AMERICAN MEDICAL CENTER

Patient Information (PLEASE PRINT CLEARLY)

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** _____ **Is this address a hotel: Y / N**

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

Social Security #: _____-_____-_____ (We need this info for billing purpose)

EMERGENCY CONTACT: _____ **Phone:** _____

How did you hear about our office?_____

Sponsor Information

Employer: _____ (ie: US Army, US Airforce, NAF, DODS, etc.)

Sponsor Name: _____

Sponsor Work Phone: _____

Where does Sponsor Work? _____ (ie: LRMC, 86 FSS, Auto Hobby Ramstein)

Commander/Supervisor Name: _____ **Rank:** _____

SOFA Expiration Date: Day _____ **Month** _____ **Year** _____

Signature of Patient/Parent or Guardian: _____

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	Past / Current	How Long: Packs/day:
Alcohol	Past / Current	Drinks/week:
Recreational Drugs	Past / Current	How often:
Exercise	Past / Current	Times/week: Duration:

AMERICAN MEDICAL CENTER

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 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 48 hour advance notice**, so please be courteous and do not wait to call.

_____ 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 or a video appointment. Your provider will not diagnose or treat over the phone.

Paperwork - *please read and initial next to each statement*

_____ Any paperwork request that requires completion and signature from a medical professional at AMC **must** be sent to info@american-care.com for prior authorization. Any paperwork that has not been authorized prior to your appointment will not be completed. Applicable fees will be applied, these fees are patients responsibility and due at time of service.

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 works with most federal employee insurance programs, and will direct bill your office visits to your insurance. You may receive a bill only if a balance remains after this process.

_____ 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 Visa, MasterCard, and GiroCard. In accordance with German law, we do not accept VAT forms.

Signature of Patient/Parent or Guardian: _____

Date _____

Print Name _____

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, invoices and open balance statements internally within the medical office, to my health insurance company, further treating medical providers and AMC Billing Department.

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.

Signature of Patient/Parent or Guardian: _____

Date: _____

Print Name : _____

AMC Medical Billing Department

1. RELEASE OF INFORMATION: I hereby authorize the American Medical Center Billing Department to release all information needed to process claim and payments to governmental agencies, insurance carriers and any other financially liable organizations / individuals.

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: For any questions regarding billing statements, invoices, payments etc. please contact our medical billing office at +49 6371 - 49 50 23 or email to billing-amc@american-care.com

4. SELF PAY PATIENTS: I understand that full payment is due at time of service or upon receipt of invoice.

5. ASSIGNMENT OF INSURANCE BENEFITS: I authorize AMC Medical Billing Department to contact my insurance company or health plan administrator to 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 am fully responsible for the costs of any medical services rendered for myself and / or my dependants provided by the American Medical Center that are not covered by my Insurance Company.

E-MAIL ADDRESS (Please print clearly): _____

PHYSICAL ADDRESS (Please print clearly): _____

APO ADDRESS (Please print clearly): _____

CELL PHONE NUMBER (Please print clearly) _____

PERMANENT STATESIDE ADDRESS (Please print clearly): _____

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

_____ _____

Signature of Patient(Parent or Guardian) **Date**

Print Name: _____

Billing Department
Konrad-Adenauer-Str. 4 ,66849 Landstuhl
Phone: +49 6371 49 50 23

AMERICAN MEDICAL CENTER
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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 Office 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 of Patient/Parent or Guardian: _____

Print Name: _____ **Date:** _____