Family Medicine Center
of the Bitterroot, P.C.

330 N. 10th Street, Ste. A • Hamilton, MT 59840 • Phone: 406-363-DOCS(3627) • Fax: 406-363-3638 • www.familymedcenter.org

PATIENT REGISTRATION / FINANCIAL AGREEMENT

Thank you for taking time to complete this form. This information is necessary for the preparation of your clinic records. You are responsible for all charges as billed. PLEASE INFORM RECEPTIONIST IF VISIT IS WORKER'S COMP OR AUTO ACCIDENT RELATED.

PLEASE PRINT AND COMPLETE THE ENTIRE FORM.
WE ARE UNABLE TO BILL INSURANCE WITHOUT BIRTH DATES AND SS#.

PATIENT INFORMATION

Patient Name:

____
First Middle Last

Gender M / F Birthdate ________________________

SS# _______________________________________

Mailing address _______________________________________

City ______________________State _______ Zip __________

Phone: home: __________________ cell:____________________

EMPLOYER INFORMATION

Employer Name ____

Employer address ______________________________________

City ______________________State _______ Zip __________

Employer Phone: ______________________________________

Occupation:____

Which pharmacy do you typically use? _______________________

EMERGENCY CONTACT INFORMATION

Name: ____

Phone: ___________________ Alt. Phone:___________________

Address: ____

____

IF PATIENT IS A MINOR

Mother's Name: _______________________________________

Phone ____

Mailing address _______________________________________

City ______________________State _______ Zip __________

Birthdate _________________ SS# ______________________

Mother's Employer: ____________________________________

Employer's Phone Number: _______________________________

Father's Name: ____

Phone ____

Mailing address _______________________________________

City ______________________State _______ Zip __________

Birthdate _________________ SS# ______________________

Father's Employer:_____________________________________

Employer's Phone Number: _______________________________

IF PATIENT IS AN ADULT

_____Married ______Single ______Divorced ______Widowed

If married:
Spouse's Name ____

Phone____

Birthdate _________________ SS# ______________________

Spouse's Employer: ____________________________________

Employer's Phone Number: _______________________________

INSURANCE

If you have **NO** insurance, check here:_______

Name of Insurance Company ____

Policy Holder's Name: ____
First Middle Last

Policy Holder's ID # ______________________________________ Group Number____

Name of Secondary Insurance Company ____

Policy Holder's Name: ____

Policy Holder's ID # ______________________________________ Group Number____

***** Please provide copies of your insurance cards to the receptionist to insure accurate billing.**

I authorize the release of any medical information which may be requested to process claims for payment of medical services through my insurance carrier, prepaid medical plan, or government agency. I authorize payments to be made to the clinic or it's physicians. I assume liability for all non-covered charges and deductibles. By providing a mobile/cell number I have authorized contact through that number for any activity involving services to me, including but not limited to the resolution of balances on my account. This number will not be shared with any party other than those in-house or any business entity contracted to perform duties resulting from services provided to me by this office. By signing this form I acknowledge that I have received a copy of the Notice of Privacy Practices of Family Medicine Center of the Bitterroot.

____
Signature of Responsible Person Date Relationship

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Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some—and perhaps all—of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Payment.** If your payment is made in full at the time of service, a discount will be applied to the balance.

8. **Nonpayment.** If your account is over 60 days past due, you will receive notification stating that you have two weeks to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____ ________________

Signature of patient or responsible party Date

Daniel Child, D.O. Brenda Kirkland, M.D. Brett Heath, M.D. Nicolett Weston, FNP-C

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PRESCRIPTION REFILLS

Dear Patient,
We take our commitment to your health seriously and prescribing medicine is an important service we provide to you. For this reason, we ask that you follow these guidelines when refilling prescription medicines.

1. **Office visits are required to obtain a prescription.** The reason for this is to evaluate the particular disease or condition that the drug is treating and also to monitor for any drug side effects.

2. **In most cases, we intentionally will give you enough refills of your medicine until we need to see you again.**

3. Please plan ahead and know when you have at least a week left of your medications.
   It will take us 72 hours to refill your medications pending doctor/insurance approval. (No after-hours/holidays/or weekend refills will be authorized.)

4. **Please call your pharmacy for refills first.** The pharmacy will send us a request. We ask that you only request telephone refills in an emergency.

5. **Please discuss any concerns with your physician.**

****I HAVE READ, UNDERSTAND, AND AGREE WITH THIS POLICY****

____   ____________________

Patient Signature   **Date**

____   ____________________

Patient Printed Name   **Date of Birth**

Family Medicine Center
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ADULT PATIENT HISTORY

Date: ______________________________

Name: ______________________________

Race/Ethnicities (You may decline to answer, however, please note that different races are associated with different health risk factors)____________
____

Occupation: ______________________________

Marital Status: S M W D

Religion: (Optional) ______________________________

Ages of Children: ______________________________

FOR WOMEN:

No. of pregnancies: ______________________________

No. of deliveries: ______________________________

No. of miscarriages: ______________________________

Type of contraception: ______________________________

Last Pap smear: ______________________________

Last Mammogram: ______________________________

Last Dexa scan: ______________________________

History of abnormal Pap smear: Yes No

ALLERGIES (meds, foods, pollens)

____
____

IMMUNIZATION (Date of last.)

Pneumonia: ______________________________

Tetanus: ______________________________

Influenza: ______________________________

Do you have any acute or chronic pain? If so, what pain medications are you taking? ______________________________

CURRENT MEDICATIONS
(Please list all, both prescription and over the counter medications)

____
____
____
____

MEDICAL PROBLEMS (If none, so state) **YEAR**
(Include all hospitalizations, past and present illnesses)

____
____
____
____

SURGERIES/PROCEDURES (If none, so state) **YEAR**

____
____
____
____

FAMILY HISTORY

	Age now	Age at death	Illnesses
Father			
Mother			
Sister(s)			
Brother(s)			
Children			

FAMILY HISTORY - Please write in relatives who have had the following:

Allergies ______________________________
Arthritis ______________________________
Asthma ______________________________
Cancer (type) ______________________________
Diabetes ______________________________
Epilepsy ______________________________
Glaucoma ______________________________
Heart disease ______________________________
High blood pressure ______________________________
High cholesterol or lipids ______________________________
Mental/emotional problems ______________________________
Migraine ______________________________
Stroke ______________________________
Suicide ______________________________
Other inherited diseases ______________________________
____
____
____

HABITS:

Do you smoke cigarettes? Yes No If yes, how much? _______ How long? ________

Have you ever smoked cigarettes? Yes No When did you last quit? ________________

Do you use other forms of tobacco? Yes No What kind? ____________________ How much? __________________

How many cups of coffee, tea, or cola do you drink per day? ______________________________

Total number of beers, glasses of wine, or mixed drinks per week? __________________________

What type of exercise do you get regularly? _____________ How often? ___________________

How often do you use seat belts? 25% 50% 75% 100%

Please Fill Out Reverse Side

MEDICAL PROBLEMS: Give the year you had the problem or a ☐ if you have it now.

________ ear trouble
________ eye trouble
________ frequent colds
________ frequent headaches
________ hayfever
________ sinus trouble
________ asthma
________ lung trouble
________ tuberculosis
________ blood cholesterol or lipid elevation
________ heart murmur
________ heart trouble
________ high blood pressure
________ phlebitis
________ rheumatic fever
________ varicose veins
________ vein problem
________ bowel trouble
________ diverticulosis/diverticulitis
________ gallbladder trouble
________ hemorrhoids
________ jaundice/hepatitis
________ liver trouble
________ pancreas problem
________ stomach or duodenal ulcer
________ breast lumps
________ DES exposure
________ hernia
________ kidney or urinary troubles
________ menstrual problems
________ prostate trouble
________ sexually transmitted diseases
________ arthritis
________ gout
________ back trouble
________ neck trouble
________ bone fracture or joint injury
________ anemia
________ blood disorder
________ diabetes
________ thyroid problems
________ seizures/epilepsy
________ neurologic disorder
________ stroke or paralysis
________ alcoholism
________ drug abuse
________ emotional problem
________ sexual problems
________ suicide attempt
________ cancer
________ congenital condition
________ skin disease
________ weight problem
________ asbestos exposure
________ radiation therapy
________ Any other problems:

____

____

SYMPTOMS: ☐ if you have any of the following:

________ ear pain
________ decreased hearing
________ persistent hoarseness
________ blood in sputum
________ frequent cough
________ shortness of breath
  __________ on exertion
  __________ lying flat
________ chest pains
________ fainting or dizziness
________ leg pain when walking
________ swollen ankles
________ unusual or irregular heartbeat
________ abdominal pains
________ bloody or tarry stools
________ change in appetite
________ constipation
________ diarrhea
________ difficulty swallowing
________ indigestion
________ persistent nausea or vomiting
________ blood in urine
________ difficulty controlling urine
________ pain while urinating
________ urinating at night (more than 2 times)
________ discharge from penis
________ difficulty having erection
________ urethral discharge
________ vaginal discharge
________ breast lumps
________ nipple discharge
________ hot flashes
________ pain with intercourse
________ leg cramps
________ muscle weakness
________ painful joints
________ bruise easily
________ memory loss
________ numbness/tingling
________ tremor
________ weakness
________ change in sleep pattern
________ feelings of despair
________ usually nervous
________ fever
________ night sweats
________ usually tired

Your reason for requesting an appointment?

____

____

____

____

NAME ____

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RELEASE RECORDS TO FAMILY MEDICINE CENTER

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize to disclose the following information from the health records of:

Patient Name: ______________________________ Date of Birth: __________
(first name, middle initial, last name)

Address: ______________________________
(street, state and zip code)

Telephone: ______________________________ Social Security # __________

(2a) Records released from: Name: ______________________________
Address: ______________________________
____

(2b) This information to be disclosed to: Name: Family Medicine Center of the Bitterroot
Address: 330 North 10th Street, Suite A
Hamilton, MT 59840

(3) This information to be disclosed will be used for: ______________________________.

(4) Covering the period(s) of healthcare: ______________________________.

(5) Information to be disclosed: All Medical Records including: Progress Notes, Lab Reports, X-ray Reports, History ad Physical examinations, Discharge Summaries, Consultation Reports, Emergency Room Records, Operative Notes, Pathology Reports, Home Health Records and Hospice Records.

(6) I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

(7) I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire six (6) months from the date of signing.

(8) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(9) I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Administrator of Family Medicine Center of the Bitterroot, P.C.

(10) I understand authorizing the use or disclosure of the information identified above is voluntary.
I need not sign this form to ensure healthcare treatment.

______________________________ __________
Signature of Patient or Legal Representative Date

If signed by Legal Representative, indicate relationship to the patient ______________________________

Daniel Child, D.O. Brenda Kirkland, M.D. Brett Heath, M.D. Nicolett Weston, FNP-C