Family Medicine Center on Coulter

Patient Information **Date** _____

Last Name		Primary Physician			
First Name		MI	Referring Provider		
Address		Date of Birth	Sex	Marital Status	
City		Social Security Number			
State	Zip Code	Employer Name			
Home #	Cell #	Work #	Ext #		

Emergency Contact Name/Number:
Pharmacy:

Responsible Party Information

Last Name	First Name		MI	
Address	City	State	Zip Code	
Home #	Cell #	Work #		
Employer	Employer Address	City, State, Zip		
Social Security Number	Relationship to the patient?	Sex	Date of birth	
Email Address	Marital Status	May we contact you at work?		

Insurance Information

Insurance Name	Policy Holder Name			
Policy / ID Number	Group Number			
Insurance Address	City	State	Zip	
Policy Holder Social Security Number	Date of Birth	Policy Holder Employer		
Policy Holder Address if different than above	City	State	Zip Code	

Consent to Treatment: I voluntarily consent to receive medical and health care services provided by Family Medicine Center physicians, employees and such associates, assistants, and other healthcare providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment.

Patient Signature: _____

Family Medicine Center on Coulter
Medical History Form

Name: _____ **DOB:** _____ **Date:** _____
Reason for visit/symptoms: _____
Primary Physician: _____
Specialists: _____

Current Medications

NAME	DOSAGE	FREQUENCY

Drug Allergies

Past Medical History: *Please circle any and all that applies.*

Asthma	Blood Clots	Blood Transfusion	Chronic Lung Disease
Cancer/Type:	Diabetes	Pneumonia	Stroke
Diverticulitis	Hypertension	Kidney Stones	Gout
Thyroid Problems	Stomach Ulcers	High Cholesterol	Heart Disease

Diagnostic Procedures:
Last Colonscopy: _____
Last Bone Density: _____
Last Mammogram: _____
Last Pap: _____

Surgeries: Please list additional information on reverse side of form.

Date	Operation	Date	Operation

Family History: If any blood relative has suffered any of the following, please indicate which relative.
(i.e. M- for maternal, P- for paternal)

Allergies	Diabetes	Hypertension
Arthritis	Epilepsy	Kidney Disease
Asthma	Glaucoma	Migraines
Cancer	Gout	Stroke
Dementia	Heart Attack	Thyroid Disease

Social History: Alcohol: Yes or No Smoking: Yes or No Caffeine: Yes or No

HIPAA

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

Patient Name: _____ **Date of Birth:** _____

Your medical information will not be released to anyone other than yourself or your designated representative. If you wish for a family member or other representative to have access to your information, please list their names below:

Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____
Name: _____ Relation: _____

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* effective September 23, 2013 prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions for the use and/or disclosure of my information:

_____

_____

_____

Patient Signature/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date: _____

****** There will be a fee of $25.00 for No-show appointments. The No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment******

Patient Portal Authorization on the Web

Family Medicine Center/CareXpress clinics offer the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables patients to communicate with our staff easily, safely, and securely via the Internet.

Patients are sent, via e-mail, a secure User ID and password, enabling them to access our secure Patient Portal to view their health records, including lab and diagnostic test results, educational information, billing statements, and other health information. You can also send a message to the office through the Portal.

In order to provide you access to the Patient Portal, please provide us your email address or select one of the boxes below:

EMAIL ADDRESS:_____

__ I do not have an email address __ I do not want to access the Patient Portal

__ I do not want to share my email address __ Other

HEALTH INFORMATION EXCHANGE (HIE)

Health information exchanges (HIEs) allow physicians to exchange patient information securely when coordinating care with referring and consulting physicians. Having the right information on the right patient at the right time can enhance physician decision making at the time of care. This occurs when physicians have access to key patient information such as current medications, allergies, lab results, and recent hospitalizations.

Opt-out – The HIE default is for patient health information to automatically be available for sharing between provider. **Patients must actively express their desire to not have information shared if they wish to prevent sharing. Patients may request an OPT OUT form or notify your clinic in writing if you do not want your electronic medical record shared on the HIE.**

Patient's Consent to Obtain External Prescription History

I grant permission to the healthcare providers at Family Medicine Center to view my prescription history from other external sources (other pharmacies and/or providers.) I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff, and it may include prescriptions back several years.

_____ _____

Patient or Authorized Person's Signature Date

_____

Patient's Printed Name

FINANCIAL POLICY

Welcome to Family Medicine Center. We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

PARTICIPATING PROVIDER

We are providers for a select group of major PPO networks and the Medicare program. However, due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. **Therefore it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list *before* making an appointment.** You will be responsible for payment in full for services rendered by your physician if he/she is not a provider in your plan. We will try our best to inform you of changes in our provider status as they occur. For non-contracted plans, you will need to pay in full and file your own claim.

YOU MUST PRESENT A VALID INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.

CO-PAYMENTS

We require your co-payment at the time of check-in. We will verify insurance and collect payment based on the information provided by your insurance company.

DEDUCTIBLE AND COINSURANCE

If you have a deductible, we will verify insurance and collect payment based on the information provided by your insurance company.

REFERRALS, PRECERTIFICATION AND PRE-AUTHORIZATIONS

Referrals, precertification and pre-authorization of additional medical services is an area in which we strive to help you. Due to the varying policy provisions of all of our patient's plans, it is impossible for us to know each patient's specific plan provisions. If you fail to disclose precertification requirements PRIOR to services being rendered, you may be responsible for payment of all related fees in full.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF AND INFORM US OF WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN FOR X-RAY, LABORATORY, DIAGNOSTIC AND REHABILITATION FACILITIES.

SECONDARY INSURANCE

We will file secondary insurance as a courtesy to you. Please keep in mind that payment of your account is ultimately your responsibility and we will look to you for payment of your account if we are unsuccessful in obtaining reimbursement by your insurance.

RESPONSIBLE PARTY (GUARANTOR)

The guarantor of the account is the patient who comes in for treatment or the adult who brings in a minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings a minor child in, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of Family Medicine Center of Amarillo to become involved in medical bill payment disputes resulting from divorce, etc.

LIABILITY OR AUTO ACCIDENT CLAIMS

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to be reimbursed. You may contact the business office for a copy of HCFA.

WORKER'S COMPENSATION CLAIMS

We do not participate in Worker's Compensation and are unable to file claims on your behalf. If you are injured on-the-job, you will be responsible for payments at time of service.

BILLING OF ACCOUNT BALANCES

Our policy is to collect at time of service. If there is a balance after insurance processes the claim, you will receive a statement for which payment is **due upon receipt.**

NSF CHECKS

We utilize the services of ReChek for any NSF items received. Once returned, these items are handled directly by ReChek LP at 806-468-9233.

NON-PAYMENT OF ACCOUNTS

Accounts for which we are unable to collect the balance due will be referred to an outside collection agency. We also reserve the right to report this activity to a national credit-reporting agency. Each physician reserves the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

ACCEPTANCE OF FINANCIAL POLICY

The undersigned hereby certifies that he/she has read, understood and agrees to the financial policy of Family Medicine Center on Coulter.

_____ _____

Signature of Patient or Legal Guardian Date

ASSIGNMENT OF BENEFITS

The undersigned hereby requests that payment from authorized insurance carrier or state benefits program be made directly to the Family medicine Centers provider who rendered services on their Behalf for the period of: LIFETIME. The undersigned also releases the disclosure of medical information for use in obtainingreimbursement by an authorized insurance carrier.

_____

Signature of Patient or Legal Guardian

If you would like a copy of our Financial Policy for your records, please let us know. Thank you!