Family First

Patient Legal Name (first, middle, last):		**Date of Birth:** / /
Patient Preferred Name:	**Social Security #:** - -	
Mailing Address:		**APT#:**
City:	**State:**	**Zip Code:**
For Minors: Please indicate responsible Parent/Guardian		
Email:		
Home Phone #: ( ) -	**Cell Phone #:** ( ) -	**Work Phone #:** ( ) -
Sex: (CIRCLE ANSWER) Male Female Other (Please specify) _____	**Marital Status:** (CIRCLE ANSWER) Single Married Partnered Divorced Widowed	
Pharmacy Name & Address:		
Emergency Contact Name:	**Emergency Contact Phone #:** ( ) -	**Relationship to Patient:**
Primary Physician Name:		
Primary Physician Address:	**Primary Physician Phone #:** ( ) -	

PRIMARY INSURANCE INFORMATION

Insurance Company:	**ID #:**	
Insurance Company Address:	**Policy Holder Date of Birth:** / /	
Policy Holder Name:	**Policy Holder SS #:** - -	**Relationship to Patient:**
Policy Holder Address:		

SECONDARY INSURANCE INFORMATION

Insurance Company:	**ID #:**
Insurance Company Address:	

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

Individual's Financial Responsibility

- I understand that I am financially responsible for any co-pay, co-insurance, deductible, or the cost of any non-covered service.
  **Please be aware that some services provided may not be covered and/or considered reasonable and necessary under the Medicare program and/or other medical insurances.*
- I understand that payment in **FULL** is due at the time services are rendered.
- I understand that if my insurance requires a referral, I must obtain it prior to my visit.
- I understand that I will be responsible for any charges should my insurance deem a service "not payable".
- Should payment be sent directly to me, I understand it is my responsibility to forward payment directly to Family First Primary Physicians
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

****REFILLS, PRIOR AUTHORIZATIONS, & REFERRALS require AT LEAST 72 Hours for completion***

MISSED/CANCELED APPOINTMENTS: In fairness to other patients, we require ***24 hour notice*** to cancel appointments. You will be charged $50.00 for missed appointments. Repeat missed appointments may result in dismissal from the Practice.
LATENESS: Arrival 20 minutes after your scheduled appointment will result in cancellation of the appointment. You may incur a $50.00 missed appointment fee.
COMPLETION OF FORMS: $25.00 to complete physical/pre-employment/sports physicals/disability paperwork/insurance request forms if not provided at time of service. *Please allow **at least 48-72 hours** for completion.*
MEDICAL RECORDS: Request for medical records must be made in writing. Please allow ***72 hours*** for completion.
COLLECTIONS: Any fees or surcharges imposed by a collection agency will be your responsibility, along with the full outstanding balance from your visit.

****PCP (PRIMARY CARE PHYSICIAN) SELECTION-ACKNOWLEDGE _____INITIALS****

Per my insurance company, my plan as a HMO, POS, or EPO requires that I select a Primary Care Physician (PCP). I certify that I contacted my insurance company prior to being seen by one of Family First Primary Physicians providers and selected one of them as my primary care physician and have given the correct addresses above.

I understand and am aware if I did not do this prior to being seen by one of the providers at Family First Primary my insurance company might not be able to backdate, and I will be responsible for the visit(s) and medical services denied by my insurance. I am also aware that any tests, referrals, and authorizations will be affected and cannot be backdated or issue for appointments with specialists or other healthcare facilities.

By signing:
I agree that I have read and understood the above policies.
I authorize the release of any information necessary to process the health claims for my care.
I authorize the insurance company to forward payment directly to the physicians.

_____	_____	____/_____/_____
Printed Name	Patient Signature	Date

Annual Physical
Financial Wavier

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

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that the **annual check-up** you are scheduled for is to assess your present condition and to help identify any potential risk or risk avoidance measures determined from your examination, pre physical lab work up, or other diagnostic tests. This may take between 15 to 30 minutes depending upon the complexity of the examination and any chronic conditions.

******Please note***: *An annual physical does not include any other evaluations or treatments for the patient.* Evaluation of chronic conditions, refills of medications, changes in medications or other acute injuries or illnesses are considered as treatments and must be coded as an examination. Most annual physicals are paid in full by the insurance company, however, any additional treatment/ examination must be coded accordingly and may require payment of a copay or deductible if it is completed simultaneously with the annual physical.

Per my insurance company my plan as a HMO, POS, or EPO requires you to select a Primary Care Physician (PCP). I certify that I contacted my insurance company prior to being seen by one of Family First Primary Physicians providers and I selected one of them as my primary care physician given the one of the correct addresses above.

I understand and aware if I did not do this before seen by one of the providers at Family First Primary my insurance company might not be able to backdate, and I will be responsible for the visit(s) and medical services denied by my insurance. I am also aware that any tests, referrals, and authorizations will be affected and cannot be backdate or issue for appointments with specialists or other healthcare facilities.

Please sign as acknowledgement that you have read and understand the above Financial Policy.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have read and received a copy of the HIPAA Notice of Privacy Practices

_____ _____ ____/_____/_____

Printed Name Patient Signature Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE CHECK ALL THAT APPLY

I authorize my physician/clinical staff to disclose my protected health information to:

- ☐ Myself only
- ☐ My spouse or significant other (specify names) _____
- ☐ My parent(s) (specify names) _____
- ☐ Others (please specify relationship) _____

I would like to be contacted in the following manner:

Home Telephone _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Cellular Telephone _____

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave messages or medical information

Written Communication

- ☐ OK to email through our patient portal
- ☐ OK to mail to my home address

I grant Family First Primary Physicians permission to obtain information from external sources (Pharmacy) regarding medications that have been prescribed to me.

- ☐ [Check here if you **DO NOT** consent for external prescription history]

_____ _____/_____/_____

Patient Signature

Medical History

NAME:_____**DATE OF BIRTH**: _____

Pharmacy (Name and Location):_____

CURRENT MEDICATIONS (prescription and over the counter)	DOSAGE	FREQUENCY

PAST MEDICAL HISTORY (Please ***CIRCLE*** all that apply to you)			
Alcohol/Drug Abuse	COPD/Emphysema	Heart Murmur	Liver Disease
Allergies	Coronary Artery Disease	Hepatitis	Pacemaker
Anemia	Congestive Heart Failure	High Blood Pressure	Psychiatric Problems
Atrial Fibrillation	Depression	High Cholesterol	Seizure
Asthma	Diabetes	Hypo/hyperthyroidism	Stroke
Cancer	Heart Attack	Kidney Disease	Vascular Disease

Please list any medical disease that you have that is not mentioned above:

_____

_____

ALLERGIES	**REACTION** (hives, anaphylaxis, etc.)

PAST SURGERIES	DATE	SURGEON

HOSPITALIZATION DATE	REASON FOR HOSPITALIZATION

FAMILY HISTORY	Status (Alive/Deceased)	Age	Diabetes	High Blood Pressure	Heart Disease	Cancer	Other
Grandfather (maternal)							
Grandmother (maternal)							
Grandfather (paternal)							
Grandmother (paternal)							
Father							
Mother							
Brother							
Brother							
Sister							
Sister							

Please list any significant medical disease that a member of your family has that is not mentioned above:

_____

SOCIAL HISTORY

Smoking History (Please circle): CURRENT/ FORMER /NONSMOKER

If Current Smoker - # cigarettes or cigars/day: _____

# of years smoking: _____

If Former Smoker – Date quit: _____

# of years smoking: _____

Alcohol History (Please circle): FREQUENT (Weekly)

OCCASSIONAL

(Monthly or less)

NEVER

How many drinks do you have on a typical day when you were drinking in the pastyear? _____

CANCER FAMILY HISTORY FORM

Name _____

Date of Birth _____

I HAVE HAD HEREDITARY CANCER GENETIC TESTING: ☐ NO ☐ YES, WHEN? _____
RESULTS: ☐ Negative ☐ Positive, Gene_____

MY FAMILY MEMBERS HAVE HAD HEREDITARY CANCER GENETIC TESTING:

☐ NO ☐ YES WHEN? _____

RESULTS: ☐ Negative ☐ Positive, Gene? _____

Please provide information about the cancer in yourself and/or family history in the table below. Specify who had what kind of cancer and estimate the age of diagnosis. Include information about yourself and the following relatives on both sides of your family:
Parents, Siblings, Half-Siblings, Children, Grandparents, Aunts, Uncles, Nieces, Nephews

	CANCER HISTORY	You	Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
NO/ YES	Ex: Breast cancer – UNDER AGE 50					
NO/ YES	Ashkenazi Jewish ancestry w/ Breast Cancer at any age					
NO/YES	Breast Cancer – **UNDER AGE 50**					
NO/YES	Ovarian cancer at **ANY** Age					
NO/YES	Pancreatic cancer at **ANY** Age					
NO/YES	Metastatic Prostate cancer at **ANY** age					
NO/YES	3 OR MORE Family Members with Breast Cancer on same side of family at any age (1st, 2nd, or 3rd degree relatives)					
NO/YES	Colon or endometrial/ Uterine cancer diagnosed **under age 50**					

NO/YES	3 OR MORE Family Members with Breast Cancer on same side of family at any age (1st, 2nd, or 3rd degree relatives)					
NO/YES	Colon or endometrial/ Uterine cancer diagnosed **under age 50**					
NO/YES	3 OR MORE family members with colon, endometrial/uterine, gastric, pancreatic, brain kidney, small bowel (same side of family at ANY age) (1st, 2nd or 3rd degree relatives)					

PATIENT SIGNATURE_____ DATE:_____

Patient offered genetic testing: Y /N Accepted /Declined/ Informed Provider Initials _____

Credit Card on File Agreement

Family First Urgent Care & Family First Primary Physicians has a convenient method of payment for past due balances with your card or debit card on file. The credit/debit card authorization allows the charge to be applied to the card for any balances not paid by your insurance for that visit only.

I authorize *First Urgent Care & Family First Primary Physicians* to charge my credit/debit card up to $200 for any outstanding patient responsibility balance that remains after insurance reimbursements have been applied for authorized medical services received at *First Urgent Care and/or Family First Primary Physicians.*
If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give *First Urgent Care & Family First Primary Physicians* a new, valid credit card which I will allow them to charge over the telephone. Even though *First Urgent Care & Family First Primary Physicians* is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented. I authorize the above-named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form. The authorization will remain in effect until you cancel this authorization. To cancel you must give 60-day notice to *First Urgent Care & Family First Primary Physicians* in writing and the account must be in good standing

You will receive an email with the notice for any charge or refund if you have provided us your email address. If the visit has a $0 balance, then there will be no further charge or refund.
If you have any questions about our policy, please read the FAQ on the back and do not hesitate to ask.

☐VISA ☐MASTERCARD ☐DISCOVER ☐AMERICAN EXPRESS

Patient Name (Print): _____ DOB: ____/____/_____

Name on Card (Print): _____

Credit Card # _____ Exp Date: _____/_____ Security Code: _____

Zip Code _____ Phone:_____

Cardholder/Representative Authorizing Signature: _____ Date: _____

Cardholder/Representative Printed Name: _____

Email Address for Notice: _____

Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy, and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in patient deductibles. The amount of time and effort to collect payments that will be saved will allow our office to focus more on patient care. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The insurance companies on average take approximately 2-3 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. It simply depends on your individual policy what you may owe. Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our PCI and HIPAA compliant practice management system. This system stores the card information for future transactions using the same sort of technology that any online retailer would. We can't see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than us storing the information. The extra time the staff has can now be spent on directly helping the patients, either over the phone, with insurance claims or in person.

I always pay my bills on time.
Why do I have to do this? The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up costing a lot of money. Reducing unnecessary costs are essential to allowing us to continue to be your provider. Nothing is changing about how much you end up paying.

What if there is a payment discrepancy or I have other payment questions?
Please contact our office directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or questions your insurance company's explanation of benefits.

Will I still receive a receipt/invoice bill by mail?
Yes. You will receive a paid receipt/invoice for each transaction by mail or email based on your preference.