



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: _____

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.

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: _____

Signature of Responsible Person Date Relationship
Daniel Child, D.O. Brenda Kirkland, M.D. Brett Heath, M.D. Nicolett Weston, FNP-C w



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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



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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 of the Bitterroot, P.C.

PEDIATRIC PATIENT HISTORY

Date: _____

Name: _____

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

Mother's Name: _____ Father's Name _____

Current School and Grade Level _____

Current Sports Played: _____

Religion (optional): _____

Are child's immunizations current: Yes ___ No ___ Unsure ___

Is your child enrolled in the state immunization registry?

Yes _____ No _____

If not, please speak with the nurse for more information.

Previous Physician's Name: _____

Type of Delivery: Vaginal _____ C-Section _____

Born at How Many Weeks: _____

Were there any birth complications? _____

Does your child have any learning disabilities or special needs issues? _____

Any mental health issues? _____

ALLERGIES (meds, foods, pollens)

IMMUNIZATION (If applicable)

Pneumonia: _____

Tetanus: _____

Influenza: _____

CURRENT MEDICATIONS

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

MEDICAL PROBLEMS (If none, so state) YEAR

(Include all hospitalizations, past and present illnesses)

SURGERIES/PROCEDURES/ BROKEN BONES (If none, so state) YEAR

FAMILY HISTORY

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

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

Allergies _____

Arthritis _____

Asthma _____

Cancer (type) _____

Diabetes _____

Epilepsy _____

Heart disease _____

High blood pressure _____

High cholesterol or lipids _____

Mental/emotional problems _____

Migraine _____

Suicide _____

Surgeries/Procedures/Broken Bones _____

Other inherited diseases _____

HABITS: (If applicable)

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? _____

Do you use alcohol? Yes ___ No ___ How often do you drink? _____

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 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 _____