Saint Alphonsus Medical Group

PATIENT REGISTRATION: PATIENTS 18 YEARS AND OLDER

Date: _____

Patient

Last Name _____ First Name _____ Initial _____

Date of Birth _____ Gender: ☐ Female ☐ Male Email _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Phone (Cell) _____

Phone (Work) _____ Preferred Message/Contact Phone: ☐ Home ☐ Cell ☐ Work

Race (please circle) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other (Multi-racial) Unknown Declined

Ethnicity (please circle) Hispanic or Latino Not Hispanic or Latino Other _____

Preferred Language ☐ English ☐ Spanish ☐ Other _____

Employer _____

Employer Address _____ City _____ State _____ Zip _____

Have you been seen at a St Alphonsus Clinic or Express Care Clinic in the past 3 years? ☐ Yes ☐ No

Who is your current / past primary care provider? _____

Preferred Pharmacy_____ Major Crossroads _____

Health Insurance
(Clinic: If unable to scan card, make copy and attach. If card unavailable, write info on this form.)

Primary Insurance _____ ***(Employer ONLY needed if different from above.)***

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance _____

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Additional Contact (not living with you)

Last Name _____ First Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

Advanced Directives (Living Will)

Would you like more information about Advance Directives? ☐ Yes ☐ No

Brochure Provided? ☐ Yes ☐ No

People assisting with paperwork:

Interpreter's name	Interpreter's Signature and/or ID #	Date and Time
Office Staff name	Office Staff Signature	Date and Time

Place patient sticker here or handwrite

Name: _____

DOB: _____

Complete both pages

Saint Alphonsus Medical Group

Today's date:_____

ANNUAL HEALTH HISTORY

Name:_____ Age:_____ Date of last physical exam: _____

Health Review: Have you had or are you now having any of the following symptoms?

GENERAL CONSTITUTION
__ Appetite decreased
__ Appetite increased
__ Chills/Rigors
__ Dizziness
__ Fainting
__ Fatigue/Malaise
__ Fever
__ Sleeping difficulties / Insomnia
__ Swollen glands
__ Weight gain, unplanned
__ Weight loss, unplanned
__ Other:_____

HEENT
Head
__ Headache
__ Neck lumps/swelling
__ Other:_____
Eyes
__ Blurred vision
__ Double vision
__ Eye changes
__ Other:_____
Date of last eye exam:
_____
Ears
__ Earache
__ Hearing loss / Difficulty
__ Other:_____

Nose
__ Hayfever
__ Sinusitus
__ Other:_____
Throat & Mouth
__ Hoarseness
__ Mouth sores
__ Teeth or gum problems
__ Other:_____
Date of last dental exam:
_____

RESPIRATORY
__ Chronic lung problems
__ Coughing blood
__ Frequent cough
__ Shortness of breath
__ Sleep apnea
__ Wheezing
__ Other:_____
Date of last CXR: _____

CARDIOVASCULAR
__ Artificial heart valves
__ Chest pains
__ History of blood transfer
__ Irregular / rapid heartbeat
__ Poor circulation
__ Swelling of ankles or feet
__ Varicose veins
__ Other:_____
Date of last EKG: _____

GASTROINTESTINAL
__ Bloating
__ Bowel changes
__ Colitis
__ Constipation
__ Diarrhea
__ Difficulty swallowing
__ Excess belching
__ Gas
__ Heartburn
__ Hemorrhoids
__ Hiatal Hernia
__ Indigestion
__ Nausea
__ Nervousness
__ Pancreatitis
__ Rectal bleeding
__ Stomach pain
__ Stools black or tarry
__ vomiting
__ Vomiting blood
__ Other:_____
Date of last Colon cancer screening: _____

GENITOURINARY
__ Blood in urine
__ Difficulty urination
__ Frequent urination
__ Kidney/bladder problems
__ Lack of bladder control
__ Other:_____

HEMATOLOGIC & ALLERGIES LYMPHATIC
__ Allergic disorders
__ Bleeding disorders
__ Cancer _____
__ Swollen glands
__ Other:_____

MUSCULOSKELETAL
Pain, stiffness, swelling in:
__ Arms __ Hips
__ Back __ Legs
__ Feet __ Neck
__ Hands __ Shoulders
__ Difficulty with balance
__ Difficulty with walking
Date of last fall: _____
Date of last broken bone:
_____

SKIN
__ Bleed or bruise easily
__ Change in mole
__ Hives
__ Itching
__ Rash
__ Skin changes
__ Other:_____

NEUROLOGIC & PSYCHIATRIC
__ Depression or anxiety
__ Forgetfulness
__ Numbness
__ Weakness
__ Other:_____

MEN Only
__ Breast lump
__ Erection difficulties
__ Lump in testicles
__ Penis discharge
__ Prostate problems
__ Sore/warts on penis
Date of last PSA: _____

WOMEN Only
__ Abnormal menstrual periods
__ Abnormal Pap smear
__ Bleeding between periods
__ Breast Lumps
__ Extreme menstrual pain
__ Hot flashes
__ Painful intercourse
__ Vaginal discharge or itching
__ Other:
Date of last period: _____
Date of last Pap smear: _____
Date of last mammogram: _____
Are you pregnant? yes / no
Birth control? yes / no

CONDITIONS: Check conditions you have or have had in the past

__ ADD / ADHD
__ AIDS
__ Anemia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bleeding disorder
__ Breast lump
__ Bronchitis
__ Cancer
__ Chicken pox
__ Developmental disability
__ Diabetes
__ Eating Disorders
__ Emphysema
__ Epilepsy / Seizures
__ Glaucoma
__ Colon cancer
__ Crohn's
__ Goiter / GERD
__ Gonorrhea
__ Gout
__ Heart attack
__ Heart disease
__ Heart problems
__ Hepatitis
__ Hernia
__ Herpes
__ High blood pressure
__ High cholesterol
__ HIV positive
__ Kidney disease
__ Liver disease
__ Measles / Mumps / Rubella
__ Migraine headaches
__ Miscarriage
__ Mononucleosis
__ Multiple sclerosis
__ Mumps
__ Pacemaker
__ Pneumonia
__ Polio
__ Prostate problems
__ Psychiatric care
__ Rheumatic fever
__ Stomach ulcers
__ Stroke
__ Suicide attempt
__ Thyroid problems
__ Tonsillitis
__ Tuberculosis
__ Vaginal discharge
__ Vaginal disease

Place Patient Sticker here or handwrite

Name: _____

DOB: _____

List doctors who currently treat you and the conditions treated:

_____

_____

_____

Patient and Provider need to Date/Time/Initial

Initial review by Provider: _____ / _____ / _____
Date / Time / Initial

Patient

_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial

Provider

_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial
_____ / _____ / _____ Date / Time / Initial

People assisting with paperwork:

_____ Interpreter's Name
_____ Interpreter's Signature and/or ID #
_____ Date / Time

_____ Office Staff Name
_____ Office Staff Signature
_____ Date / Time

Saint Alphonsus Medical Group

ANNUAL HEALTH HISTORY PAGE 2

Medications and dosages:	**Allergies:**	
1.		
2.		
3.		
4.	**Hospitalizations:**	
5.	1.	2.
6.	3.	4.
7.	5.	6.
8.	**Surgeries:**	
Injuries:		

Immunization - When did you last have? (mm/yyyy)

Immunizations: Tetanus ____ Pneumonia _____ Flu _____ TB _____ Hepatitis B _____ Other _____

Family History (Circle check mark if cause of death.)

	Alcoholism	Asthma	Cancer	Depression	Diabetes	Emphysema	Glaucoma	Heart Attack or Angina	Heart Failure (Weak Heart)	High Blood Pressure	High Cholesterol	Migraine Headaches	Osteoporosis	Stroke	Thyroid Disease	Trouble with blood clotting	Age at Death
Father																	
Mother																	
Brothers																	
Sisters																	

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Spouse's Name:** _____
Living arrangements ☐ Alone ☐ Family/Significant Other ☐ Assisted Living ☐ Daily help needed for self care
Name of care giver _____ **Children:** How many? _____ Ages: _____

Occupation: _____ ☐ FT ☐ PT ☐ Self ☐ Retired from:_____
Level of Education: ☐ HS / GED ☐ Tech / A.A ☐ B.S. / B.A. or higher

Diet: ☐ Unrestricted ☐ Low fat ☐ Low carb / diabetic **Caffeine**:☐ No ☐ Yes Type/Amt: _____

Sleep: # of hours per night _____ **Problems:** Falling / Staying asleep? ☐ No ☐ Yes
Exercise: ☐ No ☐ Yes Type: _____ ☐ Once a week ☐ 2-3x/wk ☐ Daily

Activities of Daily Living:
Any difficulty with?
☐ Speech/Communication
☐ Memory ☐ Dressing
☐ Bathing ☐ Household Duties

Fall Risk: Do you have concerns about falling? ☐ No ☐ Yes Do you use any balance/mobility devices? _____
Learning Needs: Are there any needs (learning, ethnic, cultural, or spiritual) we should know about that might impact your care or your ability to understand treatments / procedures/ educational materials? ☐ No ☐ Yes Please explain: _____

Abuse / Neglect: Are you experiencing neglect and/or conflict in your family and/or relationships? ☐ No ☐ Past ☐ Current

Tobacco: ☐ Never ☐ Past ☐ Current
Started: _____ Quit: _____
Packs per day? _____ ☐Smoke ☐Chew

Alcohol: ☐ Never ☐ Past ☐ Current
_____ # of drinks per ☐ Day ☐ Week ☐ Month

Street Drugs: ☐ Never ☐ Past ☐ Current
What? _____
Started: _____ Quit: _____

Place patient sticker here or handwrite

Name: _____

DOB: _____

Saint Alphonsus Medical Group

PROTECTED HEALTH INFORMATION RELEASE: PATIENTS 18 YEARS AND OLDER

Please check all applicable boxes and fill in any blank spaces where information is requested.

☐ Only release information to me personally.

☐ You have my permission to speak with my Spouse/Significant Other about my medical care and test results.
Spouse/Significant Other's Name _____ Phone _____

☐ You have my permission to talk with my children or other family members involved with my medical care.
Name _____ Phone _____
Relationship _____
Name _____ Phone _____
Relationship _____
Name _____ Phone _____
Relationship _____
Name _____ Phone _____
Relationship _____

☐ You have my permission to leave information on my answering machine regarding my medical care and test results.

☐ Other, please describe: _____

Emergency Contact:

Last Name _____ First Name _____ Phone Number _____
Address _____ City _____ State _____ Zip _____
Relationship to Patient _____

Patient Contact:

Patient Email _____
Phone (Home) _____ Phone (Cell) _____
Phone (Work) _____ Preferred Message/Contact Phone: ☐ Home ☐ Cell ☐ Work

_____ _____ _____
Patient Signature Date Time

People assisting with paperwork:

_____ _____ _____
Interpreter's name Interpreter's Signature and/or ID # Date and Time

_____ _____ _____
Office Staff's name Office Staff Signature Date and Time

Place patient sticker here or handwrite
Name _____
DOB: _____

Insurance/HIPAA E3
Rev 05-02-2011
Form 0003

HAVE PATIENT/GUARDIAN DATE AND INITIAL:

Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials
Reviewed _____/_____/_____ Date/Time/Initials

Saint Alphonsus Medical Group

Financial Policy

We will file your insurance claims for you. We do request a copy of your current insurance card to ensure accurate billing. Please keep in mind we do not accept all insurances. If you do not have insurance or if your insurance does not cover the services you need from our clinic, payment is your responsibility. It is also your responsibility to confirm directly with your insurance company to find out whether or not we participate with them, and if they will cover the medical services being provided to you. If your insurance requires a referral, co-pay, deductible, or coinsurance, it is your responsibility to have it with you at the time of service. Failure to do so may result in us having to reschedule your appointment.

- **Medicaid Patients**: You must have a valid Medicaid card, presumptive eligibility, or letter/printout from your caseworker at every visit. We also require photo ID, which will be scanned into our computer system. Lack of this information may result in us having to reschedule your appointment.

- **Minors**: The parent/guardian accompanying the minor at the time of service is responsible for payment.

- We will request payment at the time of service. If this is not possible, we will expect you to make acceptable payment arrangements, prior to receiving service.

- You will receive at least two statements after to your visit at our clinic. If your account is not paid in full, or if you have not established an acceptable payment plan, we will refer your account to a professional credit bureau.

- The credit bureau will send you a notification that a payment is due. The letter will arrive at your last known address. You must respond to this letter, to avoid damage to your credit record. If you do not respond to this letter, your account will be listed for collection and your credit will be adversely affected.

- I understand and agree that if I fail to pay for services for which I am responsible, after such default and upon referral to a collection agency by Saint Alphonsus Medical Group, I will be responsible for all cost of collecting monies owed, including court costs, and collection agency fees.

We are disclosing our policy to you now to avoid misunderstanding in the future.

Saint Alphonsus Medical Group

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND/OR MEDICAL RECORDS

Patient Name _____ **Date of Birth** _____

(Please print)

I authorize ("the Clinic") to use or disclose Protected Health Information ("PHI") contained in my medical records in the following manner:

From: _____

Physician/Institution that presently has data

_____

Street Address

_____

City State Zip Phone Fax

To: _____

Physician/Institution requesting data

_____

Street Address

_____

City State Zip Phone Fax

Release the following Protected Health Information:

____ All Records _____ Chart Notes _____ X-Rays _____ Labs _____ Substance Abuse Info _____Mental Health _____ HIV _____ Other (please specify): _____

(Describe the information to be used or disclosed, including date of service, type of service, level of detail to be released or specific information) Transfer of care_____

The Protected Health Information is being used or disclosed for the following purpose(s): [If the patient is requesting the release, this may state "at patient's request"]

_____

(List specific purposes the Protected Health Information will be utilized)

_____ Please FAX requested information to the fax number listed above.

(Maximum of 10 pages may be faxed, if request is more, records will be sent to the address indicated above.)

This authorization is in full force and effect until _____ (Date) or until _____ (List specific event)

If I fail to specify an expiration date/event, this authorization will expire in twenty-four (24) months.

I understand that I have the right to revoke this authorization in writing by sending notification to:

CLINIC NAME:

ATTN: Privacy Officer

ADDRESS:

I understand that when I revoke this authorization, it is not effective to the extent that the Clinic has already relied on the use or disclosure of the Protected Health Information. I understand the Protected Health Information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law. The Clinic will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating Protected Health Information for disclosure to a third-party (such as fitness for work exam). I understand that I have a right to inspect or copy the protected health information to be used or disclosed. I understand that I have a right to refuse to sign this authorization. If you have any questions concerning this form, please phone: (-)

SPECIFIC AUTHORIZATION: I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have crossed it out and initialed. YES_____ NO_____ (initials)

_____ _____

Patient Signature Date and Time

_____ _____ _____

Legal Representative Name/Relationship to patient Legal Representative Signature Date and Time

People assisting with paperwork:

_____ _____ _____

Interpreter's name Interpreter's Signature and/or ID # Date and Time

_____ _____ _____

Office Staff name Office Staff Signature Date and Time

Place patient sticker here or handwrite

Name: _____

DOB: _____

Saint Alphonsus Medical Group

Complete both sides

DETERMINATION OF MEDICARE AS

PRIMARY OR SECONDARY PAYOR RESPONSIBILITY

As part of participation in the Medicare program it is necessary for beneficiaries (patients) seeking services to identify certain items relative to insurance issues that will allow Medicare to determine primary or secondary coverage. Therefore, please answer the following questions.

1) Are you currently working full or part time? Yes _____ No _____ [12]

2) If you are married, is your spouse working full or part time? Yes _____ No _____ [12]

3) If YES to any of the above, are you covered under an employer group health plan based on your or your spouse's current employment? Yes _____ No _____ [12]

4) If YES to (3) above, please provide the following information:

_____
Name of the insured and relationship to the Medicare Beneficiary

_____
Name and address of employer

_____
Name and address of the group insurance carrier

_____
Policy number

_____
Group identification number

5) Are you entitled to Black Lung medical benefits? Yes _____ No _____ [41]

6) Is this service for treatment of a work related injury? Yes _____ No _____ [15]

_____
If YES please provide the name and address of your employer and workers compensation carrier

Place patient sticker here or handwrite

Name: _____

DOB: _____

Insurance/DMPSPR
Rev 07-31-2011
Form 0008

Saint Alphonsus Medical Group

DETERMINATION OF MEDICARE AS PRIMARY OR SECONDARY PAYOR RESPONSIBILITY, CONT'D

7) Is this service for treatment of an illness or injury which resulted from an automobile accident [47] or other accident [14]? Yes _____ No _____ If Yes, which one?

   _____

   If YES please provide the name and address of your liability insurance carrier
8) Are the services to be paid by a government program such VA benefits [42], Disability [43] or a research grant [16]?
   Yes _____ No _____ If Yes, Which one? _____
9) Are you entitled to Medicare based on ESRD (End Stage Renal Disease)?
   Yes _____ No _____ [13]
   (If yes please complete additional form)

Statement to permit payment of clinic and medical insurance benefits to Saint Alphonsus Medical Group

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf.

I assign payment for the unpaid charges of the physician(s), and other authorized care providers, to be billed in connection with its services. I understand I am responsible for any insurance deductibles and/or twenty percent of the remaining allowable charges.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Saint Alphonsus Medical Group including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Name	Patient Signature	Date/Time

The Patient is unable to sign because _____,

I therefore sign and agree to the other provisions of this form as the Patient's authorized legal representative.

Legal Representative Name/Relationship to patient	Legal Representative Signature	Date and Time
Interpreter's name	Interpreter's Signature and/or ID #	Date and Time
Office Staff Name	Office Staff Signature	Date and Time

Place patient sticker here or handwrite

Name: _____

DOB: _____

Saint Alphonsus Medical Group

Patient's Name: _____ Medicare# (HICN): _____

NOTICE TO BENEFICIARIES OF COINSURANCE LIABILITY

This facility is now an outpatient department of Saint Alphonsus Regional Medical Center. When you receive services at this facility, you will receive two separate bills – one for the facility component of your services (which will be billed by the hospital) and one for the physician/professional service (which will be billed by Physician Services). You (or your supplemental insurance carrier) are likely to owe a higher coinsurance amount than you would for the same services at a facility that is not hospital-based. The higher total coinsurance amount is based on Medicare's prescribed coinsurance rates for each of the two components. Standard Medicare supplement policies pay all or a portion of these coinsurances based on their contract terms.

If you are covered through a Medicare Advantage Plan (Part C) you may have to pay a coinsurance, co-payment or deductible amount for the facility services that you receive in addition to your physician co-payment or coinsurance. This amount may be higher than the coinsurance owed under traditional Medicare coverage. To find out your responsibility, please contact your Medicare Advantage Plan.

We are required to give you this notice before delivering health care services to you unless you are seeking treatment for an emergency medical condition and we have not yet ruled one out or stabilized the condition.

If you have any questions concerning this notice, our Patient Service Representatives in this office will be happy to assist you. If you have question regarding your coinsurance, co-payment or deductible, you may also call the Saint Alphonsus Billing Department at 208-367-2130 or 1-800-358-6407.

Finally, please understand that this notice is different from the advance beneficiary notice (ABN) that Medicare requires us to give patients to notify them of their responsibility to pay for services that Medicare is not likely to cover. Instead, this is a notice that you will have to pay a portion of the cost of services that Medicare does cover.

The following is a listing of services typically provided at this facility. The actual coinsurance amount will depend on the services you receive.

Please acknowledge receipt of this notice by signing and dating below:

Patient's Signature	Date and Time

Legal Representative Name/Relationship to patient	Legal Representative Signature	Date and Time

People assisting with paperwork:

Interpreter's name	Interpreter's Signature and/or ID #	Date and Time
Office Staff name	Office Staff Signature	Date and Time

Saint Alphonsus Medical Group Medicare Coinsurance Schedule, 2012, on Back side

NOTE: **Your health information will be kept confidential**. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Medicare will keep your health information, which Medicare sees, confidential.

Place patient sticker here or handwrite

Name: _____

DOB: _____

White: Office Copy

Left Insurance/NBCL
Rev 01-23-2012
Form 0066

Saint Alphonsus Medical Group

NOTICE TO BENEFICIARIES OF CO-INSURANCE LIABILITY

SAINT ALPHONSUS MEDICAL GROUP MEDICARE COINSURANCE SCHEDULE, 2012

HCPCS	Service Description	Estimated Facility Coinsurance Amount	Estimated Professional Coinsurance Amount - Our Facility	Estimated Total Coinsurance Amount - Our Facility	Estimated Coinsurance at a Participating Physician Office
99201	LEVEL 1 NEW PATIENT VISIT	$14.00	$4.89	$19.87	$7.87
99202	LEVEL 2 NEW PATIENT VISIT	$14.00	$9.30	$24.24	$13.50
99203	LEVEL 3 NEW PATIENT VISIT	$14.00	$14.14	$29.04	$19.55
99204	LEVEL 4 NEW PATIENT VISIT	$14.00	$24.00	$38.76	$30.02
99205	LEVEL 5 NEW PATIENT VISIT	$14.00	$30.84	$45.62	$37.42
99212	LEVEL 2 ESTABLISHED PTNT VISIT	$14.00	$4.77	$19.74	$7.87
99213	LEVEL 3 ESTABLISHED PTNT VISIT	$14.00	$9.45	$24.38	$13.16
99214	LEVEL 4 ESTABLISHED PTNT VISIT	$14.00	$14.52	$29.35	$19.51
99215	LEVEL 5 ESTABLISHED PTNT VISIT	$14.00	$20.42	$35.28	$26.26

If you have a Medicare Advantage Plan the Above Schedule Does Not Apply

Please contact your Medicare Advantage Plan for your specific benefits. Let them know you are being seen at a hospital outpatient department and they will be receiving a split billing. Saint Alphonsus will be sending a claim for the professional services with place of service 22 indicating the service was performed in an outpatient department of the hospital as well as a claim from the hospital outpatient department using type of bill 131. They will need this information to determine your correct benefit. If you are told that the hospital billed incorrectly, please let your Medicare Advantage Plan know that you were seen in an outpatient department of the hospital and that the hospital is required to bill the professional and facility services on separate claims according to Medicare regulations.

Place patient sticker here or handwrite

Name: _____

DOB: _____

Saint Alphonsus Medical Group

Patient's Name: _____ Medicare# (HICN): _____

NOTICE TO BENEFICIARIES OF COINSURANCE LIABILITY

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If you are covered through a Medicare Advantage Plan (Part C) you may have to pay a coinsurance, co-payment or deductible amount for the facility services that you receive in addition to your physician co-payment or coinsurance. This amount may be higher than the coinsurance owed under traditional Medicare coverage. To find out your responsibility, please contact your Medicare Advantage Plan.

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Office Staff name	Office Staff Signature	Date and Time

Saint Alphonsus Medical Group Medicare Coinsurance Schedule, 2012, on Back side

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Place patient sticker here or handwrite

Name: _____

DOB: _____

Yellow: Patient Copy

Left Insurance/NBCL
Rev 01-23-2012
Form 0066

Saint Alphonsus Medical Group

NOTICE TO BENEFICIARIES OF CO-INSURANCE LIABILITY

SAINT ALPHONSUS MEDICAL GROUP MEDICARE COINSURANCE SCHEDULE, 2012

HCPCS	Service Description	Estimated Facility Coinsurance Amount	Estimated Professional Coinsurance Amount - Our Facility	Estimated Total Coinsurance Amount - Our Facility	Estimated Coinsurance at a Participating Physician Office
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Place patient sticker here or handwrite

Name: _____

DOB: _____