Capstone Family Practice- Patient Registration

Patient Information:

Last name: ___________________________ First Name:_________________ Middle name: ________________

Date of birth: ____/____/______ Gender:_____ Social security number: ____-____-_______ Marital status:______

Home phone number: (______) ______-_________ Work phone number: (______) ______-_________

Cell phone number: (______) ______-_________ E-mail address: ____

Claims address: ________________________________ City: _____________ State: _________ Zip: _________

Employer: ____Current occupation: __________________________

Emergency Contact Information

Name: ___________________________Relationship: _____________ Phone number: (______) ______-_______

Please select your race below:

***Race:** _____ White (Non-Hispanic) _____ Asian _____Black or African American

_____ Hispanic or Latino _____Other Race

***Ethnic Group:** ________________________ **Decline to answer** ______

Preferred language: _____________________________________

*** Reporting of race and ethnic group is a new government requirement under the American Recovery and Reinvestment Act.**

Primary Insurance / Guarantor Information:

Insurance Company Name: ____

Claims address: ________________________________ City: _____________ State: _________ Zip: _________

Insurance phone number: (______) ______-_________

ID number: ____________________________________ Group number: ________________________________

Policyholder full name: ____ Date of birth: ____/____/______

Home address: ________________________________ City: _____________ State: _________ Zip: _________

Social security number: _______-_______-___________ Gender: _________

Employer: ____ _____________

Home phone number: (______) ______-_________ Work phone number: (______) ______-_________

Cell phone number: (______) ______-_________ E-mail address: ____

Patient's relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other: ___________________

Secondary Insurance Information (ONLY for patients with Medicare primary):

Insurance Company Name: ____

Claims address: _____________________________ City: _______________State: ________ Zip: ____________

Insurance phone number: (______) ______-_________

ID number: ____________________________________ Group number: ________________________________

Policyholder full name: ____ Date of birth: ____/____/______

Home address: ________________________________ City: _____________ State: _________ Zip: _________

Social security number: _______-_______-___________ Gender: _________

Employer: ____ _____________

Home phone number: (______) ______-_________ Work phone number: (______) ______-_________

Cell phone number: (______) ______-_________ E-mail address: ____

Patient's relationship to policyholder: □ Self □ Spouse □ Child □ Other: ___________________

We love referrals; can you please tell us how you found out about our practice? _______________________

____

Patient Health History

Welcome to Capstone Family Practice!

Please complete as much information as possible so that we can better serve you.

Name: ____ Today's date:________________

Date of birth: _______________Age:_______ Date of last physical exam: _______________

What is your reason(s) for seeing the physician today?________________________________

Symptoms: Circle any symptoms that you currently have or have had within the past year:

GENERAL
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Nervousness
Numbness
Sweats
Weight gain
Weight loss

MUSCLE/JOINT
Arm pain
Leg pain
Back pain
Hand pain
Foot Pain
Knee pain
Neck pain
Shoulder pain
Other _______________

GENITOURINARY
Blood in urine
Frequent urination
Painful urination
Urinary incontinence

GASTROINTESTINAL
Poor appetite
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

CARDIOVASCULAR
Chest pain
High blood pressure
Low blood pressure
Irregular heart rate
Poor circulation
Rapid heartbeat
Swelling of ankle(s)
Varicose veins
Heart murmur
Shortness of breath

EAR/NOSE/THROAT
Bleeding gums
Blurry vision
Coughing up blood
Crossed eyes
Difficulty swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing in ears
Sinus problems
Itchy eyes

SKIN
Bruise easily
Hives
Dry skin
Itching
Yellow skin
Change in moles
Rash
Scars
Sores that won't heal
Hair changes
Other _______________

MEN ONLY
Breast lump
Erection difficulty
Testicular lump
Penis discharge
Sores on penis
Other _______________

WOMEN ONLY
Abnormal PAP smears
Bleeding between cycles
Breast lump
Menstrual Pain
Nipple discharge
Painful intercourse
Vaginal discharge

Other _______________

Last menstrual period?

____

Are you pregnant? _____

Number of births? _____

Miscarriages? _________

Conditions: Circle conditions you have or have had in the past:

HIV / AIDS
Alcoholism
Allergies
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Blood disorders
Breast lump
Bronchitis
Bulimia
Cancer: _____________
Cataracts
Chemical dependency
Chicken pox

Diabetes
Emphysema
Glaucoma
Gout
Heart Disease
Hepatitis
Hernia
Herpes
High cholesterol
Hypertension
Kidney disease
Liver disease
Lupus
Measles
Migraine headaches
Miscarriage

Mononucleosis
Multiple sclerosis
Mumps
Pacemaker
Pneumonia
Polio
Prostate problems
Psychiatric
Rheumatic fever
Scarlet fever
Seizure
Sexually transmitted disease:

____

Skin problems
Stomach problems
Stroke
Suicide attempt
Thyroid problems
Tonsillitis
Tuberculosis
Typhoid fever
Urinary problems
Vaginal infections

Other: ______________

____

____

Medications you currently take:	Allergies to medications:

Preferred Pharmacy

Pharmacy Name: ____Phone:______________________

Pharmacy Address: ____

Family History

Are your parents currently healthy? ______________ Please list their current ages and any medical problems.

____

____

Please circle any of the following conditions that have occurred in any of your blood relatives:

Arthritis	**Heart disease**	**Schizophrenia**
Allergies	**High blood pressure**	**Thyroid problems**
Asthma	**High cholesterol**	**Lupus**
Breast cancer	**Kidney disease**	**Stroke**
Lung cancer	**Chemical dependency**	**Alzheimer's disease**
Diabetes	**Depression**	**Melanoma**

Other cancer: ____

Other: ____

Health Habits

Have you ever used tobacco? □ Yes □ No If yes, for how long and how much per day?

____

How much alcohol do you drink in an average week? ______________________________________

Have you ever used illicit drugs? □ Yes □ No If yes, what type and how frequently?

____

Hospitalizations and Serious Illnesses

Please list and explain all hospitalizations and serious illnesses during your lifetime, including outpatient procedures. ____

____

____

____

Capstone Family Practice

Capstone Family Practice provides Christ centered care to patients of all ages. We strive to meet the physical, emotional, and spiritual needs of our patients.

Our goal is to provide and maintain a good physician- patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. ***Please review our policies carefully***.

Appointments

1. We value the time we have set aside to spend with you. If you are unable to keep your appointment, please notify us 24 hours in advance so that we may give another patient the opportunity for that appointment. We reserve the right to charge for missed appointments. This $25 fee will not be covered by your insurance. Failure to comply with our cancellation policy may result in dismissal from our practice.
2. If you are more than 30 minutes late for your appointment, it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur, and we appreciate your understanding in advance.
4. All patients must complete the patient information forms prior to seeing the doctor and present a current insurance card and driver's license.
5. Reminder calls are a courtesy. You are responsible for any missed appointment fee, whether you received a call or not.

Financial Policy

1. Our office participates in a variety of insurance plans. If we do not participate with your insurance plan, the payment for services rendered is expected to be paid in full at the time of service. We do offer a discount to "Self-Pay" patients. Self-pay patients are expected to pay in full at the time services are rendered.
2. According to your insurance plan contract, you are responsible for any and all co-payments, deductibles, and co-insurances. Copayments and estimated deductibles/ co-insurances are due at the time of service.
3. If our office is unable to verify your insurance coverage at the time of service, you will be financially responsible for the visit at the time services are rendered.
4. It is your responsibility to keep us updated with the correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and responsible to submit the charges to the correct plan for reimbursement.
5. If your insurance company is an HMO or POS policy, it may require you to choose a primary care provider (PCP). You will need to choose a physician from our practice. If we are not the designated PCP, you will be considered self-pay and financially responsible for the visit in full.
6. Our office verifies your coverage as a courtesy, but there is no guarantee of payment until the claim is processed. It is your responsibility to understand your benefit plan with regards to, for instance, covered services and participating laboratories. For example:
    - A. Not all plans cover annual physicals or sports physicals. If these are not covered, you will be responsible for payment.
    - B. Some insurances limit the number of allowable well visits per year and/ or have a dollar maximum of benefits payable for services. If this benefit is exceeded, your insurance company will not pay and you will be responsible for payment.

C. Some insurance companies consider visits for ADD, ADHD, depression and anxiety as mental health and will not cover the claim for services rendered by a medical physician. In this case, you will be responsible for payment.

7. Secondary Insurance: We do not file to secondary insurance. You are responsible for the patient portion stated on the primary explanation of benefits (EOB). You may submit the EOB to your secondary insurance for reimbursement.
8. Your insurance company may request that you supply information to them directly to process claims (i.e. coordination of benefits). It is your responsibility to comply with these requests in a timely manner.
9. In the cases of divorce and/or separation, the person bringing a child in for treatment will be held responsible for the payment due at the time of service. For the past due balances, the person requesting treatment is responsible for the balance on the account. We will be happy to provide a receipt if you need to seek reimbursement from another party.
10. All prior balances must be paid before your next appointment. You will not be seen until your balance is paid in full. Payment is due at check-in.
11. We accept cash, Visa, and MasterCard.
12. Statements are sent out monthly. Your remittance is due within 10 business days upon receipt of the bill. Any accounts with balances over 90 days with no activity will be turned over for collections and you may be discharged from the practice.
13. Overpayments will be refunded to the responsible party within 30 days of the request.
14. If you have any questions about your insurance or your bill, we are happy to help. However, specific coverage issues should be directed to your insurance company. You may contact the member services phone number on the insurance card.
15. We do not file claims to automobile insurance. If your visit is a result of an automobile accident, you will be required to pay self-pay. We will provide a receipt so that you may seek reimbursement.

Referrals/Forms

1. We may charge for school forms, camp forms, Family and Medical Leave Act forms, and any other forms to be completed by the physician. Payment is due when the forms are dropped off and we request a 5-day turnaround time. A fee will be charged for medical letters requested to be written by the physician. This can vary depending on the nature of the letter.
2. Please allow 48 hours for processing referral requests.

Transfer of Records

We provide records for visits rendered by Capstone Family Practice only. For any previous records, you must request from previous providers. A release of information must be signed. If you transfer to another physician or we refer you to another physician, we will send that physician a copy of your last visit and pertinent records free of charge. Please allow 10 business days for transfer of records.

Prescription Refills

Please contact your pharmacy first for refills. For medication refills requested by phone we require 48 hours' notice. In order to get refills for controlled substances, we require an appointment with a provider every 3 months. We will not refill prescriptions after hours.

Quest Lab

For your convenience, we have an in house Quest lab for your blood work. It is your responsibility to know your lab benefits. If you receive a statement, please do not contact our office. Please call the billing phone number for Quest that is on your statement.

After hours calls
If you have an urgent concern, please contact the physician on call. If a physician receives routine calls after hours such as requesting prescription refills or cancelling appointments, you will be charged a $25.00 fee. You may leave a message on the office voicemail after hours for non urgent matters to be handled the next day.

Consent to treat
By signing this form you are consenting for the providers of Capstone Family Practice to treat and/or test you or the child you are bringing in for an appointment.

Assignment of benefits
By signing this form you are authorizing your insurance carrier to pay benefits directly to Capstone Family Practice providers for all services provided. You are authorizing the release of pertinent information required by your insurance carrier to process your claims for payment to Capstone Family Practice.

Notification of HIPAA
I acknowledge that I have received, read and understand the policies outlining my rights to privacy concerning my health information. I understand that additional information is available upon request.

Patient Privacy Rights
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all patients have certain rights to privacy regarding health information. This protected information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

We wish to inform all patients of our document, Notice of Privacy Practices, containing a more complete description of the uses and disclosures of health information. As a patient you have the right to review such Notice of Privacy Practices prior to signing the consent. Please understand that Capstone Family Practice has the right to change its Notice of Privacy Practices at any time and a current copy of Notice of Privacy Practices will always be available.

Patients may request, in writing, to restrict how private information is used or disclosed to carry out treatment, payment, or healthcare operations. Though not required to agree to requested restrictions, we are bound to abide by agreed upon restrictions.

Your signature on the consent page signifies that you have read and agree to these policies. Patients may revoke consent at any time in writing, except to the extent that action has been taken relying on prior consent.

Capstone Family Practice

Signature of Understanding:

I have read and understand the above stated office and financial policy.

Patient Name ______________________________________ Date of Birth____________

Address ____

Home phone________________Cell phone______________Work phone____________

Email Address____

Emergency Contact: Name______________________Phone number_______________

Relationship____________________________

Contact Information for lab results: Phone number______________________________

Please check one: _______I DO authorize results to be left on my answering machine

_______I DO NOT authorize results to be left on my answering machine

I wish for my test results and medical information to be released to:

________Myself only

________Myself and _______________________________________

Patient Signature____ Date: ___________

Parent/Guardian Name (Print)________________________Relationship:__________

Parent/Guardian Signature ___________________________Date:_______________

Preventive Health Update

What is your cholesterol?_______________ Blood pressure?_____________________

Have you ever had a blood transfusion? □ Yes □ No

When was your last dilated eye exam? _________________ Glaucoma screening? _________

For Men: Have you ever had your prostate checked? Yes ____ No____ Date: ____________

For Women: Do you do monthly breast exams? Yes _____ No________

When was your last pap smear? ______________ Results: ___________________________

Mammogram? ___________________ Results: ____________________________________

If you are over 50:

Have you had a:

Screening colonoscopy? Yes ____ No____ Date: ________Results:________________

Bone density scan? Yes ____ No____ Date: _______________ Results: _________________

EKG? Yes ___ No____ Pneumonia shot? Yes ___ No___ Shingles vaccine? Yes ___ No____