Patient Information

Patient Name: Last _____ First_____ MI _____

DOB: Day _____ Month _____ Year _____ Male or Female (please circle one)

Is client a child? No ___ Yes___ (If yes, name, address and phone number of the adult legally responsible for payments due. If no legal paperwork is provided, payment is required at time of service by the adult accompanying the minor child.)

APO Address: _____ # _____ Box #: _____

City: APO State: AE Zip: _____

German Address: Street _____ Number _____

City _____ Zip _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

Alternate Email Address: _____

Social Security #: _____-_____-_____

We need this for medical billing purposes and to submit medical referrals to LRMC

EMERGENCY CONTACT: _____ Phone: _____

How did you hear about our office?_____

Signature of Client:_____ Date:_____

Clinic Policies

Thank you for choosing American Medical Center as your primary care health provider. We are committed to providing you with the highest quality of health care. Below are our clinic policies which we require you to read, agree to, and sign prior to any treatment.

Medication Refills – *please read and initial next to each statement*

_____ **ALL prescriptions** require a follow-up appointment. These appointments will need to be scheduled every 3 to 12 months, depending on the type of medication. **We do not accept walk ins or same day appointments for prescription refills.**

_____ It is your responsibility to notify the office in a timely manner when medication refills are necessary. **Refills require a minimum 24 hour advance notice**, so please be courteous and do not wait to call. If you call on a Friday, it will be ready for pick up the next business day.

_____ Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

_____ If you have any questions regarding medications, please discuss during your appointment. If you feel your medication needs to be adjusted or changed, contact the office immediately.

_____ New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

Workers Compensation – *please read and initial next to each statement*

_____ All Workers Compensation appointments must be paid in full at time of service. It will be your responsibility to file the claim for reimbursement.

Financial – *please read and initial next to each statement*

_____ As your health care provider, American Medical Center would like to emphasize that our relationship is with you, our patient, and not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

_____ American Medical Center is a client of the billing company **Ransom International Partners**. Ransom works with most federal employee insurance programs, and will direct bill your office visits to your insurance.

_____ You are required to provide co-pay and coinsurance payments in full at the time of service. All of our prices are in Euro, and we accept payments in cash, Visa, MC, and Giro Card. In accordance with German law, we do not accept VAT forms.

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Patient Signature _____ **Date** _____

Print Name _____

AMERICAN MEDICAL CENTER
We care for your health.

Medical History

Name (Last, First, MI): _____ **Date of Birth:** _____

Major Health Concerns: _____

Current Medication List: _____

_____

OTC Medications/Herbal Supplements: _____

_____

Drug Allergies: _____

_____

Past Medical History

Disease/Condition	Y/N	Disease/Condition	Y/N	Disease/Condition	Y/N
Hypertension		Cancer		Anemia	
Heart Palpitations		Thyroid Disorder		Depression	
Heart Murmur		GI Disorder		Anxiety	
Heart Attack		Bleeding Disorder		Headaches	
Stroke		Epilepsy		Eye Disorder	
Diabetes		Kidney Disease		Allergies	
Asthma		Hepatitis		Other:	
COPD		HIV			
Pneumonia		Liver Disease			

Hospitalizations/Surgeries: _____

_____

Family History

	Father	Mother	Paternal Grandparents	Maternal Grandparents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer *Age Diagnosed						
Diabetes						
Epilepsy						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						

Social History

Cigarettes/Tobacco		How Long: Packs/day:
Alcohol		Drinks/week:
Recreational Drugs		How often:
Exercise		Times/week: Duration:

AMERICAN MEDICAL CENTER
We care for your health.

HIPAA Privacy Authorization Form and Data Release

Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize ***American Medical Center*** to release health information pertaining to the patient named above, to the entities listed below.

Data Release:
In accordance with the European Data Privacy Act (Europäische Datenschutz-Grundverordnung 2016/679), American Medical Center requests that each patient sign this patient privacy data release and consent form which allows us to share your protected health information (PHI) or electronic health information (ePHI) with other medical service providers, as well as your health insurance company.

_____ **(please initial)** I hereby authorize email communication for the use and disclosure of my health information internally within the medical office, as well as to my health insurance company, and further treating medical providers.

Information to be released:

_____ Results for tests, procedures, x-rays, ultrasounds, MRIs, labwork
_____ Medical information as follows: prescription pick-ups, medical records, appointment days/times
_____ Other information as described: _____

Authorized Persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ **(please initial)** In addition to the authorization for the release of my protected health information, I authorize the disclosure of information regarding my billing, condition, prognosis, and treatments.

Effective: (please initial one)

_____ This authorization shall remain effective indefinitely.
_____ This authorization shall remain effective until the following date: _____ / _____ / _____.
Day Month Year

Rights of the Patient:
I understand that I have the right to revoke this authorization in writing at any time. I understand that revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward.

Patient Signature: _____ **Date:** _____

Medical Billing Department

1. RELEASE OF INFORMATION: **I hereby authorize the MVZ & AMC Medical Billing Department to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.**

2. COLLECTION FEES: **I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, accrued interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.**

3. BILLING OFFICE: **If you have questions in regard to any of your billing statements, our accounts receivable staff at the medical billing office is available to assist you at the number 06371-4049-185 or via email to billing_amc@mvz-westpfalz.com**

4. SELF PAY PATIENTS: **I understand that full payment is due upon receipt of invoice.**

5. ASSIGNMENT OF INSURANCE BENEFITS: **I hereby assign, transfer, and set over directly to this clinic sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize MVZ & AMC Medical Billing Department to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information. I authorize this clinic and billing staff to release all medical information requested by my health insurance carrier, other physicians or providers, and any other third-party payers.**

6. RESPONSIBILITY FOR PAYMENT: **I understand that I, personally, am financially responsible for charges not covered by the assignment of insurance benefits.**

E-MAIL ADDRESS: _____

PHYSICAL ADDRESS: _____

❑ **(Please check only one) Send correspondence to this address.**

APO ADDRESS: _____

❑ **(Please check only one) Send correspondence to this address.**

CELL PHONE NUMBER: _____

PERMANENT STATESIDE ADDRESS: _____

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand that such terms may be amended by the practice from time to time. I consent to reminders of my open statements to be sent to me via e-mail, European address or to my permanent stateside address due to relocation.

_____ _____ _____

Print Name **Patient Signature** **Date**

American Medical Center Appointment "Cancellation/No Show Policy"

Effective October 1st, 2019 any established patient who fails to show or cancel/reschedule an appointment and has not contacted our office with **at least 24 hours** will be considered a No Show and charged a **25 Euro fee for 30 minute appointment slots and 50 Euro fee for 60 minute appointment slots.**
Any established patient who fails to show or cancel/reschedule an appointment with no 24 hour notice a **second time** will be charged a **50 Euro fee for 30 minute appointment slot and 100 Euro fee for 60 minute appointment slot**. If a third No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be dismissed from American Medical Center.

If you are more than 10 minutes late for your scheduled time slot, you have forfeited your appointment.

The fee is charged to the **patient**, not the insurance company, and is due at the time of the patient's next visit. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your schedule appointment. If you should experience extenuating circumstances please ask for our Nurse Case Manager, who may be able to waive the No Show fee depending on circumstances.

☐ I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

_____	_____
Signature	Relationship to Patient
_____	_____
Printed Name	Date

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www.american-care.com | info@american-care.com
Walk In & Medical Care | Telephone: (06371) 49 5021 | Fax: (06371) 49 5011
Physical Therapy & Rehab | Telephone: (06371) 49 5020 | Fax: (06371) 49 5010