Rockford Family Care **Patient Information** **Please complete all information*

Name _____ M F ___/___/___ _____
First Middle Last Sex DOB Age

Address _____
Street Address City State Zip

Home Phone (___) ___-_____ Cell Phone (___) ___-_____ Social Security # ___-___-_____

Patient Employer _____ Job Title _____

Employer's Address _____ Employer Phone (___) ___-_____
Street Address City, State Zip

If Patient is a Minor, Responsible Party

Name _____ Social Security # ___-___-_____

Address _____ Phone (___) ___-_____
Street Address City, State Zip

Employer _____ Occupation _____

Employer Address _____ Employer Phone (___) ___-_____
Street Address City, State Zip

Health Insurance Information

Insurance: _____ Policy Holder : _____
Policy Holder Name Soc Sec # Date of Birth

Insurance Address: _____ Phone (___) ___-_____
Street Address City, State Zip

Policy # _____ Group # _____

Are you claiming this as an on-the-job injury? ☐ Yes ☐ No Date: _____

Was the problem caused by an accident? ☐ Yes ☐ No Date: _____

Do you have an attorney handling this claim? ☐ Yes ☐ No Whom: _____

Were you referred to our office? ☐ Yes ☐ No By whom: _____

If not, how did you learn about us? _____

Who should we contact in case of an emergency? _____

_____ Phone (___) ___-_____
Address City, State Zip

Required Authorizations

**Please take a moment to complete all of the following required consents*

Benefits to Practice: I hereby authorize payments directly to Rockford Family Care of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract.

Signed (patient or parent of minor) _____

Release of Information: I hereby authorize release of information necessary for filing my insurance claim or filing a payment review.

Signed (patient or parent of minor) _____

I have received a Notice of Privacy Practices from the office of Rockford Family Care

Signed _____ Date _____

I have signed the patient consent for use and disclosure of protected health information from the office of Rockford Family Care

Signed _____ Date _____

HIPAA) **I authorize practice/billing company to contact me about my bill by reaching me via (Note: If all boxes are checked "no" we will require prepayment on all services)**
Phone: yes ☐ no ☐ Cell phone: yes ☐ no ☐ Work phone: yes ☐ no ☐ Mail: yes☐ no ☐

You <u>may</u> speak with the following person/s about my bill regarding medical services provided:

Name _____ Relationship _____ Phone (___) ___-_____

You <u>may not</u> speak with the following person/s about my bill regarding medical services provided:

Name _____ Relationship _____

NEW PATIENT HEALTH HISTORY

Name *(Last, First, M.I.):*	☐ M ☐ F	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:		**Date of last physical exam:**
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino		**Preferred Language:**
Race: ☐ Asian ☐ American Indian or Native Alaskan ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Please specify: _____		

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

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

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father				☐ M ☐ F	
Mother				☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		Grandmother *Maternal*		
	☐ M ☐ F		Grandfather *Maternal*		
	☐ M ☐ F		Grandmother *Paternal*		
	☐ M ☐ F		Grandfather *Paternal*		

Women only	
Age at onset of menstruation:	
Date of last menstruation:	
Period every _____ days	
Number of pregnancies _____ Number of live births _____	
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Date of last pap and rectal exam?	
Date of last Mammogram?	

Men ONLY	
Date of last prostate and rectal exam?	☐ Yes ☐ No

Pharmacy: _____

We are now offering text/call appointment reminders. If you would like to receive these reminders please provide us with the best number to text or call.

Best number for text messages: _____

Best number for phone messages: _____

☐ **Yes, I wish to receive voice/text appointment reminders**

☐ **No, I do not wish to receive voice/text reminders**

Signature: _____ **Date:** _____

Consent to Treat

I hereby authorize employees and agents; including physicians, physician assistants, and medical assistants; of this medical office to render medical care to the patient indicated on this form and to fulfill the orders of the providers; including consultants, associates, and assistants of the physicians and physician assistant's choice.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

_____ _____

Signature of Patient or Legal Guardian Date

Financial Responsibility

I hereby authorize payment of medical benefits directly to Rockford Family Care for services rendered. Authorization is hereby granted to release all information contained in my medical record to my medical insurance company (or its employees or agents) as may be necessary to process and complete my medical insurance claim.

- The patient is ultimately responsible for the payments of his/her treatment and care.
- The patient is responsible for providing accurate and up to date information as well as copies of all medical insurance cards needed for billing purposes.
- I agree that all Insurance co-pay amounts are due upon request and are payable to Rockford Family Care.
- Self pay patients will be responsible for payment of his/her treatment and care at time of service.
- The patient is responsible for making payment, or for arranging payment plan within 30 days of the date that appears on his/her statement.
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt.
- The patient will be responsible for payment of copies of medical records at $1 for first page and .25 for each additional page after that. There is no charge for medical records being sent to another health care provider or healthcare facility. (medical records cannot be mailed, faxed, or emailed to patients.)
- I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV").

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____ _____

Signature of Patient or Legal Guardian Date

Office Policies

We have created this information sheet to acquaint you with our standard policies. We suggest that you keep your copy of this sheet to refer to in the future.

Office Hours: Our office is open Monday through Friday from 8:00 am until 5:00 pm, excluding holidays. We close for lunch between 11:30 am and 12:30 pm. The phones are answered from 8:00 am to 11:30 am and from 12:30 pm until 5:00 pm. **In the event of a medical emergency after hours, please go to the Emergency Room!** Prescription refills are not considered an emergency.

Appointments: We make every attempt to schedule patients at the earliest possible opening. Many of our patients have need complex treatment, and although the provider tries to stay on schedule, a patient's condition may require that she spend additional time – and that creates delays in our schedule. We do accommodate walk-ins and same-day appointments if they are available. New patients will not be seen before from 11:00am-11:30am or 4:30pm-5:00pm. The last patient scheduled before lunch will be at 11:15am. The last patient scheduled before closing will be 4:45pm. Exceptions will be made per provider approval.

No Shows: We understand that delays can happen, however, we must try to keep the other patients on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment. If you have more than 3 no shows, we will no longer be able to provide services to you, and you will be asked to find another provider.

Cancellations: we understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 2 hours in advance you will be charged a twenty-five ($25) fee; this will not be covered by your insurance company.

Prescription Refills: Good medical care requires that a provider review a patient's chart prior to refilling or amending a prescription.

Plan Ahead • We ask that you contact your pharmacy with your request 5 days before your medication is due, and allow the pharmacist to contact our office. Please check with the pharmacy directly to see if your refill has been approved. ***No refill requests will be accepted after office hours or on weekends.***

There are strict controls for medications containing opioids. Some opioids cannot be called into the pharmacy for refills. The patients must be seen in the office for certain medications to be refilled.

-Refills can only be authorized on medications prescribed by physicians in our office. We will not refill medications prescribed by other physicians.

-If a patient has not been evaluated in 3 or more months, a follow up visit may be needed to verify medication needs.

-NO early refills if medications are overused/abused/misused/lost/stolen.

Payment Policy: Payment is due and payable at the time of service unless: 1) You are insured with Medicare. The deductible and copay is due at the time of service. 2) You are insured with a managed care plan with which our office participates. The amount due at the time of service will depend on the specifics of your plan. Copayments and deductibles are due at the time of service. For all injections that are not covered by insurance, payment will be requested before the injection is given. All self-pay patients are required to pay $125 for the first visit and $75 for each additional follow-up visit. Payment is due on the day of the visit before being seen by the provider. Any patient that has been turned over to collections will not be able to make an appointment until the balance is resolved.

Paperwork Policy: Disability policies are private policies owned by the patient. We charge $15 per form to be completed, and ***without exception the money must be prepaid*** at the time the form is left with our office. FMLA paperwork is $50. We require 10 days to complete the form. Patients may come by to retrieve their form, or they may provide our office with a stamped, self-addressed envelope and it will be forwarded as indicated.

Diagnostic tests, X-ray, and Lab Results: If the provider orders a test, you will be contacted by telephone with the results within 5 working days by our office. If the test was ordered and performed by another physician, you should contact that office for your results. Even if Rhea obtained preauthorization for the procedure, you will still need to contact the office that originally ordered or performed the test.

Family

All children and family are welcome in this clinic; however, if they become disruptive, we will ask you to reschedule your appointment for another day. The patient is allowed up to two family members in the exam room during their appointment. Exceptions will be approved by the provider.

_____ _____

Signature Date

Patient Consent for Use and Disclosure of Protected Health Information

With my Consent, Rockford Family Care may use and disclose my protected health information about me to carry out treatment, payment and healthcare operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rockford Family Care reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer at:

Rhea Buycks, PA-C at Rockford Family Care
317 N. Rockford Rd
Ardmore, OK 73401

Telephone

With my consent, Rockford Family Care may call my home or another designated location and leave a message (on voicemail, answering machine, or in person) in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations. This may include appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory and other results.

Mail

With my consent, Rockford Family Care may mail to my home or another designated location any items hat assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

Email

With my consent, Rockford Family Care may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment, and healthcare options, such as appointment reminder cards, correspondence, and billing statements.

I have the right to request that Rockford Family Care restrict the use or disclosure of my protected health information to carry out treatment, payment, and healthcare options. (Please request form)

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations by Rockford Family Care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, Rockford Family care may decline to provide treatment to me.

Print Patient Name	Signature of Patient * or Legal Guardian	Date

Attention Privacy Officer:
*If a patient wishes to limit how they are contacted by our practice or the release of their information, please refer the patient to the form titled Request for Limitations and Restrictions of PHI.