# Family Physicians Of Laramie, LLC.

The information collected on these forms is used by the physicians, schedulers, billing office, and to report meaningful use of Electronic Health record. Please complete all forms.

## INITIAL PATIENT HISTORY FORM

Patient Name (full legal):_____ AKA Name: _____

Social Security #:_____-_____-_____ DOB:_____/_____/_____ Gender: (Circle One) M F

Is English your primary language:_____Yes_____No If no, what is your primary language: _____

**Mailing Address:** _____City:_____State: _____Zip: _____

**Email Address:**_____ Are you interested in out Online Patient Portal? ____ Yes ____ No

Communication Preference (Circle One) PHONE EMAIL US MAIL PATIENT PORTAL

**Home Phone:**_____ **Cell:** _____

Place of Employment: _____ Phone: _____

**Ethnicity** (Circle One)**:** Hispanic or Non-Hispanic Nationality:_____

**Race** (Circle One)**:** Native American Asian African American/Black Pacific Islander White

**Marital Status:** Single ☐ Married ☐ Divorced ☐ Widowed ☐

Spouse / Significant Other Name:_____

## RESPONSIBLE PARTY

(To be completed by a guardian for a minor or if otherwise different from patient)

Relationship to Patient (Circle One): PARENT OTHER _____

Name: _____ Gender: (Circle One) M F

Mailing Address**:** _____City:_____State: _____Zip: _____

Contact Phone Home:_____ Work:_____ Cell:_____

Social Security #:_____-_____-_____ DOB:_____/_____/_____ Employer:_____

Insurance Company:_____Insurance Company Address:_____

## EMERGENCY CONTACT INFORMATION

(Someone outside of the home)

Name:_____ Relationship:_____ DOB:_____ Phone:_____

Name:_____ Relationship:_____ DOB:_____ Phone:_____

**Pharmacy: Local:_____ Mail order: _____**

**May we pull your pharmacy records? Yes No** Initials ____

| Medication | Dose | Times per day | How long have you been taking it? | Prescribing MD |
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# Family Physicians Of Laramie, LLC.

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**If you have a med list please give it to the receptionist to copy**

## MEDICAL HISTORY

Patient Name:_____ Date of Birth: _____

| | You | | Family | | Relation | | You | | Family | | Relation |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Y | N | Y | N | | | Y | N | Y | N | |
| Acid Reflux | | | | | | Heart Attack | | | | | |
| Allergies | | | | | | Heart Disease * | | | | | |
| Anemia | | | | | | Hepatitis | | | | | |
| Anxiety | | | | | | High Cholesterol | | | | | |
| Arthritis | | | | | | HIV/ AIDS | | | | | |
| Asthma | | | | | | Hypertension | | | | | |
| Atrial Fibrillation | | | | | | Kidney Disease | | | | | |
| Birth Defects | | | | | | Migraines | | | | | |
| Bleeding/ Clotting Disorder | | | | | | Osteopenia | | | | | |
| Bowel Trouble | | | | | | Prostate Problems | | | | | |
| Cancer | | | | | | Psychiatric Problems* | | | | | |
| COPD | | | | | | Seizure | | | | | |
| Depression | | | | | | Stroke (CVA) | | | | | |
| Diabetes | | | | | | Thyroid Problem | | | | | |
| Drug Abuse | | | | | | Other* | | | | | |

**Personal/Biological Family Medical History:** Do you or a member of your immediate family have or have had any of the following? (Immediate family: Father, Mother, Brothers, Sisters).

For items marked "Y", please make specific comments on the lines below. If '*' is indicated, please specify type.

Items marked "Y": _____

_____

_____

Have you ever been hospitalized or had surgery? If so, please specify _____

_____

Have you ever had treatment for a mental condition? _____

List any allergies to: Medications: _____

Food or environmental allergens: _____

## SOCIAL HISTORY

Do you engage in exercise? _____Yes ___No (If so, how often and what form?) _____

Do you use tobacco? ____Yes____No (If yes, indicate how much and for how long) _____

Do you drink alcohol? _____Yes___No (If yes, indicate how much and for how long) _____

# Family Physicians Of Laramie, LLC.

**Do you have any Advance Directives, such as a living will? ___Yes_____No**
**If so, please submit a copy to the front desk**

## NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Family Physicians of Laramie Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Family Physicians of Laramie may disclose and use my protected health information.

Patient Name:_____ Date of Birth:_____

Signature: _____ Date: _____

If signed by the patient's personal representative, indicate:

a. Name of signer:_____

b. Relationship to patient: _____

If acknowledgment not signed, indicate reason not signed and efforts made to have acknowledgment signed:

_____

## AUTHORIZATION FOR RELEASE OF INFORMATION

**I authorize Family Physicians of Laramie, LLC** to release protected health information, if necessary, about the above-named patient to the people named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

**I understand that Family Physicians of Laramie, LLC may need to discuss my medical condition and may need to share my medical records with any physician, physician extender, nurse, therapist or other health care provider who is involved in my care.**

Family Physicians of Laramie may leave messages (for appointment reminders, Lab or x-rays results) on my telephone answering machine **at my home**. _____ Yes _____ No

Family Physicians of Laramie may leave messages (for appointment reminders, Lab or x-ray results) on my telephone voice mail **at my work**. _____ Yes _____ No

If necessary, Family Physicians of Laramie may talk **with my spouse or significant other** about my medical condition and / or billing information. The name of this person is _____. _____ Yes _____ No

If necessary, Family Physicians of Laramie may talk **with my parent(s) or with my caretaker** about my medical condition and / or billing information. The name of my Parent(s) or caretaker are: _____. _____ Yes _____ No

Family Physicians of Laramie **MAY NOT** discuss my medical condition with: _____

### Rights of the Patient:

I understand that I have the right to change this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to: **Family Physicians of Laramie, LLC 2710 Harney Street, Suite 202 Laramie, WY 82072.** I understand that any change in this authorization is effective from the date signed going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

# Family Physicians Of Laramie, LLC.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing. This authorization shall be in effect until revoked by the patient.

Signature: _____ Date:_____

## FINANCIAL AGREEMENT// PAYMENT POLICY/ AUTHORIZATION FOR TREATMENT

Family Physicians of Laramie is dedicated to providing you with the best possible care and service. We regard your understanding of our payment policies as an essential element of your care and treatment.

Patient Name_____ Date_____

Responsible Party Name _____

Relationship to Patient: Self_____ Parent_____ Legal Guardian _____ Other (explain) _____

Family Physicians of Laramie, LLC understands with the Affordable Care Act, both the deductible amounts and the premium amounts have increased. The change in coverage has had an effect on both you, the patients, and us, the providers. In an attempt to keep costs to patients down, continuing January 1, 2016 Family Physicians of Laramie will require payment in full at the time of service until deductible amounts have been satisfied. Co-insurance amounts will be collected at the time of service once deductibles are met. Payment for services provided to self-pay/ uninsured patients will be due in full at the time of service. There will be no change in the collection of co-pays, they will continue to be collected at check in on the day of service. Family Physicians of Laramie complies with the Patient Protection and Affordable Care (PPACA).

I, the patient understand that I am obligated to provide payment for any medical services received from Family Physicians of Laramie, LLC. I understand that while insurance may cover some of my expenses, I will be personally responsible for anything not handled by my insurance. I agree to pay deductibles, co-pays, and co-insurance amounts at the time of my visit. I understand that if I choose to appeal any charges not handled by my insurance company, I am still personally responsible for paying those amounts and will be refunded by Family Physicians of Laramie, LLC if charges are paid at a later date. A refund of overpayment will be provided to me, the patient, if the amount is over $20, or if I request. Any credit amount under $20 will be held until next visit. Family Physicians of Laramie, LLC will provide billing within one (1) week of receiving Explanation of Benefits from my insurance company. Any returned checks for non-sufficient funds will be charged an additional $30.

If no payments have been received on my account and/or I have not contacted the office to make financial arrangements, my outstanding balance will be assigned to a collection agency after 90 days of no payment. A 35% fee will be assigned to each balance sent to a collection agency.

I also understand that if I do not cancel an appointment within 24 hours of that scheduled appointment, or within 2 hours of an appointment scheduled the same day, I will be charged a $50 no-show fee. This charge will need to be settled before any further appointments can be scheduled.

I authorize treatment of the person named above and I have read and understand the terms of this document. I agree to the terms stated. I understand that it is my responsibility to understand the coverage and limitations of my insurance.

By signing this document I am certifying that all of my billing information is correct including but limited to my, address, phone number and email. I will provide a copy of my insurance card and driver's license at each visit. I will notify Family Physicians of Laramie, LLC immediately of any changes in my billing information.

My signature also confirms understanding that upon notification to Family Physicians of Laramie, LLC by me or my insurance company that my coverage is not in effect, payment for any services I have incurred is due in full at the time of that notification.

Signature _____ Date _____

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Continuing January 1, 2016, Family Physicians of Laramie will be asking patients to provide a credit or debit card to be placed on file at their first visit. For established patients, the first visit following January 1, 2016. I agree that any failure to pay after 35 days of the insurance company's processing of my charges will result in the balance remaining being debited to the credit card on file. If a No-show fee is charged, my card could possibly be debited the amount if the charge goes 30 days without payment.

# Family Physicians Of Laramie, LLC.

Credit /Debit Card Type: Master Card _____ Visa _____ Discover _____ American Express _____

Credit Card Number _____ Expiration Date _____

My signature relates to the acknowledgement of responsibility of payment of my charges ***AND*** authorization of payment of those charges on the credit or debit card I have provided according to the terms of this document.

Signature _____ Date _____