Financial Policy 5-10 Adult

Patients are responsible to provide current information for billing and insurance and notify the business office of any changes in a timely manner. Patients that do not have a current insurance card or verifiable insurance will be requested to pay at time of service. Insurance cards are requested at each appointment to ensure that wee have current information to file your charges. Picture identification is requested from you to safe guard against the possibility of lost or stolen identification.

Statements are due in full each month by the statement due date. If you are unable to pay the balance by this date, please contact the billing department before the due date to set up satisfactory payment arrangements. Our providers would like to devote your appointment time to your medical care and request that you direct billing and payment matters to the billing department. $35.00 will be billed for all return checks. Delinquent accounts may be referred to an outside agency. In addition, the outside agency reports to Equifax, Experian and Trans Union credit bureau. Once reported, this information becomes part of your credit history. Patients that have outstanding bills may be asked for payment and or arrangements prior to scheduling appointments for non emergencies and prescription refills. Patients with unpaid accounts may be dismissed from our practice and asked to obtain medical care elsewhere.

Some lab work obtained at our office is sent to an independent outside lab and you may receive a bill directly from the lab depending on your insurance plan.

We will file your charges to your health insurance(s) as a courtesy and in return will ask that insurance payments come directly to us. Insurance is a contract between you and your insurance company. You are responsible for all charges incurred, including co pays (due at time of service), deductibles and fees for non-covered services. We may ask you to pay amounts that are your responsibility at time of your appointment. We will assist you in obtaining pre-certification or admission authorizations, but you are ultimately responsible for complying with insurance requirements. Insurance coverage varies by plan and company; therefore our staff is unable to be familiar with everyone's coverage. If you are unsure about your coverage, out of pocket costs and policy limits, please contact your insurance company.

When you provide your insurance information, you authorize release of any and all medical and or charge information necessary for reimbursement from any governmental agency or insurance payer involved in the payment of your treatment.

If a member of the staff becomes directly exposed to your blood or bodily fluids, patients will be required to provide a sample for testing according to state regulations. Results of those test will be released to you and to the health care workers(s) who suffered the exposure.

_____ Date _____

Name

Southwest Family Physicians PC/Gretna Family Health
Patient Registration Form
19 - above
Adult

Patient Name (Last) _____ (First) _____ (MI)_____

Birth date: _____/_____/_____ **Social Security #:** _____ - _____ - _____ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Street address: _____ **City:** _____ **State:** _____

Zip: _____ + 4 _____ **Drivers license # and state:** _____

Home Telephone: (_____) _____ **Cellular/Pager:** _____

Names of Employer: _____ Work #: (____) _____

Spouse or partner's name: _____ **Spouse/partner's work # :** (____) _____

Names of other people living in your immediate Household

_____

Emergency Contact: _____

(telephone number) _____ Relationship to patient: _____

Primary Insurance Company Name: _____

Effective date (*if known*)**:** _____ **ID #**: _____ **Group #:** _____

Name of insured: _____

Date of birth of insured: _____ **Relationship of insured to patient:** _____

Secondary Insurance Company Name: _____

Effective date (*if known*)**:** _____ **ID #**: _____ **Group #:** _____

Name of insured: _____

Date of birth of insured: _____ **Relationship of insured to patient:** _____

Please show the patients insurance card(s) and picture identification of the accompanying adult to the receptionist

_____ _____

Signature **Date**

Rev. 7/25/11

SOUTHWEST FAMILY PHYSICIANS, P.C.
GRETNA FAMILY HEALTH

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name _____
(Please print)

Patients Date of Birth _____

You can talk to my family members about my medical issues and/or leave messages with them. _____ Yes _____ No

If yes, please specify name of the family member(s) we can share information with:

_____

_____

_____

Note: All patients will receive messages for appointment reminders via televox

_____ _____(date)
Signature of Patient
Or signature of parent (if patient is under 19 and
unmarried or signature of Personal Representative if patient is unable to sign)

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for **Southwest Family Physicians/Gretna Family Health** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Southwest Family Physicians/Gretna Family Health:**

Determine the pharmacy benefits and drug copays for a patient's health plan.

Check whether a prescribed medication is covered (in formulary) under a patient's plan.

Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.

Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____

Patient Name (PRINTED) Date of Birth

_____ _____

Patient/G Signature Date

PATIENT HISTORY RECORD

NAME _____ DOB _____
RACE/ETHNIC _____

ALLERGIES ☐ None (please list allergies and what happens to you when you take it)
Drug Allergies:_____ Food Allergies: _____
_____ _____
_____ Other Allergies:_____

CURRENT MEDICATIONS ☐ None
_____ _____
_____ _____
_____ _____

PAST MEDICAL HISTORY: (please check all that apply)

☐ Allergies
☐ Anticoagulant Therapy
☐ Asthma
☐ Blood Clots
☐ Cancer, _____
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Diabetes, Type I or II
☐ Enlarged Prostate, Benign
☐ Fracture repair _____
☐ Fibromyalgia
☐ Gall Stones, recurring
☐ GERD
☐ Headaches, migrane/tension
☐ Heart Attack
☐ Hemophilla, A or B
☐ High Cholesterol
☐ High Blood Pressure
☐ Iron Deficiency Anemia
☐ Irregular Heart Rhythm
☐ Kidney Stones
☐ Osteoarthritis
☐ Osteoporosis
☐ Peptic Ulcer Disease
☐ Phychological Illness
☐ Rheumatoid Arthritis
☐ Stroke
☐ Thyroid Disease
☐ UTI, recurring
☐ Other:_____
_____
_____

PAST HOSPITALIZATIONS: (Please indicate date)

☐ Allergies
☐ Anticoagulant Therapy
☐ Asthma
☐ Blood Clots
☐ Coronary Artery Disease
☐ DVT
☐ Diabetes
☐ Heart Attack
☐ Pneumonia
☐ Stroke
☐ Other: _____
_____

OTHER MEDICAL PROVIDERS:(Please list all of your healthcare providers)
Primary Care Provider: _____
Others (specialists): _____
ADVANCED DIRECTIVES: (do you have any of the following on file?
☐ Health Care Proxy ☐ Living Will ☐ Power of Attorney ☐ DNR

PAST SURGICAL HISTORY: (please check all that apply)

☐ Appendectomy
☐ Arthroscopy, _____
☐ Biopsy, _____
☐ Carpal Tunnel Release
☐ Cataract Removal
☐ Circumcision
☐ C-section
☐ D & C
☐ Fracture Repair, _____
☐ Gall Bladder Removal
☐ Heart Surgery, _____
☐ Hernia Repair
☐ Hysterectomy
☐ Joint Replacement, _____
☐ Tubes in Ears
☐ Prostatectomy
☐ Rotator Cuff Repair
☐ Tonsil/Adenoidectomy
☐ Tubal Ligation
☐ Urinary Surgery, _____
☐ Vasectomy
☐ Other: _____
_____
_____

FAMILY HISTORY:
(Indicate which family member M=mother; F=father; S=sibling; C=child; GM=grandmother; GF=grandfather)

- ☐ Alcoholism:
- ☐ Alzheimer's Disease
- ☐ Asthma:
- ☐ Bleeding Tendency:
- ☐ Cancer, _____
- ☐ Chemical Dependency
- ☐ COPD:
- ☐ Coronary Artery Disease:
- ☐ Diabetes, Type I or II:
- ☐ Enlarged Prostate:
- ☐ Emphysema:
- ☐ Gall Stones, recurring:
- ☐ Heart Attack:
- ☐ Heart Disease:
- ☐ High Blood Pressure:
- ☐ High Cholesterol:
- ☐ Kidney Disease:
- ☐ Obesity:
- ☐ Osteoarthritis:
- ☐ Osteoporosis:
- ☐ Psychiatric Illness, _____
- ☐ Rheumatoid Arthritis:
- ☐ Seizure Disorder:
- ☐ Stroke:
- ☐ Thyroid Disease:
- ☐ Other:_____
  _____

SOCIAL HISTORY:
☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried Number of Children _____
Occupation: _____ Place of Employment: _____
☐ Full Time ☐ Part Time ☐ Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐ Disabled
Hobbies and Activities _____
Religion: _____

TOBACCO/ALCOHOL/SUPPLEMENTS:
Do you use Tobacco? ☐ None ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco
How many? _____ How often? _____ How long have you used tobacco?_____
Do you use Alcohol? ☐ None ☐ Beer ☐ Wine ☐ Liquor How much? _____ How often? _____
Caffeine intake:☐ Coffee ☐ Tea ☐ Soda ☐ Chocolate How much? _____ How often? _____
Vitamin or Diet Supplements: Type: _____ How often? _____

SUBSTANCE ABUSE HISTORY:
☐ None Other:_____

MENTAL HEALTH HISTORY:
☐ None Other: _____

COMMUNICABLE DISEASE HISTORY
☐ None Other: _____

ADDITIONAL COMMENTS, QUESTIONS, OR CONCERNS:

_____

_____

_____

_____

Date: _____ Signature: _____