Doctor: _________Date: ________Time: _____ **revised 8/25/2015**

PATIENT INFORMATION FORM

Please provide the following information and answer the questions below. Please note: the information you provide here is protected as confidential information.

Name: _____ ____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____

(Last) (First) (Middle Initial)

Home/Cell phone: **(________)** ________________ May we leave a message? ___Yes ___ No

E-mail: _______________________________May we email you? Yes__ No__

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Address: ____

____

City State Zip

Employer: ____

Occupation: ____

Social Security Number: ________________________________

Date of Birth: _______ Sex: __Male __Female Height: ______ Weight: ______

Description of visit____

To be completed by clinical Staff:

Pharmacy: ____________________

Pneumovax: ____ Prevnar 13: ____ FLU___ Smoker: __ Yes __ No Chest CT __ Yes__ No

Date of last: Bone Density: _____ Colonoscopy: _____ Mammogram: _____

Pap smear: ______Physical: ________ Tetanus: ______ Shingles_____

Allergies: ____

Blood Pressure: _____ Pulse: ________ AUDIOLOGY___PASS ____FAIL

Res______ Temp: _______ Oxygen: _______

HealthFit Family Medicine
831 S. Perry St., Ste. 200
303-218-7774

Billing Office
Po Box 3770
Parker, Co 80138
303-805-7686

Billing and Financial Agreement

Affordable Healthcare Act (AHA) has brought many changes to the area of medical insurance and these changes have affected both the patient and medical practices. These changes include higher Patient Co-pays, higher Patient Deductibles and increased complexity in dealing with insurance providers. You are asked to update your personal and insurance information at each visit. Failure to provide accurate information may result in additional charges applying to your account, for which you may be personally responsible.

The focus of HealthFit Family Medicine is to provide the highest level of patient care possible. Our providers and staff are dedicated to the care of our patients. Because of the increased cost of dealing with medical insurance providers under the Affordable Healthcare Act (AHA), HealthFit Family Medicine wants to make you aware of our billing practices. Please initial each item and sign below that you agree to the terms. If you have any questions, please contact our billing office prior to your scheduled appointment.

Some payments may be required at the time of service, even if I have medical insurance. In addition to my insurance co-payment, a $75 payment may be collected if my insurance deductible has not been met. All payments are due at the time services are rendered, unless other payment arrangements have been approved, in advance, by the office manager.	Initial
I have a contractual agreement with my medical insurance. I understand that HealthFit Family Medicine is billing my insurance only as a courtesy and that I am solely obligated to pay all fees associated with the care provided by HealthFit Family Medicine. If my insurance does not pay, for any reason, I agree to pay for medical service within 60 days.	Initial
I understand that after billing my insurance, HealthFit Family Medicine will send me a statement of my remaining balance to the address I have on file. If I do not pay the full balance within 30 days, a re-billing fee in the amount of ten dollars ($10) will be added to my balance for every additional statement that is sent.	Initial
I understand that if I fail to pay any outstanding balance on my account, my account may be turned to an outside collection agency. I agree to pay all fees and costs associated with collecting the balance.	Initial
I understand that HealthFit Family Medicine has a $50 returned check fee. If my financial institution declines payment of a check, for any reason, a $50 returned check fee will be added to my balance.	Initial
If deemed medically necessary, certain tests may be sent to an outside group for preparation and/or for review. If this is necessary, I understand that the outside group may bill separately for this service. I agree to the release of demographic, billing and medical information for this purpose.	Initials
I understand that HealthFit Family Medicine has a $25 missed appointment fee. This fee is charged for all missed appointments and for cancellations without a 24-hour notice.	Initial
I agree and provide permission for HealthFit Family Medicine and its assignees to release personal, medical and insurance information for the purpose of obtaining payment from my medical insurance.	Initial

I acknowledge and agree to the terms of this Billing and Financial Agreement

_______________________________ **Printed Patient Name**

_______________________________ **Patient or Guardian signature**

Date________________________

Marital Status:

__Never Married __Married __Domestic Partnership __Divorced __Widowed

Referred by (if any): ____

Emergency Contact Information:

Name: ____

Relation: ____

Emergency Phone: ____

Health Insurance Information (Primary Carrier)

It is your responsibility to check with your insurance carrier directly to see if we're in network, and obtain an understanding of the parameters of your coverage. Failure to do so may cause you to incur additional charges for which you will be responsible.

Your name

Insurance Company

Signature (required): ____ Date:____________________

****A copy of your insurance card is required****

Have you ever had or suffered from any of the following?

Allergies	Yes___ No___
Asthma	Yes___ No ___
AIDS/HIV	Yes___ No___
High Blood Pressure	Yes___ No___
Thyroid Problems	Yes___ No___
Respiratory Problems	Yes___ No___
Kidney Trouble	Yes___ No___
Migraines	Yes___ No___
Chronic cough	Yes___ No___
Coughing up blood	Yes___ No___
Low Blood Sugar	Yes___ No___
Epilepsy or Neurological Problems	Yes___ No ___
Cancer	Yes___ No___

Have you ever had or suffered from any of the following (continued)?

Sinus Trouble Yes___ No___

Fainting Spells Yes___ No ___

Diabetes Yes___ No ___

Hepatitis/Jaundice/Liver Problems Yes___ No ___

Stomach Problems Yes___ No ___

Tuberculosis Yes___ No ___

Sexually Transmitted Diseases Yes___ No ___

Mental Health Problem Yes___ No ___

Immune System Problems Yes___ No ___

Congestive Heart Failure Yes___ No ___

High Cholesterol Yes___ No ___

Heart Disease Yes___ No ___

Thyroid Disease Yes___ No ___

Stroke Yes___ No ___

Arthritis Yes___ No ___

COPD Yes___ No ____

Do you have any allergies to?

Anesthesia Yes___ No___

Sulfa Drugs Yes ___ No___

Narcotics Yes___ No___

Penicillin or Antibiotics Yes___ No ____

Barbiturates Yes ___ No ___

Iodine Yes___ No ___

Other Yes___ No ___

If you have other allergies, please describe: ____

____

____

Hospitalizations: ____

____

Hospitalizations continued: ____

____

____

____

Surgeries (Type and Date):

____

____

____

Medications: ____

____

____

____

____

____

____

Review of Symptoms

Please check if you have had any of the following in the ***past six months****:*

Weight Loss or Gain	Yes _____No ___	Chest Pain	Yes ___ No _____
Night Sweats	Yes ____ No ___	Racing Heart	Yes ___ No_____
Muscle Weakness	Yes ____ No ___	Difficulty Breathing	Yes ____ No ___
Skin Rashes	Yes ____ No ___	Coughing	Yes ____ No ___
Itching	Yes ____ No ___	Seizures	Yes ____ No ___
Dry Skin	Yes ____ No ___	Dizziness	Yes ____ No ___
Headaches	Yes ____ No ____	Numbness	Yes ____ No ___
Injuries	Yes ____ No ___	Breast Pain	Yes ____ No ___
Blurred Vision	Yes ____ No ___	Nipple Discharge	Yes ____ No ___
Ringing in Ears	Yes ____ No ___	Disorientation	Yes ____ No ___
Hearing Loss	Yes ____ No ___	Loss/Increased Appetite	Yes ____ No ___
Muscle Pain	Yes ____ No ___	Nausea	Yes ____ No __
Runny Nose	Yes ____ No ___	Vomiting	Yes ____ No ___
Nose Bleed	Yes ____ No ___	Diarrhea	Yes ____ No ___

Please check if you have had any of the following in the ***past six months cont:***

Joint Pain	Yes ____ No ___	Constipation	Yes ____ No ___
Cold Hands or Feet	Yes ____ No ___	Indigestion	Yes ____ No ___
Feeling Cold Often	Yes ____ No ___	Excessive Sleeping	Yes ____ No ___
Feeling Warm Often	Yes ____ No ___	Difficulty Sleeping	Yes ____ No ___
Sore Throat	Yes ____ No ___	Anxiety	Yes ____ No ___
Hoarseness	Yes ____ No ___	Mood Swings	Yes ____ No ___
Fatigue	Yes ____ No ___	Depressed Mood	Yes ____ No ___
Neck Stiffness	Yes ____ No ___	Impotence	Yes ____ No ___
Hair Loss/Growth	Yes ____ No ___	Decreased Libido	Yes ____ No ___

How would you rate your current physical health?

____Poor ____ unsatisfactory ____Satisfactory _____ Good _____ Very Good

Please list any specific health problems you are currently experiencing__________________________

____

____

____

How would you rate your current sleeping habits? ___Poor ____Unsatisfactory _____Satisfactory

_____Good _____Very Good

Please list any specific sleep problems you are currently experiencing:

____

____

Do you follow a particular diet? ____Yes ____No

If so, what type: ____

Do you use tobacco? _____Yes _____No

If so, how often: ____

Do you use alcohol? _____ Yes _____No

If so, how often: ____

What hobbies do you enjoy? ____

____

Purpose of today's visit:

____

Family Medical History

Please list all first- degree relatives who have experienced the following:

A first-degree relative is defined as a close blood relative which includes the individual's parents, full siblings, or children.

Heart Attack____

Stroke: ____

Diabetes: ____

High Blood Pressure: ____

Cancer: ____

Sudden Death: ____

Other: ____

Women Only

Date of your last menstrual period__________________________________(mm/dd/yyyy)

Do your periods come every month? ___Yes ____No

If no, how often? ____

How long do your periods last? ______________________________

Is your flow: ____Light ____Medium ____Heavy

Do you have pain or bleeding after sexual intercourse? ____Yes ____No

Have you been pregnant? ___Yes ___No

If yes, how many children do you have? ____

Are you currently taking birth control? ____Yes ____ No

If so, what kind? ____________________________________

Date of your last pap smear: ______________________(mm/dd/yyyy)

Have you ever had an abnormal pap? ___ Yes ___ No

When was your last mammogram/breast exam: ______________________mm/dd/yyyy

Was it normal? ____ Yes ____ No

Do you do self-breast examinations? ____Yes ____No

Social History

Do you exercise regularly? ___ Yes ____ No

If so, how often and what type? ____

Release of Medical Information

____

Patient Name

____

Address

___________________ ___________________ ________________________

Phone **Date of Birth** **Social Security Number**

In accordance with HIPPA regulations, we require written authorization prior to sending any protected health information. If you wish for your medical records to be sent to any family members, please list below their names and addresses. Upon signing this form, you are granting consent for our practice to use and disclose your protected health for the purposes of payment, treatment and health care operations.

If you request more detailed information about how we may use and disclose this protected health information, please consult with our staff. You have a legal right to review our full policy regarding the release of protected health information before you sign this consent, and we encourage you to ask any questions you may have. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of payment, treatment or health care operations, however, we are not required by law to grant your request. If we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Please initial if you authorize us to speak to any of the following regarding your health information:

____Spouse ____Mother ____Father ____Daughter _____Son

Please write the names and relationship of any other friends/family you authorize us to speak:

_________________________________ _______________________________

_________________________________ _______________________________

Signature **Date**