Patient Registration Form

Patient Information:

____
Last Name **First Name** **Middle Name**

____
Gender **Social Security #** **Marital Status** **Date of Birth**

________________________ Hispanic or Latino Not Hispanic or Latino ________________________
Race **Ethnic Group** **Preferred Language**

Street Address: ____

Mailing Address: ____

City: ________________________________ **State:** ________________ **Zip:** ____________

____
Home Phone **Cell Phone** **Work Phone** **Email Address**

Emergency Contact: ________________________________ **Phone:** ______________________
(Someone outside of household if possible)

Preferred Pharmacy: ________________________________ **Phone:** ______________________

Name of Employer/Company: ____

Guarantor Information:

If the above patient is under the age of 18 **or** they are not the insurance policy holder, please fill out the information below.

____
Last Name **First Name** **Middle Name**

____
Date of Birth **Gender** **Social Security #** **Martial Status**

____
Home Phone # **Work Phone #** **Cell Phone #** **Relationship to Patient**

Street Address: ____

Mailing Address: ____

City: ________________________________ **State:** ________________ **Zip:** ____________

Name of Employer/Company: ____

Please list the other members of your household

Name	Date of Birth	Sex	Relationship

Acknowledgment of Consent

By executing this agreement, I accept the following terms of treatment that are required by Family Medical Center of Hart County (FMC):

Consent for Medical Treatment: I consent to routine diagnostic procedures and medical treatment by Family Medical Center of Hart County. I understand that no guarantee of results has been made.

Protected Health Information: I consent to the use and disclosure of my protected health information, by Family Medical Center of Hart County, to carry out treatment, payment, or health care operations. I acknowledge receipt of a copy of the HIPAA Privacy Notice which provides a complete description of such uses and disclosures, and that I have the right to review the policy notice prior to signing this consent.

I understand that I have the right to cancel this consent, in writing, at any time. If I cancel this consent, I understand that information may have already been used or disclosed about me and that only future disclosures will be affected.

Insurance Authorization/Assignment: I assign the authorized benefits of my medical insurance (including any Medicare, Medicaid, or Medigap plans) to be made on my behalf to Family Medical Center of Hart County for any services furnished to me. I authorize payment of the assigned benefits directly to Family Medical Center of Hart County. I authorize Family Medical Center of Hart County to release medical information to the Social Security Administration or its intermediaries or carriers as required for payment of claims.

Family Medical Center of Hart County has the right to change its privacy terms and practices which are described in the privacy notice. A sign will be posted at the front desk to notify patients of any changes and how to get an updated copy.

______________________________	______________________________
Patient's Name	**Date of Birth**
______________________________	______________________________
Responsible Party (If not the Patient)	**Relationship to Patient (If not the Patient)**
______________________________	______________________________
Signature	**Date**

Family Medical Center

117 West South Street
PO Box 579
Munfordville, KY 42765

Phone: (270) 524-7231
Fax: (270) 524-7415
www.MunfordvilleFMC.com

OF HART COUNTY

Financial Policy

Insurance: Insurance is a contract between you and your insurance company. You are responsible for knowing the coverage of your plan. Your insurance determines your benefits. You agree to pay any portion of the charges not covered by insurance.

Payment Options:

1. If you have health insurance, we will bill your primary and secondary for your visits. You agree to pay any portion of the charges not covered by insurance. <u>All co-payments are due at time of service</u>.
2. If you don't have health insurance, you are responsible for paying your bill in full. Patients that pay their bill in full at the time of service will receive a percentage discount.

Financial Assistance:

1. Low income patients may be eligible to receive a percentage discount based on income level.
2. Financial assistance may only be authorized by our account specialist.

Monthly Statement: If you have an unpaid balance on your account, we will send you a monthly statement, however, absence of a statement does not relieve of your responsibility for payment.

No Show/Cancellation Fee: You may be charged a fee if you no show or cancel your appointment without giving a 24 hour notice.

Returned Checks: There is a $40.00 fee for any checks returned by the bank.

Newborn Care: As a courtesy, we will see newborns that have insurance coverage pending for the first 30 days without requiring payment. Infants over 30 days old without active insurance will be required to pay at time of service.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. Family Medical Center reserves the right to verify employment of any patient. The undersigned agrees that if this account is not paid when due, and Family Medical Center should retain an attorney or collection agency for collection, to reimburse Family Medical Center the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3 percent of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable interest and reasonable attorney's fees incurred by the collection agency. This contract shall cover all medical treatment and services until revoked by either party in writing. In case of suit, you agree the venue shall be in Hart County, Kentucky. <u>We shall have the right to refuse future service to any accounts that are referred to a lawyer or a collection agency.</u>

Workers Compensation: We require authorization by your employer or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for full payment. At your request, we will submit the claim to your medical insurance with a copy of the workers' compensation insurance denial if furnished.

Personal Injury/MVA/Car Accident: It is your responsibility to file a report with the liability or automobile insurance. We will bill your personal injury protection (PIP) insurance or other liability insurance if the information is furnished in a timely manner. If not paid within 30 days from filing, the bill responsibility will be transferred to you. If an attorney is involved in your case, we need their contact information. We do not accept a signed attorney lien as a method of payment nor are we in a position to defer payment obligations while a case settles. If your PIP benefit is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information in a timely manner. Ultimately, you are responsible for payment of the services.

Divorce: In case of divorce/separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. The parent bringing the child in will be asked for payment regardless of the guarantor. If the divorce decree requires the other parent to pay any of the treatment costs, the authorizing parent is responsible for collecting from the other parent.

By signing this agreement, you are responsible for payment of all services that are received.

Patient Name: ____ Guarantor Name: ____

Signature: ____ Date: ____

Family Medical Center

117 West South Street
PO Box 579
Munfordville, KY 42765

Phone: (270) 524-7231
Fax: (270) 524-7415
www.MunfordvilleFMC.com

OF HART COUNTY

New Patient Pediatric History Form

Name: ____ DOB: __________________ Sex: _________

Place of Birth: _______________________ Delivering Physician: __________________________________

Labor/Delivery Difficulties ☐ Yes ☐ No
If yes, explain: ____

Birth Weight: ______ lbs. ______ oz.
Was child a twin delivery? ☐ Yes ☐ No If yes, was child: ☐ Twin A ☐ Twin B

____
Name of Previous Family Provider **City** **State**

Complications of Newborn Period

(Check and explain answers that apply)

☐ Birthmarks
☐ Birth Defects
☐ Caesarean Section Why: ____
☐ Circumcision (male)
☐ Feeding Problems
☐ Infections
☐ Intensive Care Nursery
☐ Jaundice Were Bili Lights used? ☐ Yes ☐ No
☐ Milk Intolerance
☐ Postmaturity
☐ Prematurity
☐ Respiratory Distress
☐ Vomiting

Patient Past Medical History

(Check answers that apply)

☐ Asthma
☐ Food Intolerance
☐ Hepatitis
☐ Measles
☐ Recurrent Ear Infections
☐ Rubella
☐ Whooping Cough

☐ Chicken Pox
☐ Hearing Difficulties
☐ Learning Difficulties
☐ Mumps
☐ Recurrent Pneumonia
☐ Vision Difficulties

☐ Other ____
☐ Seizures Seizure Medication ____
☐ Surgery When ________________ Type of Surgery _________________________________
☐ Hospitalizations When ________________ Why ____
Is the patient on any long term medications? ☐ Yes ☐ No
If yes, medication names: ____
What type of water supply does your home have? ☐ Cistern ☐ Well ☐ City

Allergies

☐ Allergy Injections Allergist Name: ______________________________
☐ Food Allergy
☐ Latex Allergy
☐ Any Other Known Allergies: ______________________________

Has the patient ever had an allergic reaction to:
☐ Medication ☐ Yes ☐ No **If yes**: ______________________________
☐ Injection ☐ Yes ☐ No **If yes**: ______________________________

Tobacco History

Is the patient exposed to tobacco? ☐ Yes ☐ No
Type of tobacco exposure: ☐ Cigarette ☐ Cigar/Pipe ☐ Smokeless
Has the patient used tobacco? ☐ Yes ☐ No If yes: ☐ Current ☐ Past **Last used**: ____________
Tobacco type used: ☐ Cigarette ☐ Cigar/Pipe ☐ Smokeless

Immunization History

Vaccine	Date	Vaccine	Date
DPT Vaccine	________	MMR Vaccine	________
Hepatitis A Vaccine	________	Prevnar Vaccine	________
Hepatitis B Vaccine	________	Oral Polio/IPV	________
HIBS Vaccine	________	Rotavirus Vaccine	________
TB Skin Test	________	Adult TD/Boostrix	________
Chicken Pox Vaccine	________	Pneumovax Vaccine	________

How old was your child when they:

Learned to Read ____________
Put Two Words Together ____________
Rolled Over ____________
Sat Up ____________
Walked ____________

Feeding History

Is your child currently on:
☐ Formula Name ______________________________ ☐ Breast Milk ☐ Whole Milk

How old was your child when they started eating:

Cereal ____________
Fruit ____________
Green Vegetables ____________
Meat ____________
Yellow Vegetables ____________

Has your child had any behavior difficulties? If so please explain:

____
____
____

Family History

(Check all answers and family members that apply)

(F=Father; M=Mother; MGF=Maternal Grandfather; MGM=Maternal Grandmother; PGF=Paternal Grandfather; PGM=Paternal Grandmother)

Condition						
☐ Anemia	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Asthma or Hay Fever	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Birth Defects	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Bleeding Diseases	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Cancer	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Color Blindness	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Cystic Fibrosis	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Deafness	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Diabetes	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Eczema	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Epilepsy	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Gallbladder Disease	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Heart Disease	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ High Blood Pressure	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Kidney Disease	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Mental Retardation	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Muscular Dystrophy	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Obesity	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Sickle Cell Anemia	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Stroke before age 60	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Thyroid Disease	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Tuberculosis	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM
☐ Ulcers	☐ F	☐ M	☐ MGF	☐ MGM	☐ PGF	☐ PGM

Legal Consent Form for Minors

I, ____, being the legal parent or guardian of, ____, give permission for the providers at Family Medical Center to give necessary treatment and perform necessary procedures in the event I cannot be reached when my child is brought in by anyone of the following person(s):

Name	**Relationship**
________________________________	____________________
________________________________	____________________
________________________________	____________________
________________________________	____________________
________________________________	____________________

My contact phone number(s) are:

_______________________ Home

_______________________ Cell

_______________________ Work

____________________________________ Parent or Guardian Signature

_______________________ Date

FAMILY MEDICAL CENTER OF HART COUNTY
NOICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations.

Your Health Information Rights

The health and billing records we maintain are the physical property of Family Medical Center of Hart County. You have the following rights with respect to your Protected Health Information.

1. Request a restriction on certain uses and disclosures of your health information in writing.
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice') by making a request at our office.
3. Right to inspect and copy your health record and billing record by delivering the request in writing.
4. Right to request your health care record be amended to correct incomplete or incorrect information by written request to our office.
5. Right to request in writing that communication of your health information be made by alternative means or at an alternative location
6. If you want to exercise any of the above rights, contact Brenda Caswell, HIPAA Officer, in person or in writing, during normal hours.
7. You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Our Responsibilities

1. Maintain the privacy of your health information as required by law;
2. Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you:
3. Abide by the terms of this Notice;
4. Notify you if we cannot accommodate a requested restriction or request; and
5. Accommodate your reasonable requests regarding methods to communicate health information to you.
6. Accommodate your request for an accounting of disclosures.
7. We reserve the right to amend, change, or eliminate provision in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice". You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

Contact Brenda Caswell, HIPAA Officer, for questions or if you want to report a problem regarding the handling of your information. OR you may file a complaint by mailing it to the Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW., Atlanta, GA 30303-89009, telephone 404-562-7886, Fax 404-562-7881

- We cannot and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule

Patient Contact: We may contact you to provide you with appointment reminders, information about treatment alternatives, or with information about other health- related benefits and services that may be of interest of you.
Opportunity to Agree or Object -Notification: Unless you object, we may disclose your protected health information in the following manner:

- Notify or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and general condition, or your death.
- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care or in an emergency.
- To order to assist in disaster relief efforts.

Opportunity to Agree or Object Not Required: We may use or disclose your protected health information in the situations to the extent that the law requires or allows, without your authorization or giving you an opportunity to object to the release:

Other Uses and Disclosures besides those identified in this Notice will be made only as otherwise authorized by law or your written authorization ..

Website: We maintain a website that provides information about our entity; this Notice is on the website at www.Munfordvillefmc.com

Effective Date of this Notice: April 14, 2003 **Revised**: September 2003, February 28, 2009, October 2011