SOUTHWEST FAMILY PHYSICIANS

Physicians and Surgeons

Child Personal Health History

Name_____ Date _____

Birthdate _____ Birth Wt. _____ Birthplace _____ Dr. Delivering _____

A. **HEALTH**

Has this child ever had any of the following:

	(yes)	(no)		(yes)	(no)
1. Allergies	_____	_____	13. Fainting Spells	_____	_____
2. Anemia	_____	_____	14. Hay Fever	_____	_____
3. Asthma	_____	_____	15. Head Injury	_____	_____
4. Behavioral Prob.	_____	_____	16. Hernia	_____	_____
5. Broken Bones	_____	_____	17. Kidney Trouble	_____	_____
6. Cancer	_____	_____	18. Rheumatic Fever	_____	_____
7. Complication from Childhood Disease	_____	_____	19. Rheumatism / Arthritis	_____	_____
8. Diabetes	_____	_____	20. Severe Headaches	_____	_____
9. Dislocation	_____	_____	21. Sexually transmitted Disease	_____	_____
10. Ear Trouble	_____	_____	22. Skin Condition	_____	_____
11. Seizures	_____	_____	23. Tumor	_____	_____
12. Eye Trouble	_____	_____	24. Yellow Jaundice	_____	_____

Has this child ever been hospitalized for any illness or operation? If yes, please list giving reason and dates.

_____

_____

Immunization record: Please be prepared to supply information to the nurse. _____

_____

List medications this child is now taking:

1._____ 2._____ 3. _____

4._____ 5. _____ 6. _____

Allergies to medication: _____

B. **Personal & Family Habits**

1. Does anyone in your family smoke? _____
2. Does anyone in your family drink alcoholic beverages? _____
3. Has anyone in your family now or in the past used street drugs? _____ Type: _____
4. Are there any firearms (guns) in your home at all? _____
5. Do you regularly use sunscreen on your child? _____

C. **Family History**

Condition	**Yes**	**No**	**Relationship to Child**
Cancer	_____	_____	_____
Tuberculosis	_____	_____	_____
High Blood Pressure	_____	_____	_____
Diabetes	_____	_____	_____
Kidney Stones	_____	_____	_____
Epilepsy	_____	_____	_____
Mental/Nervous Disorder	_____	_____	_____
Heart Disease	_____	_____	_____

SOUTHWEST FAMILY PHYSICIANS PATIENT REGISTRATION

Please answer all questions

PATIENT INFORMATION

Date _____ Account# _____

Name _____
Last First Middle

Address: _____ City: _____ ST: _____ Zip: _____

Phone # ( ) _____ S.S. # _____ DL # _____

Birthdate: _____ Sex: _____ Referred by: _____

Employer: _____ Work phone # ( ) _____

If patient has ever been known under another name, list _____

Spouse Name: _____ Spouse Employer: _____

Please give full name of person to contact in case of emergency, preferably the name of a person who does not live with you.

Name: _____ Relationship to Patient _____

Address: _____ Phone # ( ) _____

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT,COMPLETE THE FOLLOWING

Name _____
Last First Middle

Address: _____ City: _____ ST. _____ Zip: _____

Phone # ( ) _____ S.S. # _____ DL # _____

Employer: _____ Work phone # ( ) _____

Occupation: _____ Relationship to Patient: _____ Birthdate _____

INSURANCE INFORMATION

INFORMATION MUST BE COMPLETED FOR INSURANCE COMPANY TO BE BILLED

PRIMARY INSURANCE INFORMATION

Insurance Company Name _____ Phone # _____

Claim Address _____

Policy Holder _____

Policy Holder Employer _____ Effective Date _____

ID # _____ Birthdate: _____/_____/_____ Group # _____ CoPay _____

FAMILY MEMBERS

	Birthdate	HOME #	WORK #
1. Self			
2. Souse			
		SCHOOL NAME	**SCHOOL #**
3. Child			
4. Child			
5. Child			

I give permission to leave a message at (circle) Home Work None

Signature_____

THERE WILL BE A $25 FEE FOR MISSED APPOINTMENTS

SOUTHWEST FAMILY PHYSICIANS
CONDITIONS OF TREATMENT

1. **Consent to Treatment:** The undersigned hereby consents to the administration and performances of all diagnostic procedures and treatment which, in the judgment of my physician, may consider necessary or advisable.
2. **Release of Information:** The clinic will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning rhe patient, except in those circumstances when the clinic is permitted or required to by law to release information. I certify that my records may be released to my primary care physician upon request. The undersigned agrees that to extent necessary to determine liability or payment, and to obtain reimbursement, the clinic may disclose portions of the patient's record, including his/her medical records to any person or corporation which is or may be liable, for all or any portion of the clinic's charges, including but not limited to insurance companies, health care service plans, or worker's compensation carriers. Special permission is necessary to release this information where the patient is being treated for alcohol or drug abuse.
3. **Medicare alignment:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I reqest that payment of authorized benefits be made on my behalf.
4. **Assignment of insurance benefits:** in the event I am entitled to insurance benefits arising out of any policy of insurance insuring me or any party liable to me I herby assign said benefits directly to this clinic for application to my bill. I agree that the clinic may issue a reciept for such payment that such payment shall discharge the insurance company of any and all obligations under the policy to the extent of the payment and that I shall be responsible for all charges not covered bu this agreement.
5. **Financial Agreement:** I herby agree that in consideration for services rendered by the clinic, I shall make prompt payments to the account to the clinic as bills are presented. I agree to pay interest at legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney for collection. I shall pay the actual attorney's fees and collection expenses.

I agree to the above conditions of treatment and understand that I will be required to sign the one time and this will be kept as part of my permanent file.

_____

Signature of patient, parent, or guardian Date

_____

Legal relationship to patient

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize southwest Family Physicians to **use and disclose** the health and medical information of _____ for the purpose of **Treatment, Payment, and health care operations.**
(Name of Patient)

* **Treatment** (includes activities performed by a physician, nurse, office staff, and other type of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on call physician).
* **Payment** (includes activities involved in determining your eligibility for health coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of of health care services for medical necessity, justification of charges, recertification and preauthorization).
* **Health Care Operations** (include the necessary administrative and business functions or our office).
* **I give my consent to release Health information to: _____**

You may review Southwest Family Physicians " **Notice of Privacy Practices " for** additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have received a copy of our Notice by placing your initials here: _____.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms Contained in the **Notice** may change also. A summary of the **Notice** will be posted in the lobby of our Office indicating the effective date of the **Notice** in the upper right hand corner. We will offer you a copy of The **Notice** on your first visit to us after the effective date of the then current Notice. We will also provide You with a copy of the **Notice** upon your request.

As more fully explained in the **Notice,** you have the right to request restrictions on how we use and disclose Your protected health information for treatment, payment, and health care operations purposes. **We are not Required to agree to your request.** If we do agree, we are required to comply with your request unless the Information is needed to provide you emergency treatment. Other physicians who call coverage for our office Are required to use and disclose your protected health information consistent with the **Notice.**

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent Southwest Family Physicians has already used or disclose the information in reliance on this CONSENT.

_____ _____ Or
(Date) (Signature of patient)

_____ _____
(Date) (Signature of Patient)

Regarding Insurance Coverage for Your Care Here

To help you understand insurance billing polices, we have outlined these tips. Knowing these issues up front can save you time, hassle, and finances. In addition, it allows us to focus on your medical care. Our aim is for your total office experience to be as effective and pleasant as possible.

Being a family practice clinic, we have a wide scope of care. We can take care of many health care needs right here - whether you need Preventive Wellness Screening, General Medicine, Pediatric care, Obstetrics, Gynecology or office surgeries.

You will be responsible for visits or procedures that your insurance company denies as "not covered" or "excluded" Many plans will not pay for Preventative Care (physicals, well - women exams, Pap smears, etc). You may be surprised at what your insurance considers "mental health" ("tiredness" or "stress" for example).

We will strive always to do our best to help you, however, we cannot re-bill charges with changed diagnosis codes just to "get it through" your insurance. This may be considered fraudulent by insurers and subjects the entire clinic to audits. Your presenting complaint becomes important in determining whether you are seen and billed as a Wellness/Preventative Medicine exam (such as a Physical, Pap. Etc) or as a problem-oriented exam (such as toe nail fungus, irregular periods, etc). Please note that these are two, distinct types of visits. We cannot do justice to your medical needs if we try to roll preventive care together with significant problem solving and we are required to bill for each separately, using mutually exclusive codes. we know many patients are frustrated by this - but we have no influence over the insurance regulations and we hope you understand that asking us to "manipulate the system" compromises our ability to simply focus on providing you good medical care. Consider that if your insurance covered everything you would doubtless have to pay a higher premium, deductible, or co-pay.

We accept most insurance plans and , as a courtesy, we will file your insurance claim for you. However, since there are hundreds of different types of insurance plans, we cannot bend individual charges for each different plan, patient, or visit (there are over 1,400 different insurances in our computer system!). We encourage you to familiarize yourself with your own plan prior to scheduling your office visit with us: what services are covered, what prior authorizations or pre-certifications are needed? If your insurance company does not pay as expected, **please call their customer service department directly** as we are unable to guarantee your insurance benefits.

We request payment for office services at the time of your visit. We accept cash, checks, and most major credit cards and we can bill your health insurance plan for you provide us with a copy of your insurance card. Please register at the front desk at each visit and update any address, phone, or insurance changes at that time. Even if you have been coming here a long, **we will need to see a copy of your insurance card at every visit.** this is because small details change from time to time and cards expire: we would rather get things billed correctly for you the first time.

Bills that are unpaid may be charged a monthly finance charge. To avoid a charge and let other patient's urgent needs be worked in please notify us at least 24 hours in advance if you need to reschedule your appointment.

Please feel free to call our Patient Accounts Representatives at 503-597-1201 if you have any questions about your account here.

Signature _____ Date _____