New Patient Registration Form

Today's Date:	Reason for Visit:

Requested Physician: ☐ Barinowski ☐ Harrover ☐ Hogue ☐ Merrill ☐ Mondi ☐ Schmidt

PATIENT INFORMATION

Full Name:		Birth Date:
Social Security Number:	☐ M ☐ F	Marital Status:

Address:

Race: ☐ African-American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Language: ☐ English ☐ Spanish ☐ Other

COMMUNICATION PREFERENCES

Home Phone:	Cell Phone:	Work Phone:

Email Address: *(for statements and patient portal)*

How Would You Like to Receive Appointment Reminders? ☐ Home Phone Call ☐ Cell Phone Call ☐ Work Phone Call ☐ Text Message ☐ Email	May we leave detailed voicemails? ☐ Yes ☐ No

EMERGENCY CONTACT

Name:	Relationship to Patient:

Primary Phone:	Secondary Phone:	☐ You can speak with this person in detail about my healthcare.

Names of other individuals that FPE may speak to about my healthcare:

INSURANCE

YOU MUST SUBMIT PHOTO COPIES OF THESE CARDS (FRONT & BACK) WITH YOUR PACKET

Primary Insurance:	ID#:
Secondary Insurance:	ID#:

GUARANTOR INFORMATION

Name:	Relationship to Patient:
Address:	Date of Birth:
	Phone:

By signing below, I am acknowledging the following:

- I have reviewed the information above for correctness and have made any and all changes necessary.
- I hereby authorize and consent to examinations, treatments, and release of medical information to insurance companies, claim representatives, adjusters, and other physicians necessary to process claims and assign to the physician payment for services.
- A copy of the Notice of Privacy Practices for Family Physicians of Evans has been made available to me on the website and in the office. I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Patient/Guardian signature Date

POLICIES

You will be asked to present your active and correct insurance card(s) at every visit. If your insurance policy has changed or is no longer active, you must notify staff at check-in prior to being seen. If you fail to do so, you risk being financially responsible for any services provided.

As a result of federal regulations on healthcare, insurance providers are shifting more financial responsibility onto you. Because of this shift, you may see an increase in the amounts that you owe for your healthcare. All copays, deductibles, and coinsurances are due at the time of service. If you dispute any copays, deductibles, or coinsurance charges that you owe, it is your responsibility to contact your insurance company as your coverage is a contract between you and your insurance company. We are unable to negotiate these fees on your behalf.

It is your responsibility to know your plan including benefits, copays, deductibles, and coinsurances. You are responsible for knowing your preferred providers for labs, procedures, or specialist referrals. Unless otherwise notified, we will perform your labs in the office.

AT EACH VISIT, YOU WILL BE ASKED TO CHOOSE BETWEEN 2 PAYMENT OPTIONS:

OPTION 1: CREDIT CARD ON FILE

At check-in, we will request a debit or credit card to place on file in our secure electronic system. You will sign an authorization for up to $250 that allows us to charge your card for your balance **after** your visit. Once your insurance company has paid their portion, we will notify you **VIA EMAIL** that we will be processing your card for your portion in 3 business days.

If you need to stop a payment, you must call the billing office as soon as possible to make arrangements. If you do not contact us and your card declines, we will charge a returned payment fee of $30.

Place a card on file at check in. → We file a claim to your insurance. → Insurance tells us what you owe. → We charge your card for your balance.

This is the preferred method of payment:

- Our system is secure and compliant with Payment Card Industry security standards.
- Nothing is charged to your card at the time of service (except your copay).
- You are only charged what you owe, not an estimated amount.
- Your card can only be used for one date of service. We will not charge your card without your authorization and notification.

OPTION 2: PAYMENT AT CHECK-OUT

We will collect your copay at check-in. At check-out, we will calculate an estimate of your amount owed for the services you received.

***If you have a deductible/coinsurance, you will be required to pay the full price for your visit. ***

We will file a claim to your insurance.

If you still have a balance, we will **EMAIL** you a statement. Payment is due upon receipt.

If you overpaid for your service, we will place a credit on your account for your next visit. If you do not have an upcoming appointment, we will issue a refund check. **You may ask for a refund of your credit at any time.**

If you refuse both options, you will be required to reschedule your appointment. Unfortunately, we are not able to make exceptions based on insurance or billing history.

ALL STATEMENTS WILL BE DELIVERED VIA EMAIL. It is your responsibility to monitor your email and to be sure that the address we have on file is correct and up-to-date.

We accept checks, cash, debit, and most major credit cards. We do have a returned payment fee of $30 for any declined cards or checks.

BALANCES: If you owe a balance, you will be asked to clear your debt prior to being seen. If you are unable to do so, you will be asked to reschedule your appointments. We may make payment plan arrangements for eligible patients; you will need to contact the billing office to discuss your account. We use the services of an outside collection agency for delinquent accounts. If we turn your account over to collections, we will charge your account 25% to cover the costs incurred by the agency.

MINORS: All services rendered to minors will be the responsibility of the accompanying adult.

APPOINTMENT POLICY: We ask that you arrive 15 minutes prior to your appointment time. If you arrive more than 15 minutes late, you may be asked to reschedule. If you need to cancel your appointment, please do so at least 24 hours prior to your appointment. There is a $50 fee for late arrivals, late cancellations, and missed appointments. We will waive this fee once you have rescheduled and come in for the appointment. Patients who do not respect our appointment policy and have a pattern of late arrivals, late cancellations, or no shows will risk being discharged from the practice.

WORKMAN'S COMPENSATION: We are not a workman's compensation provider. If you are injured on the job, you must contact your employer for information on where to seek treatment.

ADMINISTRATIVE VISITS: In most cases, we will require an appointment for the completion of paperwork, including but not limited to the completion of forms related to pre-employment, school admission/attendance, sports participation, immunizations, and accidents/disability. If we determine this is not necessary, we will charge $25.

MEDICARE PATIENTS: You authorize any holder of medical or other information about you or your dependents to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in the place of the original and request payments of medical insurance benefits either to myself or to the party who accepts the assignment. Regulations pertaining to Medicare assignment of benefits apply.

Please initial each statement as an acknowledgement:

_____ I must bring my current insurance card to every visit.
_____ All copays, deductibles, and coinsurances are due at the time of service.
_____ I must put a credit card on file or pay an estimate at each visit. If I refuse, I will need to reschedule.
_____ I am responsible for checking my email for billing information.
_____ It is my responsibility to know my benefits and preferred providers (for labs and other services)
_____ I must arrive 15 minutes prior to my appointment time.
_____ I must notify the office at least 24 hours prior to my appointment if I am unable to make it.

I have read and understand all of the above policies. I agree to be bound by their terms.

Patient/Guardian Signature _____ Date _____

Patient Name (Printed) _____ Date of Birth _____

Patient Health History Questionnaire

PATIENT INFORMATION

Full Name:	Birth Date:	Today's Date:

REASON FOR VISIT

ALLERGIES

Type	Reaction
i.e. Latex	*Rash*

PAST HOSPITALIZATIONS/SURGERIES

Description	Date

CURRENT MEDICATIONS

You must list ALL of your medications that you take regularly.
If you do not provide a complete medication list here, we may decline to establish a physician-patient relationship.

NAME	DOSAGE	FREQUENCY	REASON
i.e. Advil	*200mg*	*2 tablets once a day*	*Back pain*

PREFERRED PHARMACIES

	Name	Location	Phone
Local			
Mail Order			

CURRENT MEDICAL PROBLEMS

☐ Anxiety	☐ Depression	☐ Diabetes	☐ Heart Problems
☐ High Blood Pressure	☐ High Cholesterol	☐ Lung Problems	☐ Thyroid Problems

☐ Other:

SPECIALISTS/OTHER HEALTHCARE PROVIDERS

Previous Primary Care -	OB/GYN -
Cardiology -	Urology -
Dermatology -	Oncology -
Endocrinology -	Ophthalmology -
Other Providers -	

HEALTH MAINTENANCE

When was your last...	Date	Provider/Location	Results
Colonoscopy			
Pap Smear			
Mammogram			
PSA (Prostate Screen)			
DEXA (Bone Density Test)			
Eye Exam			
Pneumonia Shot			
- Pneumovax			
- Prevnar			
Flu Shot			
Shingles Shot			
Tetanus Shot			

FAMILY HISTORY

Do you have a family history of...		Who?	Do you have a family history of...		Who?
Breast Cancer	☐ Y ☐ N		Colon Cancer	☐ Y ☐ N	
High Cholesterol	☐ Y ☐ N		Prostate Cancer	☐ Y ☐ N	
Diabetes	☐ Y ☐ N		Osteoporosis	☐ Y ☐ N	
Heart Attack	☐ Y ☐ N		Anxiety/Depression	☐ Y ☐ N	
Heart Problems	☐ Y ☐ N		Psych/drug/alcohol problems	☐ Y ☐ N	
Stroke	☐ Y ☐ N		High Blood Pressure	☐ Y ☐ N	

SOCIAL HISTORY

Do you currently use tobacco or nicotine? ☐ No, Never ☐ Yes, Cigarettes ☐ Yes, Cigars
☐ No, Former Smoker ☐ Yes, Smokeless Tobacco ☐ Yes, E-Cig/Vape

If you do use tobacco, how often/how much do you use? ☐ I am interested in quitting.

Do you drink alcohol? ☐ No ☐ Yes – How Much/Often?

Do you currently exercise? ☐ No ☐ Yes – Type of Exercise? How Often?

What is your marital status? ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Married ☐ Engaged

Who lives with you in your home?

Do you have children? ☐ No ☐ Yes – What are their names and ages?

Are you employed? ☐ No ☐ Retired ☐ Yes - Where?

Do you attend religious services? ☐ No ☐ Yes - Where?

What are your hobbies?

How did you hear about our practice?

Do we currently see any of your family members? If so, what are their names?

Patient Name (Printed) Date of Birth