# Patient Registration

Welcome to Bozeman Creek Family Health. Our practice is committed to providing the best, most comprehensive care possible. Please assist us by providing the following information. All information is confidential and only released with your consent.

Thank you for allowing us this opportunity to care for you!

**Patient Information**

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Sex Assigned at Birth:_____ Gender Identity :_____

Pronouns: _____ Social Security #: _____ Language:_____

Ethnicity (please circle): Hispanic Non-Hispanic Race: (please circle): White Black Asian Indian/Alaska Pac Isle Other/Mult

Mailing/Billing Address:_____

City: _____ State:_____ Zip Code: _____

Primary #: _____ Secondary #: _____

Email:_____

May we leave clinical messages on your answering machine or voicemail? [ ] Yes [ ] No #: _____

Mark 'NO' if you would not like to receive notifications via Text/SMS (reminders, schedule changes or balance notifications? No_____

Permission for clinic staff to access previous Medication/ RX History: Yes_____ No _____

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**In Case of An Emergency Please Contact**

Name:_____ Relationship:_____Phone #:_____

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**Financial Information**

Insurance Company: _____ Policy #: _____ Group#: _____

**If you are NOT the policy holder on your insurance account, please fill out the following:**

**Subscriber: _____** **Subscriber DOB: _____**

**Parent(s) / Guardian(s) Name responsible for account <u>(Minors Only):</u>**

Guarantor Name:_____ Guarantor Date of Birth:_____

# Patient Financial Policy

It is the concern of our entire staff that financial matters do not become a burden, nor stand in the way of your receiving the best, most timely medical attention. It is for this purpose that we have formulated the following Financial Policy. Please read carefully.

**1.** If you have insurance coverage, we will gladly file your insurance claim for you. **We do request copayments at the time services are rendered. If you are unsure of your copayment amount, we will collect a standard $30 copay at the time of service. Patients without active insurance will be required to make a deposit of $150.00 per visit at the time services are rendered.** This partial payment will be applied towards the total balance; remaining portion will be billed directly to patients.

If you are separated or divorced, the parent bringing the child in for treatment is responsible for payment at the time of service. Whatever financial agreement exists between you and the other parent is strictly your agreement and not part of our financial policy.

**2.** We currently are member physicians with Mountain Health Coop, United Health Care, Allegiance, Cigna, Blue Cross/Blue Shield of Montana, First Health Network, Multi-Plan Network, Medicare and Medicaid of Montana. ***However, we remind you that your insurance policy is a contract between you and your insurance company and does not affect our financial policy.*** Any insurance claim which has not successfully processed within 90 days of initial submission and/or following two claim appeals resubmitted by the practice, will be automatically transferred to patient responsibility. The clinic will electronically notify the patient of this balance transfer and will provide a HCFA form at the patient's request to independently submit to the insurance, if necessary. If inactive or incomplete insurance information is provided, charges will be transferred to patient responsibility.

This practice is committed to providing the best medical treatment possible for our patients and charges what is usual and customary for our area. **You are responsible for payment in full regardless of your insurance company's determination of usual and customary allowances and out-of-network plan status.**

**3.** Accounts that **accumulate a balance over $500.00 without regular payments within 90 days,** will be required to sign a payment agreement with stored credit card information for automatic monthly payments of 10% of the patient balance. Guarantors of accounts will be contacted directly via letter and call by an office administrator. Two consecutive months of failed auto-payments could result in immediate submission to the collection agency.

**4. Should circumstances arise where your account still has a balance one year from the date of service, we ask that you seek alternative financial options and pay your account in full**. Accounts that become greater than 90 days delinquent, with no attempt by the responsible party to make arrangements for payment, will be turned over to an independent collection agency.

**5.** Accounts returned to us as "undeliverable", i.e., moved without forwarding address, etc., will be held for one month, and if no contact is made, will be turned over to an independent collection agency.

**6.** In the event that an account must be turned over to a collection agency, we will request that you and your family seek medical care from another physician in the community. Failing to fulfill your payment obligation injures the mutual respect of the patient-doctor relationship set forth to ensure the highest quality of medical care; thus, we must insist the relationship be terminated. You understand that should you default on payment of your account and collection agency services are required, all costs of collections up to 40% of the balance, including fees/interest costs will be added to the balance of your account. Account balances and fees must be paid in full with the independent collection agency. Online payments received through BCFH's online billing portals (Paywoot.com or Healow Portal) will NOT remove collection status nor guarantee closure of the collection account. Patients must contact the agency directly for accurate information and payment options.

**7.** Patients whose account has been submitted to full collections on more than two occasions may be subject to dismissal from the practice. Repeated failures to maintain financial responsibility may result in termination of the patient-provider relationship in accordance with BCFH's financial policy.

The biggest single misunderstanding and possible source of problems for you and for us occurs when there is no communication about your financial matters. Please feel free to discuss fees and financial arrangements with us at any time. We are more than happy to work with you so that there is never a time that your medical care causes a financial burden. We will do our best to ensure that we fulfill our part of this agreement with you, and trust that you will do the same.

Patient/Guardian Signature: _____ Date: _____

Print Patient Name: _____

# No Show and Cancellation Policy for Medical Appointments

Our goal is to provide quality medical care in a timely manner. The policy enables us to better utilize available appointments for our patients in need of medical care**. *We offer reminder call services as a courtesy, which does not void patient responsibility for keeping scheduled appointments***.

## Cancellation:

As a patient in our clinic, it is your responsibility to keep scheduled appointments. Bozeman Creek Family Health requires notification of cancellation at least 24 hours prior to the scheduled appointment time. BCFH will consider it a "failed appointment" any time a patient has not given the advanced notice required above or fails to arrive within 10 minutes of their scheduled appointment time. If a patient has 3 failed appointments in a one year period, BCFH will no longer schedule appointments for that patient.

## No Show:

If a patient fails to arrive at the scheduled appointment time and does not call to cancel the appointment, the patient will receive a letter in regards to the missed appointment. If a patient has 2 "no show" appointments in a one year period, BCFH will no longer schedule appointments for that patient.

**All patients will be charged a $75.00 fee for every failed appointment or no show.**
**If you feel there has been an error in scheduling or believe you deserve special consideration, please let us know and you may speak with our Office Manager.**

Print Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

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**I hereby acknowledge that I have been presented with a copy of the Bozeman Creek Family Health notice of Privacy Practices.**

**Patient/Guardian Signature**: _____**Date**: _____
**Print Patient Name**: _____
**Relationship to patient:** Self, Parent, Guardian, Responsible Party, Legal Representative, etc_____

## Authorization to Disclose Health Information

*As a patient of Bozeman Creek Family Health, you are protected under The Health Insurance Portability and Accountability Act of 1996 (HIPAA). We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.*

I authorize _____ to inquire about:
*(Print name of: parent, significant other, spouse, family member, etc.)*

**Please check all that apply:**

☐ Payments/Charges

☐ Verbal health information (prescriptions, test results)

☐ Written copies of health information (prescriptions, test results, consults)

☐ Consult with my Doctor regarding my healthcare

**Patient Signature:** _____**Date:** _____

## Insurance Authorization

I hereby authorize Bozeman Creek Family Health to furnish information to my insurance carriers concerning my illness and treatments. I also authorize payments of insurance benefits to be made directly to Bozeman Creek Family Health. I understand that I am responsible for all charges incurred.

**Patient/Guardian Signature**: _____**Date**: _____
**Print Patient Name**: _____
**Relationship to Patient:** Self, Parent, Guardian, Responsible Party, Legal Representative,etc_____

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# *Health History Form*

Name: _____
Date of Birth: _____
Date of Exam: _____

What name do you like to be called?_____

What is the best number to reach you during the day? (  )_____-_____

May we leave a brief message? □ Yes □ No

**Medical History:** Have you ever been treated for any of the following medical conditions?

□ No changes
□ Arthritis
□ Diabetes
□ High blood pressure
□ Irritable bowel
□ Osteoporosis
□ Cancer
□ Depression/anxiety
□ Heart problems
□ High cholesterol
□ Lung problems
□ Thyroid problems

Please list any additional medical conditions:

_____

Have you ever been hospitalized overnight? □Yes □No

Have you ever had surgery? □ Yes □ No _____

_____

**Medications and Allergies** will be reviewed by clinic staff.
(Please bring your bottles with you or a complete list of everything you take on a regular basis.)

**Do you take any supplements** (calcium/vitamin D/fish oil/multivitamin)? □Yes □ No

**Family History:** Please list any known medical problems for the relatives listed below:

For example: diabetes, breast/colon/ovarian/ prostate cancer, heart attacks, high blood pressure, alcohol abuse, depression, skin cancer, osteoporosis.

□ No changes

Mother:_____
Father:_____
Brothers/Sisters:_____
Children:_____
Other:_____

_____

**Habits:**

What do you do for exercise?_____

How often?_____

Tobacco (chew / smoke): _____per day
Alcohol (beer / wine, etc.):_____per day
Recreational Drugs (Cannabis, etc.):_____
Caffeine (coffee / tea / soda):_____per day
Any trouble sleeping? □ Yes □ No
Describe your eating habits: (poor, well-balanced, vegetarian, gluten-free, etc.)_____

Do you eat out more than twice a week? □ Yes □ No

**Social History:**

Are you retired? □ Yes □ No

Work Type:_____
Do you enjoy your job?_____

Any major stresses in your life?

_____
_____
_____

**Relationship Status:**

□ Married □ Single □ Widowed
□ Divorced/Separated
□ In a relationship
How long?_____

Who do you live with:_____
How many children do you have?

_____

Do you feel you ever have been abused (verbally, physically, or sexually? □ Yes □ No

Do you wear seatbelts/helmets?

□ Yes □ No □ Sometimes

Do you wear sunscreen?

□ Yes □ No □ Sometimes

Do you have an eye exam at least every two years?

□ Yes □ No

Do you have a dental exam at least yearly? □ Yes □ No

## REVIEW OF SYSTEMS

**Please circle any current symptoms below:**

**General Symptoms:**
Fever, unexplained tiredness, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out

**Eyes:**
Vision loss, eye pain, blurred vision

**Ears/Nose/Mouth & Throat:** Sore throat, runny nose, hearing loss, problems with mouth, cough, voice changes

**Breasts:**
Lumps, skin changes, nipple discharge, tenderness or swelling

**Lungs & Heart:**
Chest pain/pressure, irregular heart beat, wheezing, breathing difficulty

**Skin:**
Rashes, changing moles, changes in hair/skin/nails, dryness or itching skin

**Neurological:**
Unusual or new headaches, weakness or numbness, falling, tremors, memory loss, dizziness or lightheaded

**Abdomen:**
Nausea, vomiting, pain, heartburn, diarrhea, constipation, bloody stools

**Sleep:**
Difficulty falling asleep, frequent awakening, snoring, night sweats

**Musculo-skeletal:**
Joint/muscle pain, muscle weakness, limited range of motion

**Mood:**
Worry too much, felt down and depressed in the last two weeks, loss of desire to do things you used to enjoy, thoughts of self harm or suicide, anxiety or excessive worrying

**Urinary Systems:**
Difficulty starting or weak stream, feeling like bladder, wont empty, getting up at night to urinate, leaking urine/loss of bladder control

**Reproductive Health:**
Heavy periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, possible sexually transmitted infections, severe pain with periods, difficulty getting/maintaining erections, testicular pain/lumps

**Period Questions:**

Still having periods? □ Yes □ No
□ Regular □ Irregular

Date of last period:_____
Birth Control type:_____
Hysterectomy: □ Yes □ No
If yes, what age?_____
Due to what?_____
Number of pregnancies:_____
_____ Vaginal deliveries
_____ C-section deliveries
_____ Other(stillbirth, miscarriage/abortion)
Diabetes in pregnancy? □Yes □ No
Have you ever had an abnormal pap or colposcopy? □ Yes □ No

**Other:**
List any symptoms not mentioned:

_____
_____

*******The following will be completed and used by clinic staff:*******

**Prevention:**

Last Pap Test:_____
Chlamydia Screening:_____
Mammogram:_____
Bone Density:_____

PSA Screening:_____

Colonoscopy:_____
Lipid Panel:_____
Fasting Glucose_____ HgbA1c_____

**Immunizations:**
Tdap:_____ Shingrix:_____
Pneumovax:_____ Influenza:_____
Gardasil:_____

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# *Card on File: Automatic Payment Option*

To better serve our patients, Bozeman Creek Family Health provides a secure card on file option for monthly, automatic payments.

Automatic payments will be administered through BillFlash services. Patients can access their BillFlash account by logging onto: www.paywoot.com. Patients can create an account or select guest pay for one-time payments.

Select and initial only **ONE** option below:

1. Credit card on file will be charged the **full amount** after insurance adjustment.
   Initial:_____

2. Credit card on file will be charged monthly towards account balance.
   Initial:_____ Max amount withdrawn each month:_____(minimum $75.00)

*Accounts with a saved card and an active balance will still receive mailed and emailed statements.*

Printed Patient Name:_____Date of Birth:_____

*Card on File Information:*

*Card Number:* _____

*Card Expiration:* _____

*Security Code (CVV):* _____

*Credit Card Zip Code:* _____

*Email:* _____

Bozeman Creek Family Health holds the patient responsible for providing updated and active credit card information, email and street address. If you are unsure what information you have on file, please contact our office or ask our administration staff. Charges for family members under 18 on the same guarantor account will be included in AutoPay. Spouses will maintain separate AutoPay accounts based on their individual balances.

Signature of Patient/Guardian: _____Today's Date: _____

## imMTrax Consent Form for Children

Child's Name:_____ Sex: M__ F__ Date of Birth:_____

I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Parent/Guardian Signature: _____

Date: _____

Revised (10/2012)

## imMTrax Consent Form for Adults

Name:_____ Sex: M__ F__ Date of Birth:_____

I authorize my health care provider and a public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. In addition, information may be released to schools in order to comply with immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

Signature:_____

Date:_____

Revised (10/2012)