# Capstone Family Practice Patient Registration

## *Patient Information:*

Last name: _____ First Name:_____ Middle name: _____

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

Primary number: (_____) _____-_____ Secondary number: (_____) _____-_____

E-mail address: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____Current occupation: _____

**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 government requirement under the American Recovery and Reinvestment Act.*

## *Emergency Contact Information*

Name: _____Relationship: _____ Phone number: (_____) _____-_____

## *Preferred Pharmacy*

Pharmacy Name: _____Phone: _____

Pharmacy Address: _____

## *Social History*

Single Married Divorced Widow/Widower Committed Relationship

**Tobacco/ Vape/ E-Cigarette Use**: Nonsmoker/ Current/ Former
For current or past tobacco/vape/e-cigarette user:

What kind? _____How much? _____Quit Date_____

**Illicit Drug / Marijuana Use**: yes/ no/ former
For current or past illicit drug user:

What kind? _____How much? _____Quit Date_____

**Alcohol Use**: Nondrinker/ Current/ Alcoholic
For current or past alcohol user:

What kind? _____How much? _____Quit Date_____

## *Patient Health History*

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 for seeing the healthcare provider today?

_____

_____

Have you had any prior treatment for this condition?

_____

## *Personal Medical History:* **Please circle any diagnosis you have now or have had in the past**

| | | |
|---|---|---|
| Heart Disease | Seizure Disorder | Bladder infection |
| Heart Attack | Migraine | Prostate Problem |
| Irregular Heart Beat | Headache | Menstrual Problem |
| Heart Failure | Stroke | Neuropathy |
| Heart Murmur | Ulcer | Osteopenia/Osteoporosis |
| High Blood Pressure | GERD | Arthritis |
| High Cholesterol | Irritable Bowel | HIV |
| COPD/emphysema | Diverticulosis | Dementia |
| Pulmonary Embolism | Liver Disease | Bipolar Disorder |
| Pneumonia | Diabetes | Depression |
| Asthma | Thyroid Disorder | Anxiety |
| Seasonal Allergies | Anemia | ADD/ADHD |
| Sleep Apnea | Kidney Disease | Cancer: _____ |

Other Problems not listed above: _____

| **Medications you currently take (including over the counter/vitamins/supplements)** | **Dosage / How often** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## *Please list any allergies to medications as well as the reaction you had:*

**Allergy** **Reaction**

_____

_____

_____

### *Family History*

Please list any known health conditions for the following family members:

**Father**: _____

**Mother**: _____

**Siblings:** _____

**Grandparents**: _____

### *Hospitalizations and Surgeries*

List all prior surgeries and approximate dates performed. Please also list any hospitalizations, date and for what condition

_____

_____

_____

_____

_____

_____

### *Preventive Health:*

| | DATE | OUTCOME |
|---|---|---|
| Last Menstrual Period | _____ | Normal/ Abnormal |
| Mammogram | _____ | Normal/ Abnormal |
| PAP smear | _____ | Normal/ Abnormal |
| Bone Density | _____ | Normal/ Abnormal |
| PSA | _____ | Normal/ Abnormal |
| Colonoscopy | _____ | Normal/ Abnormal |
| Tetanus Vaccine | _____ | |
| Influenza Vaccine | _____ | |
| Pneumonia Vaccine | _____ | |
| Shingles Vaccine | _____ | |

***Please list all other healthcare providers or specialist that you see:***

**Name** **Phone**

_____

_____

_____

_____

# Capstone Family Practice

## Signature of Understanding:

I have read and understand the attached stated office and financial policies.

Patient Name _____ Date of Birth_____

***Contact Information for lab results***: Phone number_____

**Please Circle One:** I DO / I DO NOT authorize results to be left on my voicemail

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

_____Myself only

_____Myself and _____

**Consent to Treat Unaccompanied Minor**

**Please Circle One:** I DO / I DO NOT authorize and give consent for my child, listed above, to go independently to appointments and consent to all medical and/or surgical treatment without the presence of a parent or legal guardian. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments.

**Patient Signature_____ Date: _____**

**Parent/Guardian Name (Print)_____Relationship:_____**

**Parent/Guardian Signature _____Date:_____**

# 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 20 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, MasterCard and Discover.
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.