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

FMC 1106

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**

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NEWBORN/INFANT INITIAL PATIENT HISTORY

Date:_____ Date of Birth_____

Baby's Name_____

Birth weight _____ Discharge weight_____

Mother's Name_____

Father's Name_____

Phone Number:_____

How many brothers/ sisters_____

Did the baby get its first Hepatitis B immunization in the hospital?_____

Was the baby full term?_____ If early, at how many weeks? _____

Any problems with delivery? _____

_____

Did baby pass hearing screen done in hospital?_____

Any previous surgeries/ procedures or known medical problems?_____

Does anyone in the household smoke?_____

Is the baby breastfeeding or bottle feeding? _____

If taking formula,which brand, how much and how often? _____

FAMILY HISTORY - Please write in relatives who have had the following: (Mother, Father, Paternal Grandparents, Maternal Grandparents, Paternal Uncle, brother)

Allergies _____ Cystic Fibrosis _____

Arthritis_____ Mental/emotional problems_____

Asthma_____ Hemophilia_____

Cancer (type) _____ Autism_____

Diabetes _____ Downs Syndrome_____

Epilepsy _____ Congenital Heart disease_____

High blood pressure_____ Other inherited diseases_____

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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 immuno-deficiency 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 _____