Family Physicians Of Laramie, LLC.

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

INITIAL PATIENT HISTORY FORM

Patient Name (full legal):____ **Preferred Name:** ______________

Social Security #:______-______-______ **DOB:**_____/_____/_____ **Birth Sex:** M F **Gender:**________________

Is English your primary language? Yes No **If no, what is your primary language?** ______________________________

Mailing/Billing Address: __________________________City:_______________________State: _________Zip: __________

Physical (can write same): __________________________City:_______________________State: _________Zip: __________

Email Address (for patient portal communication only):____

Are you interested in our Online Patient Portal? ____ Yes ____ No

Communication Preference: (please circle only one and note we do not offer email or text message services at this time):

CELL PHONE HOME PHONE WORK PHONE US MAIL PATIENT PORTAL

Cell Phone:____ **Home Phone:** ____________________________________

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 Name of spouse/significant other, if any _________________

RESPONSIBLE PARTY

To be completed by a guardian for a minor or if otherwise different from patient (leave blank if not applicable)

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:__________________________

EMERGENCY CONTACT INFORMATION

(Please list at least one person 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

If you need to include more medications or have a med list, please let the receptionist know

Family Physicians Of Laramie, LLC.

MEDICAL HISTORY

Patient Name:____ Date of Birth: _________________

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.

	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*					

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) ______________________

Do you have any Advance Directives, such as a living will? ______Yes__________No

If so, please submit a copy to the front desk

Family Physicians Of Laramie, LLC.

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 of Signature: ________________

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. _______ Yes _______ No
The name of this person is ____

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

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 100 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.

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:__________________________

Family Physicians Of Laramie, LLC.

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: 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 $67 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 _____________________________

Family Physicians Of Laramie, LLC.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORDS) ***TO*** FAMILY PHYSICIANS OF LARAMIE

Name: ____
Date of Birth: ____
Phone: ____
Address: ____

1. I, ____, do hereby authorize the release of my medical records.

TO: **FAMILY PHYSICIANS OF LARAMIE, LLC.**
2710 HARNEY STREET, SUITE 100
LARAMIE, WY 82072
PHONE: (307) 742-3242

FROM: ____ **Fax:** ___________________ **Phone:** _________________

2. INFORMATION TO BE RELEASED- Please check all that apply and specify dates. To obtain a copy of test results, procedure and/or visit note(s) that were done at another care facility, please contact that facility directly

- ☐ **Entire medical record**______________
- ☐ **Visit notes**______________________
- ☐ **ECG/echo/cardiology**______________
- ☐ **Vaccines/Immunizations**___________
- ☐ **Lab report(s)**____________________
- ☐ **Mammogram(s)**_______________
- ☐ **Pathology**______________________
- ☐ **Sleep study/pulmonary** _________
- ☐ **Stress test(s)**____________________
- ☐ **X-ray report(s)**___________________
- ☐ **Other radiology** _________________
- ☐ **Financial records**________________
- ☐ **Other** ____

3. PURPOSE OF INFORMATION RELEASE

- ☐ **Further medical care/transfer of care**______________________
- ☐ **Legal investigation**________________________________
- ☐ **Vocational rehabilitation evaluation**_____________________
- ☐ **At the request of the individual**_________________________
- ☐ **Payment of insurance claim**____________________________
- ☐ **Applying for insurance**_______________________________
- ☐ **Disability determination**______________________________
- ☐ **Other (specify)**_____________________________________

4. INCLUSION OF PRIVILEGED INFORMATION

- I understand that if my record contains information concerning alcohol or drug abuse/treatment that is protected by Federal regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDs-related condition, generic testing, STDs, domestic, sexual abuse, or developmental disabilities, that is protected by MGL c111, such information will be included in this disclosure. If you do not wish to have any of the above information released, please specify: ______________________________________

5. PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits.
- I understand that I may revoke this authorization by providing a written statement to the Family Physicians of Laramie medical records service, except to the extent that medical record service has already completed the action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release Family Physicians of Laramie, from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosure of the specified protected health information to the recent above for a period of six months, and it automatically expires six months after the date this form is executed.

6. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:_________________________________ **DATE:**______________

Personal representative, print name: ____

This Medical Records request will expire 1 year from the date of signature.

Family Physicians Of Laramie, LLC.

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORDS) ***FROM*** FAMILY PHYSICIANS OF LARAMIE

Name: ____
Date of Birth: ____
Phone: ____
Address: ____

7. I, ____, do hereby authorize the release of my medical records.

FROM: FAMILY PHYSICIANS OF LARAMIE, LLC.
2710 HARNEY STREET, SUITE 100
LARAMIE, WY 82072
PHONE: (307) 742-3242

TO: ____ **Fax:** __________________ **Phone:** ____________________

8. INFORMATION TO BE RELEASED- Please check all that apply and specify dates. To obtain a copy of test results, procedure and/or visit note(s) that were done at another care facility, please contact that facility directly

- ☐ **Entire medical record**______________
- ☐ **Visit notes**______________________
- ☐ **ECG/echo/cardiology**______________
- ☐ **Vaccines/Immunizations**___________
- ☐ **Lab report(s)**___________________
- ☐ **Mammogram(s)**_________________
- ☐ **Pathology**______________________
- ☐ **Sleep study/pulmonary** _________
- ☐ **Stress test(s)**____________________
- ☐ **X-ray report(s)**__________________
- ☐ **Other radiology** _________________
- ☐ **Financial records**________________
- ☐ **Other** ____

9. PURPOSE OF INFORMATION RELEASE

- ☐ **Further medical care/transfer of care**______________________
- ☐ **Legal investigation**______________________________________
- ☐ **Vocational rehabilitation evaluation**_______________________
- ☐ **At the request of the individual**___________________________
- ☐ **Payment of insurance claim**_______________________________
- ☐ **Applying for insurance**___________________________________
- ☐ **Disability determination**__________________________________
- ☐ **Other (specify)**____

10. INCLUSION OF PRIVILEGED INFORMATION

- I understand that if my record contains information concerning alcohol or drug abuse/treatment that is protected by Federal regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDs-related condition, generic testing, STDs, domestic, sexual abuse, or developmental disabilities, that is protected by MGL c111, such information will be included in this disclosure.
  If you do not wish to have any of the above information released, please specify: ____

11. PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits.
- I understand that I may revoke this authorization by providing a written statement to the Family Physicians of Laramie medical records service, except to the extent that medical record service has already completed the action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release Family Physicians of Laramie, from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosure of the specified protected health information to the recent above for a period of six months, and it automatically expires six months after the date this form is executed.

12. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:________________________________ **DATE:**______________

Personal representative, print name: ____

This Medical Records request will expire 1 year from the date of signature.