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New Patient Information and Responsible Party Information

Patient Information:

Full Name			Primary Care Physician		
Address			Referring Provider		
			Date of Birth	Sex	Marital Status
City			Social Security Number		
State	Zip Code		Emergency Contact		
Primary Phone	Alternate Phone		Relationship to the patient	Phone Number	
Work Phone		Ext	Emergency Contact Address		
E-mail Address			Preferred Pharmacy		

Responsible Party (if different from above):

Full Name			
Address			
Primary Phone	Alternate Phone		
Employer Name	Employer Address	City, State, Zip	
Social Security Number	Relationship to the patient	Sex	Date of birth
Email Address	Marital Status		

Insurance Information:

Insurance Name	Policy Holder Name		Self-Pay	
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	

Reason for your Visit Today:

_____

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Patient Medical History

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Past Medical History: Has a doctor or other health care provider ever told you that you have any of the following?

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Asthma
- ☐ HIV or AIDs
- ☐ Cancer (type) _____
- ☐ Stroke
- ☐ Blood clots
- ☐ Kidney Stones
- ☐ Other _____

Past Surgical History: Do you have a surgical history of the following? Please list all others with dates.

	Date:		Date:		Date:
☐ Appendix	_____	☐ Gallbladder	_____	☐ Hip Replacement (L or R)	_____
☐ Heart Bypass	_____	☐ C-Section	_____	☐ Knee Replacement (L or R	_____
☐ Cardiac Stent	_____	☐ Tubal Ligation	_____	☐ Hernia	_____
☐ Pacemaker	_____	☐ Hysterectomy	_____	☐ Tonsillectomy	_____
☐ Colonoscopy	_____	☐ EGD	_____	☐ Other	_____

Social History:

- ☐ Non-smoker
- ☐ Current smoker _____ packs per day
- ☐ Former smoker _____ quit date
- ☐ Married / Widow / Single / Divorced
- ☐ Chewing Tobacco
- ☐ Dip
- ☐ Vape
- ☐ Alcohol

Family Medical History: If any blood relatives have suffered from any of the following, please indicate which relative:

M - Mother, **F** - Father, **PGM** - Paternal Grandmother, **PGF** - Paternal Grandfather
MGM - Maternal Grandmother, **MGF** - Maternal Grandfather, **B**- brother, **S** - Sister, **C** - Child

- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Stroke _____
- ☐ Cancer (type) _____
- ☐ High Cholesterol _____

Mom: Alive / Deceased / Unknown Dad: Alive / Deceased / Unknown

Medications: Please list all medication you are taking, including over the counter:

Name:	Dosage:	How Often:

Drug Allergies: Please list all drug allergies and the type of reaction

_____ _____ _____ _____

_____ _____ _____ _____

Allergy Screening

FMC Kim

Patient Name: _____ Date of Birth: ____/____/_____

Patient Phone: _____ Today's Date:_____/_____/____

Do you take allergy medications frequently (Allegra, Zyrtec, Benadryl, Zyzal, Flonase, Nasocort)? Yes _____ No_____

Do your symptoms disturb your sleep? Yes_____ No_____

Do you have to miss school or work because of respiratory issues (Asthma, Congestion, Sinus Infections)? Yes_____ No_____

Have you had a reaction to any foods in the past? If so, describe the event.
Yes _____ No _____

What Happened?

_____

_____

_____

_____

Have you ever been tested for food allergies? Yes _____ No _____

FOR PROVIDER USE ONLY:

Order Allergy Test 95004 – Yes _____ No _____

Please Select: Food _____, Environmental _____, Both Food & Environmental _____.

Diagnosis Code: J30.89 Other Allergic Rhinitis _____, J30.1 Allergic Rhinitis due to Pollen _____, J30.02 Other Seasonal Allergic Rhinitis _____, Other _____.

Provider Signature: _____

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CONSENT, ASSIGNMENT, AND RELEASE FORM

Consent For Medical Treatment

I voluntarily present to Family Medicine Centers/CareXpress and consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

____(Initial)

Assignment of Insurance Benefits and Payment Guarantee

In consideration of services provided, I hereby assign and transfer to Family Medicine Centers/CareXpress any and all rights, which I have against insurance companies or third-party payers, for payment of charges for services provided by Family Medicine Centers/CareXpress to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third-party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Family Medicine Centers/CareXpress. It is our policy that any insurance co-pays and deductibles or any balance of a bill owed by those without insurance is due at the time of service.

_____(Initial)

Patient's Consent to Obtain External Prescription History

I grant permission to the healthcare providers at Family Medicine Centers/CareXpress 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.

____(Initial)

Patient Portal Authorization on the Web

Family Medicine Centers/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 email, a secure User IDs 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. To provide you access to the Patient Portal, please provide us your email address

Email Address: _____

Acknowledgment of the Family Medicine Centers/CareXpress Financial Policy (see attached forms)

Patient Signature: _____

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RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. TREATING PHYSICIANS on staff at Family Medicine Centers/CareXpress and their staff, agents of another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow up care.
2. AN EMPLOYER who requests services. This may include your personal medical history, physical, laboratory and diagnostic tests, and drug screenings (including the presence of drugs, alcohol, or marijuana).
3. INSURANCE COMPANY or other third-party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided, and insuring government compliance.
4. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.

I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected and that I could be held liable for the full cost of services provided by Family Medicine Centers/CareXpress. I understand this information may contain my personal medical history, physical, and treatments (if necessary), radiographic and laboratory results, and more specifically results in reference to alcohol/drug abuse, mental health, or infectious disease (including human immune-deficiency virus, hepatitis, or other infectious diseases). I understand that I have the right to revoke this authorization.

____**(Initial)**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of Family Medicine Centers/CareXpress to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. I authorize Family Medicine Center/CareXpress to release all information (including verbal information, copies of x-rays and medical paperwork) concerning my medical care to the following individuals listed below.

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third-party payers and their agents. I authorize Family Medicine Centers/CareXpress to verbally discuss financial information with the following individual listed below.

____**(Initial)**

Name: _____Relationship: _____ Phone Number: _____

Name: _____Relationship: _____ Phone Number: _____

_____ **I DO NOT** authorize Family Medicine Centers/CareXpress to release any information concerning my care to any individual.

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Family Medicine Centers/CareXpress may use and disclose my protected health information. I understand that Family Medicine Centers/CareXpress reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

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Signature of Patient or Parent/Guardian: _____ Date: _____

Notice of Privacy Practices

This notice describes how Medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At our facility privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you when necessary to provide treatment, verify eligibility and obtain authorization about you when considering a request from you or when exercising our rights under the law or any agreement with you.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name, address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Also, in order to remind you of appointments or changes in appointments we may leave a message with someone in your household or answering machine either at home or place of employment. From time to time, we may send information via US Mail regarding appointments, follow ups, or other health information.

Keeping information accurate

Keeping your health information accurate and up to date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please contact the office manager at this clinic. We take appropriate action to correct an erroneous information as quickly as possible through a standard set of practices and procedures.

How and why information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within our organization.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- *Other:* Patient-specific personally identifiable date us released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further unless you give us permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties including government agencies.

Our organization does not share any customer information with third-party marketers who offer their products and services.

Count on our community to your privacy

You can count on us to keep your informed about how we protect your privacy and limit the sharing of information you provide to us-whether it is at our office, over the phone or through the internet.

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Family Medicine Centers and CareXpress Financial Policy (Patient Copy)

Thank you for choosing Family Medicine Centers and CareXpress. We are committed to providing you with quality, compassionate, and convenient healthcare. We believe that a good provider/patient relationship is based on understanding and communication. We feel it is important to provide you with this Financial Policy, which outlines patient financial responsibilities related to payment for our services. If you are concerned about the potential charges, please speak to our staff immediately.

Patients Without Insurance

We accept patients without insurance. Payment is due, in full, at the time services are rendered. Best efforts will be made by the clinic to estimate the total charges for your visit. Payment for a basic visit is required up front. Any additional diagnostic testing, procedures, medications administered, and/or supplies/equipment used during the visit, will be due, in-full, upon discharge.

Patients with Participating Insurances & Medicare

We participate with a variety of insurance plans and with Medicare, however, we do not accept Medicaid. It is your responsibility to:

- Understand your insurance plan benefits, including co-payment/co-insurance and/or deductibles.
- Know if your insurance requires a referral or an authorization for you to be seen and obtain it PRIOR to your visit.
- Bring your insurance card and picture ID to every visit. You will not be seen without them.
- Bring an accepted form of payment and be prepared to pay any unmet deductible and your co-payment before each visit.
- For medical care not covered under insurance, payment in full will be required at the time of service.
- Update us of any changes in insurance coverage since last visit.

Financial Responsibility

The patient and/or guarantor are ultimately responsible for all charges associated with your visit regardless of insurance coverage. All balances from previous visit(s) are due and payable prior to any new visits. We will verify your insurance benefits to the best of our ability, however, there may be additional balances due after your health insurance processes your claim according to your benefits. If we cannot verify your health insurance benefits, we will expect payment in full at the time of service.

Copayment and Deductibles

We want to help patients better understand why they are being charged a certain amount, and why these amounts may differ from those charged to other family members or friends. It is important to understand that a patient's out of pocket amount is determined by the insurance plan chosen by the policy holder and/or their employer. Some employers offer employees a variety of plans, from several different insurance companies, from which to choose. The cost of the plan is often directly related to the deductible/copayment amounts, the higher the monthly premium, the lower the deductible/co-payments, and vice versa. Rest assured, we charge from a standard fee schedule, and any differences in charges from person-to-person stem from differences in insurance coverage and/or the status of an individual's deductible at the time of visit. Copayments and deductibles are a contract responsibility between you and your insurance company and are non-negotiable. It is our policy to collect all co-payments and/or any unmet deductible at every visit, during the registration process. If you still have questions regarding your charges, you are encouraged to call our billing office at 806-358-9400.

Billing Terms

Payment is due upon receipt of your statement. Balances will be considered past due if no payment is received within 30 days of the statement issue date. All past due amounts may be subject to a monthly late fee. All balances that are not paid within 90 days will be referred to a collection agency. Payment arrangements are available. If payment is made by check and the check is returned by your bank for any reason, a $25 returned check fee will be added to your account.

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Payment Arrangements

Typically, we do not make payment arrangements. In the event you have a balance remaining after insurance has paid or if they deny the claim, the balance is due in full; however, if you are unable to make the full payment, you may call us to make arrangements to bring your account current.

Past Due Accounts & Collections Accounts

If your account is past due or has been turned over to a collection agency and you want to be seen, you must pay the past due balance in full, as well as any current charges for which you are responsible. We reserve the right to refuse service to you and your family for repeated non-payment.

Non-Participating Insurances

If you have insurance that the office does not participate in, you will be responsible for full payment of all services at the time they are rendered. As a courtesy, our Billing Office will file a claim with your insurance. If any portion of your visit was covered, you will be sent a refund.

Medicaid

We DO NOT see Medicaid patients who request to pay cash. Doing so shows the "ability to pay," and may result in the loss of Medicaid coverage. Additionally, any prescriptions written may be rejected/not covered by Medicaid because our providers are considered "non-participating. "

Non-Covered Services

Please be aware that some, and perhaps all, of the items or services you receive may not be a covered benefit under your insurance plan. You will be responsible for payment, in-full and at the time of service, charges for any non-covered items and/or services. Medicare patients may be required to provide an executed Advanced Beneficiary Notice (ABN). Secondary Insurance If you have insurance coverage under more than one plan, we will courtesy file with your secondary insurance. To do this, we will need to know which plan primary and which plan(s) is secondary.

Motor Vehicle Accidents & Third-Party Payers

In most cases, we consider this a private matter between you and your auto carrier. Your medical carrier may not cover care. Therefore, you may be required to pay for all services at the time of service. We do not file claims to auto carriers or accept liens.

On the Job Injuries

We accept patients for **initial** evaluation, treatment, and/or stabilization of workplace/work-related injuries. If your employer carries Worker's Compensation Insurance, we will file your claim for you and bill your employer's worker's compensation plan directly. Any denied services are your responsibility. Once you have reported to CareXpress staff that your visit is due to a workplace or work-related injury, it will be documented as such. All circumstances of the injury will be documented, including where, when, how etc. We WILL NOT omit information or alter/change documentation to receive payment. If you request that we submit the claim to your medical insurance carrier, we cannot guarantee that they will pay for your visit. If your claim is denied for any reason or if your employer fails to timely file your claim, you will be held responsible for the full payment for the services rendered. If your claim is rejected due to errors in the information you provided, you will be responsible for all charges.

Additional Charges

Medical Records may be obtained upon written request for a small administrative fee. X-ray images on CD may be obtained for $25 for the first 20 pages and $0.50 per page thereafter.

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Treatment of a Minor

If the patient is a minor (under 18 years of age), the parent or legal guardian must complete all registration forms. The parent or legal guardian of a minor is financially responsible for payment at the time of service, as well as obtaining any required referrals and providing insurance and picture ID cards. Minors must be accompanied by a parent/legal guardian or by a designated adult who has been given written permission to make medical decisions on behalf of the parent/guardian, for the minor child. Please Note: Our office can only discuss billing information (no medical information) regarding patients 18 years of age and older, regardless of whether or not the parent is financially responsible.

Forms

We recommend you bring to your visit all forms that need to be completed by us (such as employer return to work, etc.). Completion of forms during your visit will be done free of charge; however, if you require us to complete any forms after your visit, you will incur a $25 administrative fee for each request. All requests must allow at least 3 business days for completion.

Disclaimer

Family Medicine Centers and CareXpress reserve the right to refuse treatment to anyone who fails to comply with these policies.

These policies are subject to change without notice. By signing the forms provided by Family Medicine Centers and CareXpress Urgent Care, you are acknowledging that you have received, signed, and agreed to the terms of the Financial Policy.