FAMILY PRACTICE CENTER
PATIENT *UPDATE* FORM, YEAR 2017
(Please print)

Today's Date: / /			Primary Care Physician:		
PATIENT INFORMATION					
Patient's last name: First: Middle:			□ Mr. □ Mrs.	□ Miss □ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid / Partnered
Name you preferred to be called:	(Former/Maiden Name):	Social Security no:	Birthdate: / /	Age:	Sex: □ M □ F
Home phone no: ( )	Cell phone no: ( )	Other phone no: ( )	Preferred contact method: □ Home ph □ Cell ph □ Oher ph		
Email Address:					
Street address:	City:	State:	ZIP Code:		
Occupation (if student please specify):	Employer:	Employer/Work phone no:			
Spouse/Partner Name:	Spouse/Partner Sex: □ M □ F □ Other: _____				
Referred to clinic by (please check on box): □ Dr.			□ Insurance Company/plan		
□ Our Website	□ Other Website	□ Friend/Family	□ Internet	□ Newspaper	□ Other
Preferred language	□ English □ Spanish □ Other (please specify):				
FINANCIAL INFORMATION					
(Please give your insurance card(s) and identification card/driver's license to the receptionist)					
If you are under 18, person responsible for bill:	Birthdate: / /	Address (if different):	Home phone no: ( )		
Is this person a patient here? □ Yes □ No					
Occupation (if student please specify):	Employer:	Employer/Work phone no:			
INSURANCE INFORMATION					
Is patient covered by Insurance? □ Yes □ No Primary Insurance Company:					
Subscribers name:	Subscribers S.S.no:	Birthdate: / /	Policy no:	Group no:	
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Policy no:	Group no:		
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other					
IN CASE OF EMERGENCY					
Name of local friend or relative to contact in an emergency:	Relationship to patient:	Home phone no: ( )	Work phone no: ( )		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize FAMILY PRACTICE CENTER or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

FAMILY PRACTICE CENTER COMMUNICATION

APPOINTMENT REMINDERS:
I wish to be reminded of upcoming appointments via:

□ HOME PHONE (call)	□ CELL PHONE (call)	□ EMAIL	□ TEXT (*to opt in to text, text PPG to 622622*)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In the event you must be contacted by phone with regards to appointments, test results, referrals, or any other reason, please indicate how you wish to be contacted.

Phone Number: _____

Is it ok to leave a message? _____ Yes _____ No

Do you want Family Practice Center, and all employees thereof, to be able to determine financial matters or medical care with any family members or emergency contacts? This permission will be valid indefinitely and must be revoked in writing. If so, please specify who and which information, below.

You may discuss my financial matters or medical care with the following:

INFORMATION OK TO DISCUSS	**NAME**	**RELATIONSHIP**	**PHONE NUMBER**
□ FINANCIAL □ MEDICAL			

_____

Patient's Printed Name Date of Birth

_____

Patient/Legal Representative Signature Date

_____

Relationship to patient

Patient Name:_____Today's Date:_____/_____/_____

MEDICAL HISTORY UPDATE

Within the past month:

New Diagnoses, Injuries, Operations:_____

_____

_____

_____

Last Pap:_____ Abnormal Pap tests: Y N Last Mammogram:_____ Contraception(Type): _____

Immunizations: (Date)

Tetanus_____ HPV_____ Pneumonia_____ Shingles_____ Hepatitis B_____ Meningitis_____

Medication Changes:

_____

_____

_____

Allergies (medications, pollens, foods, etc.):_____

How often do you exercise?_____ How long do you exercise?_____

Alcohol (average # of drinks per day): _____ Recreational drug use(include type & age):_____

Do you smoke? Y N How long?_____ How Much?_____ Ready to quit smoking? Y N

Updates to Family Medical History: _____

_____

_____

_____

_____

_____

_____

RIGHTS AND RESPONSIBILITIES

YOU HAVE A RIGHT:

- To be treated with respect, consideration and dignity at all times.
- To receive assistance in a responsible manner
- To receive information about your health including your diagnosis, treatment, testing or procedures and medical alternatives including associated risks that may be involved in your healthcare.
- To know the identity and professional status of individuals providing services to you.
- To expect that your medical records and communications will be treated in a confidential manner.
- To refuse treatment and be advised of the alternative and likely consequences of your decision.
- To express a complaint to the Administrator, and/or Physician.

YOU HAVE A RESPONSIBILITY:

- To review and understand your health insurance coverage and benefits.
- To learn and understand the proper use of your insurance plan services and procedures for obtaining coverage. This includes knowing the referral policy for your plan, laboratory restrictions and outpatient facilities covered by your plan as well as co-pay requirements.
- To always carry your insurance plan identification card and be prepared to show it at each visit, if asked.
- Patients will be required to pay for all services provided if insurance information is not provided by the patient at the time services are rendered or the information provided is inaccurate.
- To treat all office personnel respectfully and courteously.
- To keep scheduled appointments and to notify the office promptly if you will be delayed or unable to keep an appointment.
- To pay all charges for co-payments, deductibles, non-covered benefits or services at the time of your visit, unless prior arrangements have been made.
- To ask questions and seek clarification until you fully understand the care you are receiving.
- To follow the advice of your medical provider and consider the alternatives and/or likely consequences if you refuse to comply.
- To provide honest and complete information to those providing medical care.
- To express your opinions, concerns, or complaints in a constructive and appropriate manner.

I have read and understand the office policy as stated above:

_____

Patient's Printed Name Date of Birth

_____

Patient/Legal Representative Signature Date

_____

Relationship to patient

James H. Wheeler, M. D. **Tyler H. Wheeler, M.D.** **C. Steven Schramm, M. D**.

FAMILY PRACTICE CENTER

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Family Practice Center, P.C. may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). You have the right to review our Notice of Privacy Practices prior to signing this contract. We reserve the right to revise our Notice of Privacy Practices at any time.

With your consent, Family Practice Center, P.C. may call, email or send mail to your home or office and leave a message in reference to any items that assist the practice in carrying our TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent.

<u>If you decline to sign this consent, we may decline to provide treatment for you.</u>

_____

Patient's Printed Name Date of Birth

_____

Patient/Legal Representative Signature Date

_____

Relationship to patient

FINANCIAL POLICY and

ADMINISTRATIVE SERVICES FEE

Patient Name:_____

(Please Print)

We are committed to meeting your healthcare needs. Our goal is to keep your insurance and financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask you to adhere to the following guidelines and choose a plan that meets your needs:

1. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.
2. It is your responsibility to confirm with your insurance company that our physicians participate in your insurance plan.
3. You are ultimately responsible for payment for services you receive from our office. Any non-payment, including non-payment of co-pays and returned checks will result in a $35 billing fee in addition to the balance owed.
4. Canceling an appointment less than 24 hours in advance or no-showing an appointment will result in the following charges: $35 for a regular office visit, $75 for an annual physical and $100 for an ECHO, Ultrasound or Flexible Sigmoidoscopy. **3 late cancellations or no-shows in one year may result in your dismissal from our practice.**
5. The vast majority of prescription refill requests will require an office visit. "Emergency" prescription refills maybe subject to a $35 fee.

6. **Our office collects an Administrative Service Fee (ASF) of $6 on *each visit* or $65.00 *annually* to cover the cost of certain administrative services we may provide that are not covered by your insurance. Examples of these services are forms and letters such as the following:**
   - **a. Prior Authorizations**
   - **b. Pre-Certifications**
   - **c. School/Sports Physical/Camp form**
   - **d. Employee Health/Biometric form**
   - **e. Life Insurance forms**
   - **f. Parking/Handicap permit**
   - **g. Other miscellaneous forms**

- *You are not required to pay the Administrative Service Fee; however, if you choose not to pay the optional fee, you will be charged for all administrative services, as needed. You will not be given a chance to pay the ASF at the time you request a form to be filled out.*

□ I elect to pay the $6.00 per visit ASF Initial_____

□ I elect to pay the $65.00 annual ASF Initial_____

□ I choose not to pay the ASF. I understand that with this decision, I will pay for services as I need them at a minimum rate of $60 per form/drafted letter and $35 per prior authorization per medication. **Initial_____**

I acknowledge the terms of the financial policy and administrative service fee. I understand that failure to comply with the policies may result in my dismissal from Family Practice Center, PC.

_____

Patient's Printed Name Date of Birth

_____

Patient/Legal Representative Signature Date

_____

Relationship to patient