# WELCOME

## ATTENTION ALL PATIENTS

The Jones Family Practice welcomes you as a patient. We will make every effort to work with you and your insurer to maximize your healthcare benefits. Please notify us immediately of any changes in your insurance coverage or carrier.

To avoid any problems and to expedite the services you may require, please be aware of the following:

- Bring your insurance card/s with you for each visit.
- Patients are responsible for co-payments and deductibles at the time of service.
- If your insurance company requires specialist referrals, you must see your physician **before** a referral can be made to a specialist. Also, please note that this office is prohibited from issuing **retroactive** referrals. We are not permitted by your insurance company to write a referral for a specialist visit after that visit has occurred.
- If this practice provides services not covered by your insurance plan, you will be billed directly for those services.
- Please obtain routine prescription refills during office visits. For non-routine refills, please contact the office at 487-5228 with your prescription information, including the patient's name, the name of the medication, and the name and telephone number of the pharmacy. We make every effort to call in prescriptions within 24 hours of your telephone call.
- If you have any concerns or complaints about the healthcare benefits provided by your insurance company, we encourage you to contact your employer's Human Resources Department.
- If you are experiencing any difficulties with your insurance benefits, you have access to the Consumer Services Division of the North Carolina Department of Insurance. You can contact the Consumer Services Division with complaints or concerns at 800-546-5664.
- Please bring all your medicines when coming for your visits.

Please let us know if you have any concerns or problems with the services provided by this office. Your feedback helps us continue to improve our service to you. We are committed to quality patient care and your satisfaction.

Dr. Stephen W. Jones MD
Meleah G. Hilton PA-C

John A (Lyn) Cheshire III PA-C
Elizabeth A. Jones NP-C

***Jones Family Practice and MyQuest Patient Portal***

MyQuest allows patients to use their mobile or web-enabled device to view, store, and share their vital health information anytime from anywhere.

1. Download MyQuest on your mobile device from the Apple App and Google Play stores or add on your computer, iPad, etc.
2. Go to the web portal at Questdiagnostics.com/MyQuest.
3. You need a Quest Diagnostics account, so sign up with an email address.
4. Complete questions.
5. Select "Sign Up", and select "Register Now."
6. You will receive an email from Quest to confirm your registration.
7. Once confirmation of your registration is confirmed go to Questdiagnostics.com/MyQuest and enter login credentials.
8. Click on Health Record Messages on the left side of the screen. The system will create a direct email address: ____________________@direct.care360.com
9. Click on Create Message and send a request to the Jones Family Practice Manager at heatherjfp@direct.care360.com requesting a PIN to communicate with your provider.
10. The Practice Manager will email your PIN to your email address.
11. After you receive your PIN, on a computer, log into Questdiagnostics.com/MyQuest and click on Health Record Messages on the left side of the screen. If you are using a cell phone, click on drop-down menu at top and click "Establish Physician Connection."
12. Click on Establish Physician Connection and enter the PIN provided and click on Submit.
13. Once your PIN has been approved, you can now communicate with your provider by clicking Create Message and sending a request using your provider's address. You may also ask the office general question, request a return call regarding billing, insurance, or appointment information using the below address list.
14. On the Home Page, you will be able to select from the menu to the left what you wish to see: Labs, Medical Information, My Contacts, Quest Lab Appointment, and Quest Billing Services.
15. You may share this information with anyone you choose – another doctor, a friend, or a family caregiver. Just add the contact and send.
16. Following is an email address list for the office.

**Practice Manager:** heatherjfp@direct.care360.com

**Lyn Cheshire:** dtjfp@direct.care360.com

**Elizabeth Jones:** christianruss@direct.care360.com

**Meleah Hilton:** janebrooks@direct.care360.com

**Bill questions:** kmcjfp@direct.care360.com

**Insurance questions:** thomasmcswain@direct.care360.com

**Appointment questions:** francesgrooms@direct.care360.com

# Jones Family Practice

Stephen W Jones, MD * John Allyn (Lyn) Cheshire III, PA * Meleah G Hilton, PA
* Elizabeth A Jones, NP

*Please complete the following form to help us in converting our paper charts to electronic health records. Thank you.*

***What Provider are you seeing today?** ______________________ ***How did you locate us?**_______________
(PMS/EHR)

| Last Name: | First Name: | Middle Initial: |
|---|---|---|
| SS# | ***DOB**: | ***GENDER**: |
| Married : ☐Yes ☐No | Employed: ☐Yes ☐No<br>If so, where? ______________________________________ | |

Patient Address:

Street: ____________________________________________________________

City: ______________________ State: ________ Zip Code: _______________

Patient Contact Info

Home Phone: ________________ Work Phone: __________________ Mobile Phone: ___________________

E-mail address: ______________________________

Emergency Contact:

Contact Name: ____________________________ Phone: __________________ Relation: ____________

Who is responsible for the bill if patient is under 18 years old?

Name: ____________________________

Address: Street: ____________________________________________________________

City: ______________________ State: ________ Zip Code: _______________

| ***ETHNICITY**: | ***RACE**: | ***PRIMARY LANGUAGE**: |
|---|---|---|
| ______ Hispanic or Latino<br>______Not Hispanic or Latino | American Indian: ___<br>Alaska Native: ___<br>Asian: ___<br>Black or African American: ___<br>Native Hawaiian or Other Pacific Islander: ___<br>White: ___<br>Other Race: | |

Have you signed a "DO NOT RESUSCITATE" form? ☐Yes ☐No

***WE APPRECIATE YOU***

**JONES FAMILY PRACTICE**
**STEPHEN W. JONES, M.D.**
**MELEAH G. HILTON PA-C**
**JOHN A (LYN) CHESHIRE III PA-C**
**ELIZABETH JONES NP-C**

Telephone (704) 487-5228 FAX (704) 487-1766

Dear Patient:

We are pleased you have chosen Jones Family Practice as your healthcare provider. As the Providers provide the medical care you need, we, the staff members, will be available to help you schedule appointments and understand our office procedures. The following information concerning the financial policy of the practice is important.

**Payment is expected at the time service is rendered.**

If you have an insurance that we are not under contract to file, you will be provided with papers to file the claim as you leave the office so that you will be reimbursed. Your insurance is a contract between you and your insurance company. Any balances your insurance does not pay will automatically become your responsibility.

If we participate with your HMO or PPO plan, we will file your insurance after the copayment has been paid. If your insurance has a deductible, you will be asked to pay the patient responsibility after that deductible is met. However, if a claim, is denied you will be responsible for the remaining balance. Please refer to your handbook, as all services **are not** covered by all HMO and PPO plans.

If you are a MEDICARE patient, our office is happy to file your MEDICARE, and secondary insurance.

If you have Medicare only, you are responsible for paying the (Medicare deductible) in each calendar year and then your responsibility will be 20% of the charges.

If you are a Medicare patient, you have a secondary insurance and they pay your Medicare deductible, you will have no payment responsibility unless Medicare does not approve a procedure.

If you are a Medicare patient and your secondary insurance does not pay your Medicare deductible, you are responsible for paying the first amount in each calendar year and then you will have no payment responsibility unless Medicare does not approve a procedure.

If you are a MEDICAID patient, you must present your MEDICAID card and pay your $3 copayment before the doctor sees you. Without your card and copayment we cannot perform services for you under the MEDICAID program. We are NOT a Carolina Access facility and cannot see you here if you have a PCP on your Medicaid card.

Our practice contracts with Quest Diagnostics for Laboratory and Pathology services. If you are in need of these services, Quest will obtain the specimen at our office. You may receive a bill for this service from Quest Diagnostics, in addition to the bill from Jones Family Practice. If you have questions about statements from Quest, please contact Quest. The phone number is on the billing statement, as the statement is generated Quest Diagnostics.

**If your balance is over 90 days old and no attempt has been made to make or abide by payment arrangements, interest will be charged at 8% per annum.**

| | |
|---|---|
| ***If you no-show for two appointments, you will be notified that you will need to pay a non-refundable amount of $25 before you can schedule another appointment.*** | ***If you are over 15 minutes late for your appointment, you may reschedule your appointment or you can still be seen. However, you may have to wait to be worked in as we have moved on to the next scheduled patient who was on-time for their appointment.*** |

I have read and understand the financial policy of Jones Family Practice.

_______________________________________ ______________

Signature of Patient or Guarantor Date

***PLEASE KEEP YOUR CELL PHONE OFF WHILE IN OUR OFFICE. THANK YOU.***

# JONES FAMILY PRACTICE

113 East Grover Street

Shelby, North Carolina 28150

Phone: 704-487-5228

Fax: 704-487-1766

Stephen W Jones, MD

Elizabeth A Jones, NP

Meleah G Hilton, PA

John A Cheshire III, PA

I understand that Jones Family Practice, P. A. does not prescribe controlled substances for pain or anxiety.

Signed____________________________________________

Printed Name______________________________________

Date______________________________________________

# CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

| Jones Family Practice<br>113 East Grover Street<br>Shelby, NC 28150 | insert label |
|---|---|

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Jones Family Practice and its physicians and staff to disclose the following:

| NAME | Phone/Cell #'s | CAN PICK UP MEDICAL INFORMATION, MEDICINE AND PRESCRIPTIONS ON MY BEHALF (Please check if applicable) | CAN PARTICIPATE IN DISCUSSIONS AND DECISIONS RELATED TO MY MEDICAL CARE (Please check if applicable) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Any other conditions of disclosure ______________________________

**I GIVE MY PERMISSION TO LEAVE APPOINTMENT INFORMATION, TEST RESULTS, AND FINANCIAL INFORMATION ON MY ANSWERING MACHINE. ___ YES ___ NO

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I understand that this consent may be revoked by me at any time by written notice to the practice.

**I have been offered a Notice of Practice Privacy Policy. ____ yes ____ no**

Patient Signature: ______________________________ DOB: ____________

Date of Signature: ____________________ Phone/Cell # ______________________

Witnessed by: ______________________________

Title/Position: ______________________________

Print Name of Witness: ______________________________ Date: ____________

*This form must be completed and returned to the front office before becoming effective.*
*It must be signed in the presence of a Jones Family Practice employee.*

# RECURRING CREDIT CARD AUTHORIZATION

| **Jones Family Practice**<br>**113 East Grover Street**<br>**Shelby, NC 28150** | **insert label** |
|---|---|

As the cost of postage has increased, so has the cost of billing. It is our goal at Jones Family Practice to provide the very best care possible by maintaining a quality staff that is here to meet your needs. To that end, we must look at every avenue of reducing costs while maintaining the collection of our patient's payment responsibility. We would like to use the approach that is widely used by mail order pharmacies, internet shopping sites, hotel reservations, and airline reservations to mention a few.

Here is how it would work:

1. Nothing is charged to your credit card until we receive your Explanation of Benefits (EOB) from your insurance company and we can accurately determine your patient payment balance.
2. The only amounts that will be charged to your credit card will be the PATIENT RESPONSIBILITY portion as defined by your insurance company's EOB, a missed copay, a returned check, tests not covered by your insurance, etc.
3. And THIS INFORMATION IS ALWAYS CONFIDENTIAL AND <u>YOU ARE NOT REQUIRED TO PARTICIPATE</u>.

If you would, please enter all the following information and sign below:

PATIENT NAME: ______________________________________________

PHONE #: ____________________ ALTERNATE #: ___________________

NAME AS IT IS ON CREDIT CARD: _________________________________

TYPE OF CARD: _____ Visa _____ MasterCard EXPIRATION DATE: _________

CREDIT CARD: _____________________________ 3-DIGIT CV CODE: _____

***I give Jones Family Practice, PA permission to charge the above credit card with the balance due (patient responsibility) portion of my insurance explanation of benefits (EOB, and any charge not paid by my insurance). I understand I can dispute the charge at any time with my credit card company; however the actual amount of the charge can only be disputed with my insurance company. If an inaccurate charge with my insurance company results in a corrected EOB, any change will be reflected as a credit or additional charge on my credit card.***

AUTHORIZATION SIGNATURE: _______________________________ DATE: _____________

WITNESS SIGNATURE________________________________________ DATE: _____________

INSERT LABEL HERE

**Complete only if the patient is a minor…..**

**The following persons have my permission to bring my child in to be seen, and I will be responsible for any charges incurred.**

________________________________________

________________________________________

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________________________________________

________________________________________

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________________________________________

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________________________________________

**Signed**