ID: _____ Group #: _____

Do you use Medicaid transportation to travel to your medical appointments? Y / N

PHARMACY INFO

Do you use a **Mail Order Pharmacy**? Y / N If Yes: Name: Address: Phone #:	**Local Pharmacy** Name: Address: Phone #:

SIGNATURE

_____ _____

Signature **Date**

Your Name, if completed by someone other than the patient: Relationship:

UB|MD PRIMARY CARE

Dear Patient,

We ask all new patients at UBMD Primary Care to completely fill out the records release form on the following page. Please have your records sent to us via fax or mail (paper copies). We are not able to accept CDs, USB drives or password-protected electronic files.

Incomplete forms may be returned and will cause delays in receiving your records.

Welcome to UBMD Primary Care!

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
UBMD Primary Care Medical Records, 77 Goodell Street, Suite 240, Buffalo NY 14203 // FAX: 716.829.2447

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

UB|MD PRIMARY CARE

HIPAA CONTACT FORM

UBMD PRIMARY CARE OF AMHERST
850 Hopkins Road
Williamsville, NY 14221

UBMD PRIMARY CARE AT CONVENTUS
1001 Main Street, 4th Floor
Buffalo, NY 14203

UBMD PRIMARY CARE AT SHERIDAN
2465 Sheridan Drive
Tonawanda, NY 14150

UBMD PRIMARY CARE - ADDICTION MEDICINE
850 Hopkins Road
Williamsville, NY 14221

Patient Name:	**Date of Birth:** / /	**Email Address:**

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the UBMD Primary Care Notice of Privacy Practice (also available at UBMDPRIMARYCARE.COM).

Signature:	Date: / /

☐ Patient refused and/or unable to sign.
Staff member signature:

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY AND/OR FRIENDS

(BE SURE TO INCLUDE YOURSELF)

Name	Relationship	Primary Phone	Secondary Phone

AUTHORIZATION TO LEAVE MESSAGES

From time to time it may be necessary to leave you a message concerning appointments, financial issues, or other protected health information (PHI). Please indicate how you prefer we leave a message for you.

	Phone Number	May we leave a voice message?	May we leave a message with another person answering this phone?
Voice Mail on Preferred Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
Voice Mail on Alternate Phone Number	- -	☐ Yes ☐ No	☐ Yes ☐ No
		May we send a message?	
Send through US Mail		☐ Yes ☐ No	

RESTRICTIONS TO RELEASE OF INFORMATION

Please list any restrictions regarding information to be released:

SIGNATURE

Signature:	Date: / /

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Revised 03.28.2024

UB|MD
PRIMARY CARE

Patient Financial Policy

Thank you for choosing UBMD Primary Care for your medical care. We are dedicated to providing the best possible care for you. We offer the following information to help you understand our financial policy and to aid you in planning for payment.

UBMD Primary Care believes that financial difficulties should not prevent you from receiving the medical care that you need, when you need it. Please contact our Billing Department to discuss any concerns. Payment plans are available if needed. Our Billing Department may be reached at: 1.866.853.9551 Option 4.

Insurance Verification and Co-payments

You are expected to present an insurance card at each visit. We will bill your primary insurance company as a courtesy. Failure to provide complete insurance information to us may result in your responsibility to pay the entire bill. All co-payments, deductibles and past due balances are due at the time of service. Failure to pay your co-pay at time of service will result in an additional $10.00 fee. All payments are expected to be made in U.S. dollars. UBMD Primary Care accepts cash, personal check, and credit card (Visa, MasterCard, American Express, Discover). There is a $35.00 fee for returned checks.

It is your responsibility to be aware of the details of your insurance coverage, including any requirements for referrals or pre-authorization. Not all of our providers participate with all insurance companies. Please verify whether your physician accepts your insurance coverage when scheduling an appointment. In addition, please ensure that you have designated a UBMD Primary Care physician as your Primary Care Physician (PCP) if your insurance company requires you to designate a PCP (not applicable to Addiction Medicine).

Self-Pay Accounts

Patients without insurance coverage, patients without an insurance card on file with the practice, or whose insurance is not accepted by the practice have "self-pay" accounts. This includes patients who have applied for Medicaid who do not yet have a valid Medicaid number. Liability cases are considered self-pay accounts unless a case number is provided. UBMD Primary Care does not accept attorney letters or contingency payments. If there is a discrepancy with the insurance information you provided to UBMD Primary Care, you will be considered self-pay until otherwise proven. If you are a self-pay patient, you will be expected to make a down payment of at least $150.00 at the time of service. If this down payment does not cover all treatment charges, you will be billed for the remaining balance (or issued a refund within 60 days if your overall patient account has a credit balance.

Failure to make your deposit at time of service will result in an additional $10.00 fee.

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High Deductible Plans (Health Savings Accounts or Heath Reimbursement Accounts)
If your insurance is a High Deductible Plan you will be required to make a down payment of at least $75.00 at the time of service. If the total cost of services rendered is more than down payment you will be billed for the remaining amount. If the cost of your visit is less than the down payment we will send you a refund of the difference within 60 days if the deposit causes your overall patient account to have a credit balance.

No-Fault/Workers Compensation
You are responsible for providing our office with all information required to properly submit charges on your behalf (name of insurer, address, claim number, date of injury, etc.). Without this information you will be responsible for payment for the full cost of your visit(s). If you have private insurance with which we participate and you obtain any necessary referrals/authorizations, we will submit on your behalf and bill you for any unpaid balance.

Medicare
We are "participating physicians" with Medicare. This means that we must accept Medicare's allowed charge for services rendered. Traditional Medicare will pay 80% of the approved amount. You are responsible for the remaining 20% plus any deductible that your plan may require. This payment is due at the time of service. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance to your secondary insurance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, must be held responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

Responsibility for Minors
The parent/guardian who holds the insurance policy for the child is considered the guarantor for the child and is responsible for payment regardless of personal circumstances.

No-Show/Cancellation Fee
A fee of $35.00 may be charged for any appointments missed or not canceled at least 24 hours before the scheduled visit. It is your responsibility to notify the office when an appointment needs to be canceled or rescheduled.

Form Completion Fee
There will be a $10.00 service charge for completion of forms not associated with an office visit. This fee is required to be paid at the time of the request. Please allow at least one week for forms to be completed.

UB|MD
PRIMARY CARE

Late Fees
Payment is due within 30 days from the date of the initial billing statement. A $10.00 late fee will be assessed on each statement generated after the first statement until the outstanding balance is paid. Please contact the billing department if you are unable to pay your balance so a payment plan can be set up, and late fees may be avoided.

Referrals and Authorizations
Please be aware of and provide any required referrals or authorizations in advance of the appointment of service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

Past Due Accounts and Failure to Follow Payment Arrangements
Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. If your account is unpaid, and no payment arrangement has been made within 120 days, your account will be turned over to a collection agency.

Financial Difficulties
We encourage our patients to discuss any unexpected financial circumstances with our Billing Department. We realize that financial difficulties may sometimes arise and the Billing Department will work with you to make a payment plan under these circumstances.

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PRIMARY CARE

Release of Information
By signing below, you authorize the release of necessary medical information to UBMD Primary Care for the purpose of processing any claims. You also authorize UBMD Primary Care to release and obtain any information pertinent to your case for purposes of payment.

Assignment of Payment
By signing below, you authorize payment directly to UBMD Primary Care for the surgical and/or medical benefits, if any, otherwise payable to you under the terms of your insurance.

By signing below, you acknowledge that you have read, understand, and will cooperate with the financial policy of UBMD Primary Care.

_____	_____
Patient Name (Printed)	Patient Date of Birth
_____	_____
Patient Signature or Responsible Party if Minor	Date

Policy effective date: 03.24.2014
Last reviewed/revised: 11.29.2017, 02.05.2018, 02.01.2024, 03.28.2024