HOW DID YOU HEAR ABOUT US: ❒Friend/Family ❒Doctor Referral ❒Drive By ❒Employer ❒Internet

PRIMARY CARE PROVIDER NAME: _____

EMAIL ADDRESS/CORREO ELECTRONICO (REQUIRED FOR PATIENT PORTAL): _____

Name/Nombre: _____
(Last/Apellido) (First/Primer) (Middle/Segundo)

Parent's Name (If under 18 years old)/Padres del Menor _____
(Last/Apellido) (First/Primer)

Mailing Address/Dirección: _____
City/Ciudad State/Estado Zip Code/Código Postal

Sex/Sexo: Male/Hombre / Female/Muje Marital Status/Estado Civil: Single/Soltero(a) Married/Casado(a) Divorced/Divorciado(a) Widow/Viudo(a)

Race/Ethnicity: White _____ Hispanic _____ African American _____ Asian _____ Other _____

Employer/School / Empleado/Escuela: _____

Home Phone/ Teléfono de Su Casa: _____ Cell Phone/Teléfono de Celular: _____

Work Phone/Teléfono de Su Trabajo: _____ Ext.: _____

Social Security Number/
Numero de Seguro Social: _____

Date of Birth/
Fecha de Nacimiento: _____

BILLING INFORMATION
INFORMACION DE SU CUENTA

Person responsible for paying bill if under age of 18/ Persona responsable para pagar: Patient/Paciente Parent/Padres Spouse/Esposo(a)
Other/Otro_____

Name (if different from above)
Nombre (si diferente de arriba): _____

Date of Birth/
Fecha de Nacimiento: _____

Address/Dirección: _____
City/Ciudad State/Estado Zip Code/Código Postal

INSURANCE INFORMATION
INFORMACION DE ASEGURANZA

PLEASE PRESENT YOUR INSURANCE CARD AT EACH VISIT

IS THIS A WORK RELATED INJURY?_____ IS THIS A MOTOR VEHICLE ACCIDENT?_____

PRIMARY INSURANCE / PRIMERA ASEGURANZA

Insurance Company Name
Nombre de Aseguranza

Address, City, State, Zip Code, Telephone Number
Dirección, Ciudad, Estado, Código Postal, Número de Teléfono

Subscriber's ID Number
de Identificación del Subscriptor

Group Number
Del Grupo

Policy Holder's Name
Nombre de Asegurado/a

Social Security
de Seguro Social

Date of Birth of Subscriber
Fecha de Nacimiento del Asegurado

Patient's Relationship to Policyholder (please circle one)
Relación del Paciente con el Asegurado (circulo uno)

Self El Mismo | Spouse Esposo(a) | Child Hijo/a | Other Otro_____

SECONDARY INSURANCE / ASEGURANZA SEGUNDARIA

Insurance Company Name Nombre de Aseguranza	Address, City, State, Zip Code, Telephone Number Dirección, Ciudad, Estado, Código Postal, Número de Teléfono

Subscriber's ID Number # de Identificación del Subscriptor	Group Number # Del Grupo	Policy Holder's Name Nombre de Asegurado/a	Social Security # de Seguro Social	Date of Birth of Subscriber Fecha de Nacimiento del Asegurado

Patient's Relationship to Policyholder (please circle one) Self Spouse Child Other
Relación del Paciente con el Asegurado (circulo uno) El Mismo Esposo(a) Hijo/a Otro_____

IN CASE OF EMERGENCY

Name/Nombre: _____

Address/Dirección: _____

Phone Number/Teléfono: _____ Relationship/Relación: _____

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL AGREEMENTS:

INITIAL

_____ I have no insurance coverage. I understand that I am responsible for payment of services rendered to myself or dependents **at the time of service**.

_____ I understand if I fail to pay amounts owed; the office has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

INSURANCE AUTHORIZATION AND ASSIGNMENT

INITIAL

_____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ I understand I am responsible **at the time of service** for paying any required co-payment and deductible.

AUTHORIZATION TO TREAT

I authorize the doctor, physician assistant, or medical staff to provide necessary medical treatment. I promise to make reasonable payments for services provided by the clinic. I authorize my insurance company to make payments for services provided directly to Roswell Family Care. I authorize information to be released to persons that are responsible for my treatment or payment of my treatment..

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

_____ _____

Patient/Parents/Guardian Date

familycare

PATIENT HISTORY AND PHYSICAL FORM

NAME: _____ DOB: _____ DATE: _____

PARENT NAME (If patient is under 18 yrs old) : _____ PRIMARY PHARMACY: _____

MEDICAL HISTORY			
☐ Anemia	☐ Chest Pain	☐ High Cholesterol	☐ Seasonal Allergies
☐ Arthritis	☐ Depression/Anxiety	☐ Headaches	☐ Shortness of Breath
☐ Asthma	☐ Diabetes	☐ Kidney Disease	
☐ Bowel Irregularity	☐ Heart Disease	☐ Osteoporosis	☐ Stroke
☐ Cancer	☐ High Blood Pressure	☐ Prostate Disease	

HOSPITALIZATIONS OR SURGERIES			
Reason	Date	Reason	Date

Pregnant? *Yes / No* **Last Pap?** _____ **LMP:** _____ # of pregnancies ___ # of children ___ # of termed preg.___

DRUG ALLERGIES	
DRUG	REACTION

CURRENT MEDICATIONS/OVER THE COUNTER/HERBALS	
MEDICATION	STRENGTH/HOW MANY TIMES A DAY

Family History? _____

SOCIAL HISTORY

Smoke/Tobacco ☐ **YES** ☐ **NO** _____ packs daily _____How Long? _____When Stopped?

Alcohol ☐ **YES** ☐ **NO** Type/Amount: _____

Coffee ☐ **YES** ☐ **NO** _____ Cups Daily **Recreational Drugs?** *Yes / No*

Employment? _____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

- A patient's medical information may be shared with doctors, nurses, technicians, medical students, other facility personnel involved in their care, family member, friends, and caregivers as required
- A patient's medical information may be shared with third parties involved in the reimbursement such as insurance firms, billing firms, and patients' friends and family members involved in payment
- A patient's medical information may be utilized for treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review.

Health care operations include the business aspects of running our center, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

- A patient's medical information may be utilized as part of the oversight of activities, including audits, investigations, licenses, and inspections required for with government programs and laws.
- A patient's medical information may be utilized for scheduling procedures, treatment alternatives, fund-raising activities and research
- A patient's medical information may be shared as required by law with regard to court or administrative order, subpoena, discovery request, or other lawful process, when requested by national security, intelligence, and other federal officials, and/or when the patient is an inmate or under the custody of law enforcement
- A patient's medical information may be shared upon to prevent a serious threat to health and safety A patient's medical information may be shared upon military command if the patient is serving in the military or the veterans.
- A patient's medical information may be shared with worker's compensation representation.
- A patient's medical information may be shared with local public health officials in the event of deaths, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent/control disease, injury or disability.

- Each patient has the right to copy and inspect their medical information
- Each patient has the right to amend medical information contained in the medical information
- Each patient has the right to receive an accounting of disclosures of their medical information
- Each patient has the right to request restrictions on the disclosure of the medical information
- Each patient has the right to receive a paper copy of this notice upon request

This facility is responsibility for serving the right to make changes to this notice upon notification from HIPAA of changes to requirements and to post the effective date and posting location.

Roswell Family Care
Notice of Privacy Practices Acknowledgment Form

Patient Name: _____ **Date of Birth:**_____

I have received a copy of the Notice of Privacy Practices

Signature: _____ **Date:** _____
(Patient or Parent Signature)

Individual or Personal Representative with legal authority to make healthcare decisions

If signed by a Personal Representative:

Print Name_____ Role_____
(Parent, guardian, etc.)
Witness:_____ Date:_____

If the individual has a personal representative with legal authority to make health care decisions on the Individual's behalf, the notice must be given to and acknowledgment obtained form the personal Representative. ***If the individual or Personal Representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on_____ **by**_____
(Date)

Reason Individual or Personal Representative did not sign this form:

- ❑ Individual or Personal Representative chose not to sign
- ❑ Individual or Personal Representative did not respond after more than **one** attempt
- ❑ Email receipt verification
- ❑ Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature.
Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

- ❑ Face to face presentation(s)_____
- ❑ Telephone contact(s)_____
- ❑ Mailing(s) _____
- ❑ Other_____

Staff Signature:_____ **Title**_____