Patient Registration Form

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work
	Date of Birth:		Sex: ☐ Male ☐ Female ☐ Transgender
Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____	Social Security #:		
	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Email Address:

Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	Ethnicity (please select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian ☐ Other

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Colbert Family Health & Wellness payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to CFHW all money to which I am entitled for medical expenses related to the services performed from time to time by CFHW, but not to exceed my indebtedness to CFHW. I authorize CFHW to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due. I choose to receive communications from CFHW by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to CFHW. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party: **X** _____ **Date:**

Printed Name of Responsible Party: **X** _____ **Date:**

PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____
ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____
_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Continued on other side.

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type:_____Amount/day:_____Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐ Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐ Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

Patient Financial Policy

Colbert Family Health & Wellness

Thank you for choosing the practitioners of **Colbert Family Health & Wellness** as your family health care providers. We are committed to providing you with quality family health care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. If you have any questions about our fees, our policies or your financial responsibilities, please do not hesitate to ask the office staff or contact us at (937) 529-4376. Please take time to carefully review the following information and return this form to the front desk with your signature and today's date.

We require that all patients complete our Patient Financial Policy prior to seeing the practitioner. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

INSURANCE

- It is the patient's responsibility to provide our office with current insurance information. We will ask for and copy your insurance card at your first visit. Please bring your current insurance card to each visit. We will ask to verify the card.
- If current information is not obtained at the time of service, it will become the patient's responsibility to pay the entire balance until current information is provided to our office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, and pursuant to contractual obligations, we file all your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. **You are ultimately responsible for the timely payment of your account.**

CO-PAYS

- Co-payments are due at the time you check in **PRIOR** to your being seen by our practitioners.

DEDUCTIBLES and CO-INSURANCE and ESTIMATES for in-office procedures:

- Balances related to unmet deductibles and estimation of co-insurance, as per the contract you have with your insurance, is to be paid at the time of service.
- For in-office procedures, an estimation of patient responsibility will be provided to you and is to be paid **in full** PRIOR to services being rendered.
- Additional balances due, if applicable, will be billed to you after the insurance carrier has processed the claim.

UN-PAID/OUTSTANDING BALANCES – (Collection Agency/Bankruptcy)

- Payments are to be made at the time of service unless prior arrangements have been made through the practitioner's office staff in advance of your appointment.
- Any overdue balances may be processed to a collection agency for additional collection efforts. ***If the account is referred to a collection agency, this may result in referral from the practice and/or the inability to schedule an appointment.***
- All balances not paid by your insurance carrier will be billed to you. Questions about how your claim was processed are to be directed to your insurance carrier or you may call our business office at (937) 529-4376.
- Filing of bankruptcy, resulting in the waiving of balances due to the practitioner, constitutes a breach in our financial policy and could result in referral from the practice or delay in scheduling an appointment.

Forms of payment accepted:

Cash, checks, Visa, and Mastercard.
(Contact our billing office at (937) 529-4376 for additional information)

RETURNED CHECKS *(FEE APPLIED)*

- The charge for a returned check is **$25.00** payable by cash, money order or charge (no checks accepted). This will be applied to your account in addition to the insufficient funds amount.

DISABILITY FORMS *(FEE APPLIED)*

- Disability, Life Insurance and other forms are often requested to be completed by the practice. Many of the forms require review by the practitioners and completion of detailed medical history questionnaires. Please allow 5-7 days for completion of any requested forms. The charge for this service is **$20.00**. The fee for document completion must be paid in full when forms are submitted to our office. We will not satisfy requests for completion or release of these documents until we are paid in full.

MISSED APPOINTMENTS *(FEE APPLIED)*

- Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment we request, at minimum, a **24 hour notice**. Failure to provide notice will result in a **$25.00** missed appointment charge. This charge is the responsibility of the patient and is not covered by any insurance carrier.

CREDIT BALANCES

- If your account reflects a credit balance of ***$25.00 or less***, Colbert Family Health & Wellness' policy is to carry the balance on the account until your next appointment or your transfer from the organization. If your account reflects a credit balance of ***more than $25.00***, Colbert Family Health & Wellness will maintain your credit until our Accounts Receivable staff processes your credit or a request is made by you, the patient, to receive a refund. All refunds are reviewed and processed every 45 days, if you make a request please allow ample time for review of your entire account and processing through our accounting department. Refunds are not issued when outstanding insurance claims are still "in processing" with your insurance company. Please call (937) 529-4376 with questions.

MEDICAL RECORD COPIES - Please reference the details below regarding the cost associate with the copying of a patient's medical record according to the Ohio State Medical Board Regulation.

Ohio Practice: Ohio State Medical Board Regulation [§ 3701.74.1]

If you request a copy of your medical records you will be charged the following fees:

a) With respect to data recorded on paper, the following amounts apply:
   - i) $3.07 per page for the first ten (10) pages;
   - ii) $0.64 per page for pages eleven (11) through fifty (50);
   - iii) $0.26 per page for pages fifty-one (51) and higher
   - iv) $2.10 per page with respect to data resulting from X-ray, MRI, or CAT scan, recorded on paper or film

b) With respect to data recorded other than on paper (I.e. electronic copy):
   - i) Eight dollars ($8.00) per flash drive required
   - ii) The actual cost of any related postage incurred by Colbert Family Health & Wellness

If a request is made other than by the patient or the patient's personal representative, total costs for copies and all services related to those copies shall not exceed the sum of the following:

a) An initial fee of eighteen dollars and ninety-one cents ($18.91), which shall compensate for the records search;
b) With respect for data recorded on paper, the following amounts apply:
   - i) $1.24 per page for the first ten (10) pages;
   - ii) $0.64 per page for pages eleven (11) through fifty (50);
   - iii) $0.26 per page for pages fifty-one (51) and higher
   - iv) $2.10 per page with respect to data resulting from X-ray, MRI, or CAT scan, recorded on paper or film
c) The actual cost of any related postage incurred by the health care provider or medical record company.

Like all businesses it is our intention to thoroughly explain our financial policies and set forth our expectations. Your assistance and cooperation is appreciated.

We are pleased to have the opportunity to meet your health care needs and encourage you to contact (937) 529-4376 with any questions or concerns.

I have read the Patient Financial Policy and acknowledge my responsibilities by affixing my signature below.

_____ _____
Patient Name (please print) Patient Date of Birth

_____ _____
Patient/Responsible Party Signature Date

_____Colbert Family Health Rep Initials

Medical Records Release

Patient Name _____ **Date of Birth** _____

Previous Name _____ **Daytime Phone** _____

Please check one:

I request and authorize PHMG to: ☐ Release To ☐ Obtain From

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

You may use or disclose the following health care information (check all that apply):

Patients who request more than the last 2 years of their records may be charged a $10 service fee. All payments are required prior to copying. All records are burned to a CD, faxed or e-mailed. If paper copies are requested, there will be additional charges.

☐ Chart Notes ☐ Patient Visit Summary ☐ All Records

☐ Labs / Pathology ☐ Most Recent Specialist(s) Visit ☐ Billing

☐ X-rays / Diagnostics ☐ Last Well Child Check

☐ Immunizations ☐ Growth Chart

Other _____ Time Frame Requested _____

Pick up _____ Where? _____ Faxed _____ Mailed _____ E-mailed _____

E-mail address _____

Reason for Authorization: ☐ At the request of the individual ☐ Other: _____

Expiration: ☐ Date: _____ OR ☐ Event (one time release): _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my consent to the use or disclosure of my protected health information for purposes of treatment, payment or health care operations. I may inspect or copy any information used/disclosed under this authorization. I have authorized PHMG to photocopy this authorization, and you may accept a photocopy of this authorization as if it were the original.

I understand that I may revoke this authorization in writing at any time to PHMG, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 12 months unless otherwise dated above.

SPECIFIC AUTHORIZATION

I understand that my health information to be released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or drug abuse. My signature below authorizes release of all such information, unless I have marked NO and initialed it.

_____ YES _____ NO _____ INITIALS

_____ _____ _____

Signature/Legally Responsible Party Relationship to Patient Date

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

- I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.
- I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.
- I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
- I understand that telehealth services can only be provided to patients, including myself, who are residents of or physically located in the state of Idaho at the time of this service.
- I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.
- I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
    - *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
    - *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
    - *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*
- I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.
- I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

- I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
- I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
- I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- By beginning the visit, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
- I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
- To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- I certify that I have read and understand this agreement and that I have had the opportunity to have questions answered to my satisfaction.

_____

Signature and Date

_____

Printed Name

_____

Relationship to Patient (If patient unable to sign)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
- We participate in one or more **Health Information Exchanges (HIE)** which allows disclosure of your electronic health record via electronic transfer to other facilities and providers for your treatment purposes. Your health information and basic identifying information regarding your visits to our facilities may be shared with the HIEs for the purposes of diagnosis and treatment.

This includes health information for your continuing care, as well as care you may seek at other locations. Other providers participating in these HIEs may access this information as part of your treatment.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below**.**

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.

- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.

- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

By signing below, I am agreeing that I have received and read the privacy policies at CFHW/

_____

Signature and Date

_____

Printed Name

_____

Relationship to patient (if signing on their behalf)