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:_____

Email:_____ Portal: ❑ Yes ❑ No

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

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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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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 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 _____

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PATIENT AUTHORIZATION FORM

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of test, procedures and financial information. Under the requirements of H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures regarding your prior consent.

I authorize Family Medicine Center of the Bitterroot to release my records and any information requested to the following individuals.

1. _____ **Relation to Patient** _____
2. _____ **Relation to Patient** _____
3. _____ **Relation to Patient** _____
4. _____ **Relation to Patient** _____

Authorization Regarding Messages

(please check all that apply)

_____ **I authorize you to leave a detailed message on my home or cell number regarding appointments**

_____ **I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information.**

_____ **I authorize you to leave a message with anyone who answers the phone.**

_____ **Messages may only be left with** _____

Patient Name (Please print) (Date)

_____

Patient signature

_____