DC RANCH FAMILY MEDICINE & AESTHETICS

PATIENT INFORMATION

Name: _____ Preferred Name: _____
Last First MI

Address: _____ Date of Birth: _____
Street Unit#

_____ Age: _____ Gender: M F TG
City State Zip

Marital Status: S P M D W

Responsible Guardian(s) _____ Relationship _____

Billing Address if different: _____
Street Unit#

_____
City State Zip

Home ( ) _____ Cell ( ) _____ Full Time AZ Resident: ☐Yes ☐No

Emergency Contact: _____ Phone: _____ Relationship: _____

E-mail Address for Patient Portal:

*REQUIRED OFFICE POLICY TO HAVE PORTAL ACTIVATED FOR LAB RESULTS, PROGRESS NOTES, COMMUNICATION WITH OFFICE, ETC

Referring Provider: _____ OR you heard about us by? Web Search/ Insurance/ Friend/ Media

Employer/Occupation: _____ Status: ☐Full Time ☐ Part Time

Students: School Name_____ Status: ☐Full Time ☐Part Time

Primary Insurance: _____ Subscriber ID #: _____Group #_____

Claims Address:_____ Payor ID#_____
Street City State Zip

Policy Owner: _____ Date of Birth _____ Phone _____

Relationship of Patient to Policy Owner: ☐Self ☐Spouse ☐Child

Secondary Insurance: _____ Subscriber ID #: _____Group #_____

Claims Address:_____ Payor ID#_____
Street City State Zip

Policy Owner: _____ Date of Birth _____ Phone _____

Relationship of Patient to Policy Owner: ☐Self ☐Spouse ☐ Child

Primary Pharmacy:_____ Cross Streets:_____Phone: _____

Secondary if applicable:_____ Cross Streets:_____Phone: _____

FINANCIAL POLICY

Please initial next to each paragraph to acknowledge that you have read and agree to the terms discussed

_____ I understand it is my responsibility to know my insurance coverage and network. I understand I am responsible to pay for any charges that could be denied or not covered by my policy. Any dispute for unpaid charges will be billed to the member. I understand in the event I am entitled to health insurance benefits relating to my medical treatment, I hereby assign those benefits to this office and apply to my bill.

_____ I understand filing a claim is time sensitive (90 days) and it's my responsibility to provide the office with updated policy information, including keeping my Coordination of Benefits up do date or claims will be denied and I will be responsible. *The practice does not become involved in any disputes between the patient and the insurance company.*

_____ I understand I am required to pay at the time of visit my portion according to my insurance, including co-pays, deductibles, or co-insurance. Account balances, Aesthetic Services, B-12 injections, and Self-Pay visits are to be paid in full at time of service. *Returned checks will result in a fee of $25.*

_____ I understand invoices are due immediately upon receipt. Three statements will be mailed before being considered delinquent. After 60 Days the delinquent account will be turned over to an outside collection agency of our choice with or without notice. The patient/guarantor agrees to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35% of the delinquent balance, such contingency fee to be added and collected by the collection agency immediately upon our referral of your account to them.

_____ I understand it is my responsibility to arrive on time for my appointment and I may be asked to reschedule if more than 15 minutes late. I understand there is a $25 fee for missed appointments. I understand if 3 or more appointments are missed without proper notice, a pre-payment will be required to hold future appointments. I understand if there is a missed appointment without proper notice for a complimentary service, the service will be forfeited and considered used. *Please notify us 24 business hours in advance to cancel and/or reschedule your appointment.*

_____ I understand the Annual Wellness Physical is a preventative well visit, allowed once a year. The wellness visit and diagnosis codes do not include current ailments or disease management. A separate visit charge will apply if time is spent outside the insurance guidelines of prevention.

_____ I understand my provider will communicate with me through the patient portal to deliver lab results. I understand it is my responsibility to provide the office with a current email address for these portal notifications. I understand diagnostic images and lab orders are from an outside facility. I understand these facilities are separate entities and billing is not associated with DC Ranch Family Medicine, PLLC. Nor does the practice have access to those billing statements.

I have read the Financial Policies and I understand these terms and agree to pay this account in accordance with the rates and payment terms of DC Ranch Family Medicine, PLLC.

_____ _____

Printed Guarantor Name *Patient Name if different*

****Guarantor Signature:** _____ **Date:** _____

DC RANCH FAMILY MEDICINE & AESTHETICS

Acknowledgement Re: Notice of Privacy Practices AND Financial Policy:

I have been offered a copy of the Notice of Privacy Practices. I understand that DC Ranch Family Medicine, PLLC has the right to change its Notice of Privacy Practices and that I may contact DC Ranch Family Medicine, PLLC at any time to obtain a current copy. I have also read, understand, and agree to the provisions of the Financial Policy.

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

Authorization for Release of Health Information:

I hereby authorize the release any medical or incidental information to my referring physician or any other provider(s) who have been or may become involved with my care.

I hereby authorize the release of health information and record(s) of my visit(s) to my insurance company If needed in the processing of any insurance claim and/or other third parties responsible for payment of my medical charges.

I hereby authorize DC Ranch Family Medicine, PLLC and its Employees permission to discuss, send and/or receive my personal health information to/with the following individual(s):

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

I understand it is my responsibility to update any changes with the office about the above individuals

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

Please initial next to each paragraph to acknowledge that you have read and understand the following Office Policies:

_____ I understand medication refills are handled during normal business hours and not prescribed or refilled after hours**.**

_____ I understand the practice does not treat pain management or ADD/ADHD and the provider will referring to an outside provider.

_____ I understand verbal abuse towards office staff or providers will not be tolerated and will lead to immediate dismissed from the practice.

_____ I understand if I have a medical need after hours and cannot wait until the next business day to immediately contact the E.R. or Urgent Care of my choice for immediate medical attention.

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

****Printed Signature Name:** _____

DC RANCH FAMILY MEDICINE & AESTHETICS

MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

DOB: _____ Height: _____ Weight: _____ Date of **Last Annual Physical**: _____

If Diabetic; Date of Last Retinal Eye Exam: _____ Ophthalmologist's Name _____

Date of Last **Colorectal Cancer Screening**: _____ Type: ☐Colonoscopy ☐Cologuard ☐FIT

Drug Allergies: ☐Yes ☐No Drug:_____ Reaction:_____
Drug:_____ Reaction:_____

Daily Medications: (include pain, herbal, vitamins, supplements & any over the counter medication)

Name Dosage/Strength Times/day Month/Year Start Date

_____

_____

_____

_____

_____

Do you **use tobacco**? ☐Yes ☐No ☐Quit Date _____ Use **e –cigarettes**? ☐Yes ☐No ☐Quit Date _____

How Many Per Day? _____ How many years? _____ Interested in Quitting: ☐Yes ☐No

Do you **exercise**? ☐Yes ☐No How Often? _____ What type? _____

Do you drink **alcohol**? ☐Yes ☐No If yes, average consumption is _____ drinks per ☐day ☐week

Do you experience **sadness** or have been **depressed** the past year? ☐Yes ☐No (If Yes, Complete Full Risk Assessment)

Do you have **children**? ☐Yes ☐No If yes, gender & age(s) _____

Sexually active **last 12 months**? ☐Yes ☐No Birth Control Method _____

Females: Pregnant/nursing? ☐Yes ☐No Last Menstrual Cycle Date: _____ Last **Mammogram** Date:_____

Vaccine Administration History:

Influenza	☐Yes	☐No	Date: _____	Pneumonia	☐Yes	☐No	Date: _____
Tetanus	☐Yes	☐No	Date: _____	Shingles	☐Yes	☐No	Date: _____
HPV	☐Yes	☐No	Date: _____	Meningitis	☐Yes	☐No	Date: _____
MMR	☐Yes	☐No	Date: _____	Chicken Pox	☐Yes	☐No	Date: _____
Hepatitis A/B	☐Yes	☐No	Date: _____	DTaP/Tdap	☐Yes	☐No	Date: _____

Past Surgical History including Cosmetic: (list type and date)

_____ _____

_____ _____

Past Hospitalizations: (list reason and date)

_____ _____

_____ _____

Current Specialists Providing Medical Care: (list Provider's name and medical condition)

_____ _____

_____ _____

Medical History: (check conditions)

☐ Anemia	☐ Diabetes	☐ Cancer/Type _____
☐ Kidney Trouble	☐ Bladder Issues	☐ High Blood Pressure
☐ Heart Trouble	☐ High Cholesterol	☐ Phlebitis/Blood Clots
☐ Depression	☐ Stroke	☐ Neurological Disorder/Seizures
☐ AIDS/HIV	☐ Arthritis	☐ Thyroid Disorder
☐ Gout	☐ Asthma	☐ Ulcer/Stomach Problems
☐ ADHD/ADD	☐ Hepatitis/Type _____	☐ STD(s)/Type _____
☐ Eating Disorder	☐ Fibromyalgia	☐ Autoimmune Disorder: _____
☐ Substance Abuse/Type_____		☐ Other _____

Major medical conditions (Diabetes, Hypertension, Heart Disease, Stroke, Mental Illness, Cancer) of your **1st Degree Relatives**:

Father:				□ Alive □ Deceased
Mother:				□ Alive □ Deceased
Sibling:	□ M	□ F		□ Alive □ Deceased
Sibling:	□ M	□ F		□ Alive □ Deceased
Children:	□ M	□ F		□ Alive □ Deceased
Children:	□ M	□ F		□ Alive □ Deceased

Genetic Cancer Screening (If you answer Yes to at least 1, Complete Full Risk Assessment)

Have you or a relative **aged 50 and under** been diagnosed with breast or ovarian cancer? ☐Yes ☐No

Has a family member been known to have the BRCA mutation? ☐Yes ☐No ☐Unknown

Have you or a relative **aged 50 and under** been diagnosed with colon or uterine cancer? ☐Yes ☐No

Has a family member been known to have Lynch Syndrome Mutation? ☐Yes ☐No ☐Unknown

Do you have an **Advance Directive**? (Legal document specifying actions to be taken if you are no longer able to make decisions due to illness or incapacity) ☐Yes ☐No