VIK Medical Concierge

512.494.4825

HOW DID YOU HEAR ABOUT US?

☐Family/Friend Referral ☐Facebook / Social Media ☐Google / internet ☐Other (specify):_____

PATIENT INFORMATION

Last Name_____ First Name_____ MI_____

Address_____ Apt. #_____ City_____ State_____ Zip_____

Home# (_____)_____ Cell# (_____)_____ Work# (_____)_____

Date of Birth _____/_____/_____ Sex: ☐ M ☐ F Marital Status: ☐S ☐M ☐D ☐W ☐P

Drivers License#_____ Race/Ethnicity_____

Email Address_____ May we contact you via email? Yes No

Emergency Contact_____ Phone# (_____)_____ Relationship_____

REASON FOR TODAY'S VISIT

_____ Date of onset_____

***Is this a workers' comp. injury? **Y / N** ***If **YES**, please note we are NOT a workers' compensation provider; we will NOT file to your medical insurance and will NOT complete any workers' comp forms. Any charges will be an out of pocket expense if you choose to be seen at our facility.

PAYMENT

- **VIK Medical Concierge requires payment at time of service**. We are a fee for service practice and are out of network for all insurances.
- As a courtesy, we will submit your insurance claim on request. We cannot guarantee amount of reimbursement, if any, as this may vary depending on your insurance carrier. We will also request that the lab bill your insurance company at your request.

The above information is true to the best of my knowledge. I understand I am financially responsible for any cost associated with today's visit unless otherwise specified.

_____ _____ _____

Print Name Signature of Patient or Guardian Date

VIK Medical Concierge

Financial Policy

Thank you for choosing VIK Medical Concierge as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign, and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- We accept cash, check or MasterCard/VISA/Discover credit cards.

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty.

Past Due Accounts

Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a returned check fee of $25.00.

Cancellation Policy

A 24 hour cancellation notice is required if you cannot keep your appointment. There will be a fee applied to your account if we do not have 24 hours notice of cancellation. Fees will be assessed as follows: New Patient - $100.00, Established Patient $75.00.

Please contact our Billing Office if you have questions or concerns at 512-327-4262.

I have read, understood, and agree to the Financial Policy.

_____ _____ _____

Print Name Signature Date

VIK Medical *Concierge*

Authorization and Agreement for Medical Treatment

The undersigned hereby makes the following acknowledgements and agreements regarding medical treatment to be provided to the patient whose name appears on this page.

Consent for Treatment: I understand that medical treatment will be performed by independent physicians at VIK Medical Concierge between the posted hours, and that no responsibility will be taken during non operating hours. VIK Medical Concierge recommends the use of VIK Complete Care, open 24 hrs/day, 7 days a week for all acute or urgent issues. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has been made as to the results which may be obtained.

Agreement to Pay at Time of Service: For an in consideration of the care and treatment provided to this patient, I promise to pay VIK Medical Concierge all charges for services rendered to or on behalf of the patient
Estimation of charges – I understand that any prices quoted to me prior to treatment are only an estimate. Exact costs can only be determined after assessment by the physician.

Release of Medical Information: I hereby authorize VIK Medical Concierge to release any medical information obtained from these services to:
1) health insurance provider as may be required for reimbursement, 2) my personal physician, or 3) to specialist physician if referral is required.
Work Related Injury of Illness – I hereby authorize VIK Medical Concierge to release my employer's insurance representative, as may be required for reimbursement, any information obtained in evaluation, treatment, diagnosis, and disposition of any work related injury or illness. I understand this may include personal medical information (e.g. lab results, medications, etc.) concerning HIV status and/or mental health status.

Employment Physical Exams: I hereby authorize VIK Medical Concierge to release to my employer or prospective employer any information obtained by VIK Medical Concierge in connection to job suitability or pre-placement evaluations required by my employer regarding employability, including limited physical exam, spirometric, audiometric, radiographic exam, functional capacity exams and result of any blood, urine, and hair specimens collected, in connection with such job placement evaluations.

VIK Medical Concierge does NOT accept insurance reimbursement.

Patient's Name: _____ Date of Birth: _____

Legal Guardian's Name: _____ Relationship to Patient: _____

Signature of patient **OR** legal guardian: _____ Date: _____

VIK Medical Concierge

Acknowledgement of Notice of Privacy Practices

Patient Name: _____

I hereby acknowledge that I have received a copy of VIK Medical Concierge's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment if I so choose.

_____ _____

Signature of Patient or Legal Representative Date

_____

Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)
_____Parent or guardian of non-emancipated minor
_____Court appointed guardian
_____Executor or administrator of decedent's estate
_____Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices on the following date _____, but acknowledgement could not be obtained because:

_____ Patient / Representative refused to sign

_____ Emergency situation prevented us from obtaining acknowledgment at this time.
(An attempt to obtain acknowledgment will be made at a later date).

_____ Communication barriers prohibited obtaining acknowledgment (Explain)

_____

_____ Other

VIK Medical *Concierge*

As an out of network provider, VIK Medical Concierge does not accept assignment of insurance benefits from private insurances or Medicare. Patients will be given a claim form after their appointed time which they can use to submit to their insurance company. We cannot guarantee the amount of reimbursement, if any, as this will depend on your insurance provider and your individual policy.
MEDICARE PATIENTS: VIK Medical Concierge is not credentialed with Medicare. Patients will not be reimbursed by Medicare.

I have read and understand the paragraph above and have been given an opportunity to ask questions regarding payment, billing and insurance.

_____ _____
Patient or guardian name Date

_____
Signature