Grand Ave Family Medicine

The information collected on these forms is used by the providers, schedulers, billing office and to report to meaningful use of Electronic Health Record. Please complete all forms.

INITIAL PATIENT HISTORY FORM

Patient Name (full legal):_____ AKA name:_____

Social Security #: _____-_____-_____ DOB: _____/_____/_____ Gender: (circle one) M F

Mailing Address:_____ City: _____ State:_____ Zip:_____

Cell Phone:_____ Home Phone:_____

Email:_____ Language Preference: _____

Place of Employment: _____ Work Phone: _____

Ethnicity: (circle one): Hispanic or Non-Hispanic Nationality: _____

Race (circle one): Native American Asian African American/ Black Pacific Islander White

Marital Status (circle one): Single Married Divorced Widowed Maiden Name: _____

Spouse/ Significant other name:_____

RESPONSIBLE PARTY/ INSURANCE POLICY HOLDER

Relationship to patient: (circle one): Parent Spouse Other: _____
Name: _____ Gender (circle one): M F

Mailing Address:_____ City: _____ State:_____ Zip:_____

Social Security #: _____-_____-_____ DOB: _____/_____/_____ Employer: _____

(please give insurance card to the front desk to ensure correct information is in your medical chart)

EMERGENCY CONTACT INFORMATION

Name: _____ Phone #: _____Relationship:_____
Name: _____ Phone #: _____Relationship:_____

MEDICATION INFORMATION

Pharmacy: Local: _____ Mail Order: _____

May we pull your pharmacy records? (circle one): YES NO Initials:_____

Medication Allergies: _____

Food or Environmental Allergies: _____

IF YOU HAVE A MEDICATION LIST, PLEASE GIVE IT TO THE RECEPTIONIST TO COPY

Medication	Dose	Times per day	How long have you been taking it?	Prescribing Provider

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MEDICAL HISTORY

Personal/ Biological Family Medical History: Do you or a member of your immediate family have or have had any of the following? (Immediate family: Father, Mother, Brothers, Sisters). Please mark "Y" for yes and "N" for no

Condition	You	Family	Relation	Condition	You	Family	Relation
Acid Reflux				Heart Attack			
Allergies				Heart Disease*			
Anemia				Hepatitis*			
Anxiety				High Cholesterol			
Arthritis*				HIV/ AIDS			
Asthma				Hypertension			
Atrial Fibrillation				Kidney Disease			
Birth Defects*				Migraines			
Bleeding/ Clotting disorder*				Osteopenia/ Osteoporosis			
Bowel Trouble*				Prostate Problems			
Cancer*				Psychiatric Problems*			
COPD				Seizure			
Depression				Stroke (CVA)			
Diabetes				Thyroid Problems			
Drug Abuse				Other*			

For Items marked "Y", please make specific comments below. If "*" is indicated, please specify which type.

Items Marked "Y": _____

_____

Have you ever been Hospitalized or had a surgery? If so, Please Specify: _____

_____

Have you ever been treated for a mental health condition? If so, please specify: _____

_____

_____

SOCIAL HISTORY

Do you exercise? ___Y ____N (If so, how often and what form):_____

Do you use tobacco? ___Y ___N (If so, how much & for how long):_____

Do you drink alcohol? ___Y ___N (If so, how much & for how long):_____

Do you have a LIVING WILL or ADVANCED DIRECTIVES? _____YES _____NO

(If yes, please give a copy to the front desk)

Grand Ave Family Medicine

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Grand Ave Family Medicine Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Grand Ave Family Medicine may disclose and use my protected health information.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date:_____

If signed by the patient's personal representative, Indicate:

a. Name of signer: _____
b. Relationship to patient: _____

If acknowledgement is not signed, indicate reason not signed and efforts made to have acknowledgement signed:

_____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Grand Ave Family Medicine to release protected health information, if necessary, about the above-named patient to the people named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

I understand that Grand Ave Family Medicine may need to discuss my medical condition and may need to share my medical record with any physician, physician extender, nurse, therapist or other health care provider who is involved in my care.

Grand Ave Family Medicine may leave messages (for appointment reminders, Lab or Xray results) **on my personal voicemail** _____Yes _____No
Phone: _____

Grand Ave Family Medicine may leave messages (for appointment reminders, Lab or Xray results) on my voicemail **at my work**. _____Yes _____No
Phone #:_____

If necessary, Grand Ave Family Medicine may talk with **my spouse or significant Other** about my medical condition and/or billing information. The name of this Person is: _____ _____Yes _____No
Phone #:_____

If necessary, Grand Ave Family Medicine may talk with **my parent(s) or with my Caretaker(s)** about my medical condition and/or billing information. The name of my Parents(s) or caretaker(s) is: _____ _____Yes _____No
Phone #:_____

Grand Ave Family Medicine **MAY NOT** discuss my medical conditions with: _____

Rights of the Patient:

I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document be sending written notification to: Grand Ave Family Medicine 3236 Grand Ave, Suite I Laramie, WY 82070. I understand that any change to this authorization is effective from the date signed going forward.

I understand that information used or disclosed as a result for this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

Grand Ave Family Medicine

Signature:_____ Date: _____

FINANCIAL AGREEMENT/ PAYMENT POLICY/AUTHORIZATION OF TREATMENT

Grand Ave Family Medicine is dedicated to providing you with the best possible care and services. We regard your understanding of our payment policies as an element of your care and treatment.

Patient Name: _____ Date: _____

Responsible party Name: _____

Relationship to patient: Self_____ Parent_____ Legal Guardian_____ Other (explain)_____

Grand Ave Family Medicine understands that with the Affordable Care Act , both the deductible amounts and the premium amounts have increased. The change in coverage has had an effect on both you, the patients, and us, the providers. In an attempt to keep costs to patients down, Grand Ave Family Medicine will require payment in full at the time of service until deductible amounts have been satisfied. Co-insurance amounts will be collected at the time of service once deductibles are met. Payment for services provided to self-pay/ uninsured patients will be due in full at the time of service. There will be no change in the collection of co-pays, they will continue to be collected at check in on the day of service. Grand Ave Family Medicine complies with the Patient Protection and Affordable Care Act (PPACA).

I, the patient, understand that while I am obligated to provide payment for any medical services received from Grand Ave Family Medicine. I understand that while insurance may cover some of my expenses, I will be personally responsible for anything not handled by my insurance company. I agree to pay deductibles, co-pays, and co-insurance amounts at the time of my visit. I understand that if I choose to appeal any charges not handled by my insurance company, I am still personally responsible for paying those amounts and will be refunded by Grand Ave Family Medicine if charges are paid at a later date. A refund of overpayment will be provided to me, the patient, if the amount is over $20, or if I request. Any credit amount under $20 will be held until my next visit. Grand Ave Family Medicine will provide billing with one (1) week of receiving an Explanation of Benefits from my insurance company. Any returned checks for non-sufficient funds will be charged an additional $30.

If no payments have been received on my account and /or I have not contacted the office to make financial arrangements, my outstanding balance will be assigned to a collection agency after 90 days of no payment. A 35% fee will be assigned to each balance sent to a collection agency.

I also understand that if I do not cancel an appointment within 24 hours of that scheduled appointment, or within 2 hours of an appointment scheduled the same day, I will be charged a no show fee of $67. The charge will need to be settled before any further appointments can be scheduled.

I authorize treatment of the person named above and I have read and understand the terms in this document. I agree to the terms stated. I understand that it is my responsibility to understand the coverage limitations of my insurance.

By signing this document, I am certifying that all of my billing information is correct, including but not limited to, my address, phone number, and email address. I will provide a copy of my insurance card and driver's license at each visit. I will notify Grand Ave Family Medicine immediately of any changes in my billing information.

My signature also confirms my understanding that upon notification to Grand Ave Family Medicine by me or by my insurance company that my coverage is not in effect, payment for any services I have incurred is due in full at the time of that notification.

Signature: _____ Date: _____

Grand Ave Family Medicine asks patients to provide a credit or debit card to be placed on file at their first visit. I agree that any failure to pay after 35 days of the insurance company's processing of my charges will result in the balance remaining being debited to the card on file. If a No-Show fee is charged, my card on file could possibly be debited the amount if the charge goes 30 days with out payment.

Credit/Debit card Type: Master Card:_____ Visa:_____ Discover:_____ American Express:_____

Credit/Debit card number: _____ Expiration Date: _____ CVV:_____

My signature relates to the acknowledgment of responsibility of payment charges AND authorization of payments of those charges on the credit or debit card I have provided according to the terms of this document.

Signature: _____ Date: _____