Glacier View Plastic Surgery
KALISPELL REGIONAL HEALTHCARE

245 Windward Way, Suite 109 | Kalispell, MT 59901
(406) 756-2241 | www.kalispellregional.org

NEW PATIENT WORKSHEET

Patient Name: _____ DOB: _____ Age: _____
Bra Size: _____ Weight _____ Height _____

Name and dosage of any medications (including vitamin & herbals) you currently take :

_____ _____
_____ _____
_____ _____
_____ _____

Do you take Aspirin, Ibuprofen or Naprosyn? Yes/No
Which ones, dose and date last taken:

_____ _____
_____ _____
_____ _____

Please list any known drug allergies and reaction to drug.

_____ _____
_____ _____
_____ _____

Please list any known problems with tape or latex?

_____

Circle all health problems you have had in the past or have presently:

Diabetes	Stroke	Kidney problems
High blood pressure	Bleeding / clotting problems	Stomach ulcers
Asthma / COPD	Thyroid problems	Heart failure
Heart attack	Circulation problems in your legs	Another cancer
Difficulty with anesthesia		

Have you been hospitalized for any reason in the past 3 months? Yes/No
Describe any other health problems not mentioned above: _____
_____

How old were you when you had your first menstrual period? _____
How many times have you been pregnant? _____
How many children did you have? _____

Have you ever had a surgery that required anesthesia? Yes/No

Please list any surgeries including date requiring anesthesia:

_____ _____
_____ _____
_____ _____

Have any of your blood relatives been diagnosed with any of the following? **Yes/No**
And if yes, which relative and age of diagnosis:
Breast cancer _____
Ovarian cancer _____
An adverse reaction to anesthesia _____

Do you smoke? _____ packs/day for _____ years **Yes/No**
Have you ever smoked? _____ packs/day for _____ years **Yes/No**
Do you drink alcohol? _____ drinks per (day/week/month) **Yes/No**
Do you use recreational drugs? **Yes/No**

Circle any symptoms you have had recently:

Weight gain or loss	Difficulty swallowing	Chest pain
Changes in appetite	Heartburn	Palpitations
Fever	Nausea / Vomiting	Swelling in legs
Dizziness / /Fainting	Diarrhea	Pain / burning with urination
Headache	Constipation	Blood in urine
Changes in vision	Change in bowels	Easy bruising / bleeding
Fatigue / Tiredness	Short of breath	Rashes
Anxiety	Cough	Change in color of moles
Depression	Wheezing	Back pain
Bone or joint pain	Vaginal Dryness	Numbness or tingling in hands or feet

What pharmacy do you prefer?

_____

Describe any symptoms not mentioned that you want to share with your provider:

_____

How did you hear about us?

_____

Patient signature: _____ Date: _____

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Michael V. Hromadka, MD

I _____ would like to give authorization to Glacier View Plastic Surgery to discuss my medical care with the following persons. Please include any friends or family. I understand this authorization will stay in effect until I ask to have it removed in writing.

Individual(s) Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Printed Name:_____

Patient Signature:_____ Date:_____

Kalispell Regional Healthcare - New Patient Registration Form

(Please Print)

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Name or Initial:	email address:

Mailing Address:	City:	State:	Zip Code:

Physical Address:	City:	State:	Zip Code:

Home Phone: OK to leave message Y N	Cell Phone: OK to leave message Y N	Work Phone: OK to leave message Y N
( ) -	( ) -	( ) -

Date of Birth:	Age:	Gender:	Marital Status:
/ /		☐ M ☐ F	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Social Security No:	Employer Name and Address:
- -	

Employment Status:	Student Status:
☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired	☐ Full Time ☐ Part Time ☐ Not a Student

If patient is a minor, please give parent/guardian names and specify relationship to patient:	Race _____ ☐ Other ☐ Unreported/Refused to Report
Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Other _____ Language: ☐ English ☐ Russian ☐ Indian (Includes Hindi & Tamil) ☐ Spanish ☐ Other	Pharmacy Name:
Primary Care Provider:	Referring Provider:

IN CASE OF EMERGENCY

Name of Emergency Contact Person:	Relationship to Patient:	Home Phone No:	Work Phone No:
		( ) -	( ) -

Mailing Address:	City:	State:	Zip Code:

RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip this section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Guarantor's Last Name:	First Name:	Middle Name:

Mailing Address, if different from Patient:	City:	State:	Zip Code:

Phone No:	Relationship to Patient:	Date of Birth:	Social Security No:
( ) -		/ /	- -

Employer Name and Address:	Work Phone No:
	( ) -

INSURANCE INFORMATION

Name of Primary Insurance:	Policy Subscriber's Name, if not Patient:	Policy Subscriber's Date of Birth:
		/ /

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:

Subscriber/Policy No:	Group No:

Name of Secondary Insurance (if applicable):	Policy Subscriber's Name, if not Patient:	Policy Subscriber's Date of Birth:
		/ /

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:

Subscriber/Policy No:	Group No:

KALISPELL REGIONAL HEALTHCARE

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Kalispell Regional Healthcare Joint Notice of Privacy Practices. I understand that the Joint Notice of Privacy Practices describes how Kalispell Regional Healthcare may disclose and use my protected health information.

Patient Name:_____ Medical Record Number:_____

Signature: _____ Date: _____ Time: _____

If signed by the patient's personal representative, indicate:

a. Name of signer:_____

b. Relationship to patient: _____

If acknowledgment is not signed, indicate reason not signed and efforts made to have acknowledgment signed:

_____

_____

_____

_____

REPORTING OF IMMUNIZATION RECORDS

As described on page 4 of the KRH Joint Notice of Privacy Practices, the Montana Department of Public Health and Human Services (DPHHS) has requested that we seek your consent to share your/your child's immunization data with the DPHHS Immunization Information System (IIS).

Therefore, if you do not check the "I Opt Out" box, below, we will collect and enter your/your child's immunization data into the DPHHS IIS database. DPHHS may release your/your child's IIS immunization data to other public health agencies as well as to your/your child's health care providers to assist in your/your child's medical care and treatment. In addition, DPHHS may release your/your child's IIS immunization data to schools in order to comply with immunization requirements. If you do not check the "I Opt Out" box at this time, you can always choose to opt out at a later time and/or have your/your child's immunization data removed at any time by contacting your county's health department. You understand that any such revocation will not be effective as to uses and/or disclosures already made in reliance upon this authorization.

THIS IS NOT CONSENT TO RECEIVE ANY IMMUNIZATION, IT IS ONLY A CONSENT TO REPORT YOUR/YOUR CHILD'S IMMUNIZATION DATA TO THE DPHHS IIS.

☐I OPT OUT OF THE DPHHSS IMMUNIZATION INFORMATION SYSTEM

_____ Date _____

Name of Patient (please print)

_____

Signature of Patient/Parent, Authorized Representative or Guardian, if applicable

A copy of this receipt has been offered to this patient

Original – Patient's Medical Record Photocopy to Patient

KALISPELL REGIONAL HEALTHCARE

ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

KALISPELL REGIONAL HEALTHCARE PATIENT SERVICE AGREEMENT

Kalispell, Montana

CONSENT TO SERVICES

Patient hereby consents to any services provided in connection with Patient's treatment by Kalispell Regional Healthcare ("KRH") health service providers and by any independent health service providers affiliated with KRH, including but not limited to, Glacier Regional Pathology, LTD.; Clinical Pathology Associates, LLC; Northern Rockies Anesthesia Consultants, PLLC; Northwest Imaging, PC; Silvertip Emergency Physicians, PC (collectively, "KRH Affiliated Providers"). These services may include, but are not limited to, inpatient, outpatient, and/or emergency services; diagnostic procedures; transportation; nursing care; and other healthcare services provided to Patient upon the instructions of Patient's physicians. Patient acknowledges that no guarantees have been made regarding the outcome of these services. If Patient is unable to sign, consent for treatment: (1) is hereby given by representative(s) authorized to make decisions and sign this agreement on Patient's behalf, or (2) in cases of emergency, shall be implied. The term "KRH" includes the health care services providers owned or controlled by KRH, including their employed physicians.

FINANCIAL AGREEMENT

Agreement to Pay Charges and Billing Statements – In consideration of any services provided to Patient, Patient and any persons that are legally responsible for Patient's medical bills (collectively, "Guarantors") agree to pay any charges related to those services whether or not insurance exists for those charges. Patient understands and agrees that: (1) any KRH Affiliated Providers that provide services in connection with Patient's treatment at KRH may have their own billing and collection practices and may send one or more separate bills for which Guarantors are responsible to pay; and (2) the terms of this Financial Agreement prevail over any conflicting terms and conditions in any other contract to which Patient claims to be a party or a beneficiary.

Payment – Payment may be made: (1) at the time services are provided; (2) in accordance with billing statements received from KRH; or (3) in accordance with a payment schedule that is agreed upon by both KRH and Guarantor(s). If Guarantors fail to make any scheduled payment when due, Guarantors understand and agree that: (1) KRH may declare the entire balance to be immediately due and payable, and (2) Guarantors will be responsible for all costs associated with collection of the owed charges, including reasonable attorney's fees.

Third Party Liability – In the event that any third party is or could be liable for part or all of Patients' bill, Guarantors acknowledge that KRH is legally authorized to bill and recover KRH's normal and customary charges from that third party instead of submitting a bill to any federal, state, or private health care insurance/plans covering Patient; whether or not those health care insurance/plans have contracted with KRH and whether or not the services provided to Patient would otherwise be covered under those health care insurance/plans. Guarantors acknowledge that KRH may submit a Health Care Provider/Facility Lien, as allowed by MCA §71-3-1111 et seq., to those third parties for recovery of KRH's charges.

ASSIGNMENT OF BENEFITS

Without waiver of the above Financial Agreement, Patient hereby: (1) assigns Patient's rights to accept, negotiate and deposit payment from any insurers or health care plans and responsible third parties providing coverage for or otherwise liable for the services being provided to Patient; and (2) directs those insurers, health care plans or other third parties to make payment(s) directly to KRH, as well as to any KRH Affiliated Providers for benefits covered by those insurance, health care plan or third party agreements. This assignment is limited only to the rights to accept, negotiate and deposit payment for the services provided to Patient by KRH and does not include any other rights Patient may have under those insurance, health care plan or third party agreements. Patient hereby consents to KRH providing notice of this assignment to applicable insurers, health plans and third parties.

INSURANCE DISCLAIMER

If Patient is covered by a health insurer/health plan that requires pre-authorization for services, it is Patient's responsibility to obtain pre-authorization from the health insurer/health plan. Patient understands that he/she is liable for any charges incurred should Patient's health insurer/health plan deny all or any portion of Patient's KRH treatment or otherwise fail to make payment for charges incurred.

RELEASE OF INFORMATION

Patient acknowledges that KRH and KRH Affiliated Providers are authorized by law to release medical and account information necessary for the purposes of treatment, payment, and hospital operations. This information may be released to health care insurance/benefits companies, liability insurance companies, billing companies, attending/consulting healthcare providers, governmental programs or medical review organizations.

PERSONAL VALUABLES

Patient acknowledges that KRH maintains a safe for securing money and/or other valuables. KRH shall not be liable for the loss or damage to any money, valuables, articles of unusual value, or any other personal property, unless that property is deposited with the hospital for storage in KRH's safe.

BY SIGNING BELOW, YOU INDICATE THAT YOU: (1) UNDERSTAND AND AGREE TO THE TERMS OF THIS PATIENT SERVICE AGREEMENT AND (2) THAT YOU HAVE RECEIVED, REVIEWED AND, IF NEEDED, COMPLETED THE FOLLOWING:

- **LIST OF KRH ENTITIES**
- **PATIENT BILL OF RIGHTS & RESPONSIBILITIES**
- **AN "IMPORTANT MESSAGE FROM MEDICARE" or "IMPORTANT MESSAGE FROM TRICARE"**
- **INITIAL DISCLOSURE STATEMENT & STATEMENT OF BILLING RIGHTS (see reverse side of this Agreement)**
- **ADVANCE DIRECTIVES –** Patient has been advised of Patient's right to formulate and execute Advance Directives and has been provided with written information regarding the same.

_____ / _____ Date _____

Patient Signature/Authorized Representative/Guarantor Printed Name

Patient Name _____ Acct # _____

Witness _____ MRN # _____

IN CASE OF ERRORS OR INQUIRIES ABOUT YOUR BILL

The Federal Truth in Lending Act requires prompt correction of billing mistakes.

1. If you want to preserve your rights under the Act, here's what to do if you think your bill is wrong or if you need more information about an item on your bill:
   a. Do not write on the bill. On a separate sheet of paper write the following:
      i. Your name and account number.
      ii. A description of the error and an explanation as best you can why you believe it is an error. If you only need more information explain the item you are not sure about. Do not send in your copy of the itemized statement or other documents unless you have a duplicate copy for your records.
      iii. The dollar amount of the suspected error.
      iv. Any other information (such as your address) which you think will help us identify you or the reason for your complaint or inquiry.
   b. Send your billing error notice to the address listed on your billing statement. Mail it as soon as you can, but in any case early enough to reach us within 60 days after the bill was mailed to you. YOU MAY TELEPHONE YOUR INQUIRY, BUT DOING SO WILL NOT PRESERVE YOUR RIGHTS UNDER THIS LAW NOR OBLIGATE US TO FOLLOW THE OUTLINED PROCEDURES.
2. We must acknowledge all letters pointing out possible errors within 30 days of receipt unless we are able to correct your bill within 30 days. Within 90 days after receiving your letter, we must either correct the error or explain why we believe the bill to be correct. Once we have examined the bill, we have no further obligation to you even though you still believe there is an error, except as provided in paragraph 4 below.
3. After we have been notified, in writing, neither we nor an attorney nor a collection agency may send you collection letters or take other collection action with respect to the amount in dispute; but periodic statements may be sent to you. You cannot be threatened with damage to your credit rating or sued for the amount in question, nor can the disputed amount be reported to a credit bureau or to other creditors as delinquent until we have answered your inquiry. However, you remain obligated to pay the part of your bill not in dispute.
4. If our explanation does not satisfy you and you notify us in writing within 10 days after you receive our explanation that you still refuse to pay the disputed amount, we may report you to credit bureaus and other creditors and may pursue regular collection procedures. But we must also report that you think you do not owe the money, and we must let you know to whom such reports were made. Once the matter has been settled between you and us, we must notify those to whom we reported you as delinquent of the subsequent resolution.

DISCLOSURES REQUIRED BY FEDERAL LAW

Your account is subject to the following terms and conditions:

1. If an account is referred for collection, patient shall pay all collection and court costs, including a reasonable attorney's fee. Otherwise than herein and above specified, patient shall incur no additional charges to his account.
2. No security interest in any property is retained or acquired for purposes of securing payment of any credit extended on the account, except: (1) any security interest acquired by virtue of Montana's Hospital Lien Law, R.C.M. 1947 ss 45-1205, and (2) any security interest in property retained by hospital to secure payment of patient's account.