South Routt Medical Center Health Service District

300 Main Street P.O. Box 8 Oak Creek, CO 80467

Phone: 970-736-8118 Fax: 970-736-0678

info@southrouttmedical.com

PATIENT INFORMATION FORM

Today's Date:_____Email Address_____

Patient's Name:

(Last)_____(First)_____(M.I.)_____

Mailing Address:_____City_____State_____Zip_____

Home Phone:_____May we leave a message? Y N

Cell Phone:_____May we text? Y N

Date Of Birth:_____Age:_____ Sex: M F

Social Security #_____Marital Status_____

Employer:
Name:_____Address_____

Occupation:_____Work phone:_____May we contact you at work? Y N

Preferred Language:_____Race:_____Ethnicity:_____

Parent/Guardian/Spouse Information:

Relationship to Patient:_____Date Of Birth:_____

(Last)_____(First)_____(M.I.)_____

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Social Security Number:_____Marital Status:_____

South Routt Medical Center

South Routt Medical Center Health Service District

Patient Name:_____

Primary Medical Insurance

Insurance Company Name:_____ID#_____

Policy Holder Name:_____Social Security Number_____

Date Of Birth_____

Secondary Medical Insurance

Insurance Company Name:_____ID#_____

Policy Holder Name:_____Social Security Number_____

Date Of Birth:_____

****

Workers Compensation (If applicable)

Date of accident or injury:_____

Insurance Company Name:_____Claim#_____

Adjuster Name and Phone:_____

Emergency Contact Information

Name: Phone Relationship

Address: City State Zip

South Routt Medical Center Health Service District

Office Financial Policy

It is our mission to provide the finest quality healthcare available. In an effort to make our services available to as many patients as possible on an affordable basis, this office has established the following financial policies.

New Patients

Welcome! Please bring insurance coverage information, including the insurance company's name, policy number and group number.
We will require a copy of your insurance card at every visit.

Method of Payment

This office will accept payment using cash, personal check drawn on a local bank, Visa, MasterCard, Discover, and American Express, or money order. Payments may also be made on our website: www.southrouttmedical.com.

Insurance Coverage & Third Parties

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party in this contract. We will bill your insurance company for all services rendered within our practice. It is however, your responsibility to understand the benefits and policy restrictions that your insurance plan provides. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance as well as any change of insurance information. Failure to provide complete insurance information may result in a patient responsibility for the entire bill. Although at times we may try to estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with our providers, you agree to pay any portion of the charges not covered by your insurance company, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company, the insurance company will pay you directly and you are responsible for payment and agree to forward the payment to us immediately. For those out of network plans, you also agree to pay any portion of the charges not paid by your insurance company.

Medicare/Medicaid

We participate with Medicare and Colorado Medicaid. We agree to bill and accept contractual adjustment for both programs and will not apply interest or finance charges to those accounts unless turned over to an outside collection agency. There may be services and supplies rendered that are not covered by Medicare and/or Medicaid. Depending on these services/supplies we may ask for payment up front and/or request for you to sign an Advanced Beneficiary Notice (ABN) prior to the services being rendered. By signing this ABN , you understand that you are financially responsible for payment of those services and/or supplies.

Quick Pay Discount

A quick pay discount is available to patients who pay their bill at the time of service. 15% for cash or check and 10% for credit card.

South Routt Medical Center

Sliding Fee Statement:

Our sliding-fee program allows us to reduce or "slide" the fees for the care of you or your family. You can apply for the program if you need assistance.

To apply for the sliding fee, please provide two consecutive months of paycheck stubs for all family members OR last years' 1040 Federal Tax Form OR a signed letter from your employer(s) on company letterhead indicating hours worked and salaries received.

Broken/Missed Appointments

A fee of $40.00 will be charged for a missed appointment. Please call as soon as possible if you need to change your appointment.

Payment Plans

Payment plans with no interest and extended payment plans are available for those who qualify. Inquire within

Past Due Accounts

If your account becomes past due, we will take necessary steps to collect this debt. We will use all phone numbers/addresses provided on this form to contact you. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. If we have to refer collection of the balance to an attorney, you also agree to pay all attorneys and court fees incurred.

Finance Charges

A finance charge of 1.5% per month (18% APR) will be assessed 60 days after your date of service on any unpaid balances.

Collection Accounts

All balances sent to an outside collection agency will incur a $50.00 collection agency fee. Overdue accounts may be turned over to a collection agency at our discretion when a good-faith effort is not made to pay the balance.

Returned Checks

A service charge of $20.00 will be charged each time a check is returned. If a check is returned two or more times on yours or a dependents account, you will be required to pay with certified fund for all future services.

Waiver of Confidentiality

We have the option to report your account status to any attorney, collection agency, credit reporting agency, credit bureau, or for court litigation; and the fact that you received treatment at our office may become a matter of public record.

Personal Injury, Auto and Third Party

We require payment in full at time of service. We do not bill your attorney for charges incurred due to personal injury cases nor will we suspend the balances until settlement. It is the patient's responsibility to submit their claims to their attorney.

Effective Date

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and agreement will be in full force and effect.

Summary

If you have any questions regarding these issues, please contact our office as soon as possible. We look forward to helping your family achieve and maintain optimal health.

Your signature below signifies that you understand and agree to adhere to our financial policies as written.

X _____

Signature

X _____

Print Name Date

Agreement to pay for treatment

I, the responsible party, herby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or third party insurer or other payer. (For additional and/or more detailed Financial Police guidelines, please see the Financial Policy notification form).

X_____

Signature Date

If you wish to give Parental Permission to treat your Minor Children:

I hereby request and authorize South Routt Medical Center to deliver medical care to my dependent child in the event that I am unable to be at the appointment or be reached. All reasonable efforts will be made to contact me prior to treating my child.

X Signature_____Date_____

South Routt Medical Center

South Routt Medical Center Health Service District

Patient Name_____

Release and statement to permit payment of private insurance benefits to the provider

I, the undersigned responsible party hereby authorize this office/it's employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable , for all or part of the provider charges. I authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals or other health care providers which may be of assistance in the opinion of this office, in providing treatment to the patient. I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I, authorize this office and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care. I, authorize and request that payment of any third party or insurance company benefits be made directly to this office for any services furnished by the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X Signature_____ **Date**_____

Notice of Privacy Practices

I, the undersigned have reviewed a copy and understand the Privacy Practices of South Routt Medical Center.

X Signature_____ **Date**_____

Please initial:_____I agree that South Routt Medical Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payer for treatment purposes.

At times a family member may call on your behalf. South Routt Medical Center may disclose my health care information to:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Medical History Questionnaire

Pediatric/Family (Birth-12 years)

PriorityHealth®

Date			
Patient Name	Sex (circle one) M F	Date of Birth	Today's Date:
Form Completed By:	Informant (guardian, parent):		Ethnicity:

CHILD'S MEDICAL HISTORY

Has your child ever had:

Allergies (List) (Food or Meds)	☐ No	☐ Yes
Asthma/Wheezing	☐ No	☐ Yes
Asthma Action Plan	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes
Chicken Pox (Year) _____	☐ No	☐ Yes
Frequent Ear Infections	☐ No	☐ Yes
Vision Problems	☐ No	☐ Yes
Hearing Problems	☐ No	☐ Yes
Skin Problems/Eczema/Hives	☐ No	☐ Yes
TB/Lung Disease	☐ No	☐ Yes
Seizures/Epilepsy	☐ No	☐ Yes
High Blood Pressure	☐ No	☐ Yes
Heart Defects/Disease	☐ No	☐ Yes
Liver Disease/Hepatitis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Kidney Disease	☐ No	☐ Yes
Bladder Infections	☐ No	☐ Yes
Physical or Learning Disabilities	☐ No	☐ Yes
Bleeding Disorders/Hemophilia	☐ No	☐ Ye
Sexually Transmitted Infections	☐ No	☐ Yes
Emotional/Behavioral Problems	☐ No	☐ Yes
Depression/Suicidal Thoughts	☐ No	☐ Yes
Hospitalizations/Surgeries Physical/Sexual Abuse	☐ No	☐ Yes
Emotional Abuse	☐ No	☐ Yes
Bone or Joint Injuries	☐ No	☐ Yes
Dental Problems	☐ No	☐ Yes
Obesity/Overweight	☐ No	☐ Yes
Eating Disorders	☐ No	☐ Yes
Anorexia Nervosa	☐ No	☐ Yes
Bulimia	☐ No	☐ Yes
Learning Disabilities	☐ No	☐ Yes
Attention Deficit Disorder	☐ No	☐ Yes
Lead Poisoning	☐ No	☐ Yes
Vaccines Up-to-Date (√ MCIR)	☐ No	☐ Yes

Other Concerns:

Current Medication(s): (List):

Reviewed by:

FAMILY MEDICAL HISTORY

Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), or brother (B) had:

Allergies (List)	☐ No	☐ Yes	Who?
Asthma/Wheezing	☐ No	☐ Yes	Who?
TB/Lung Disease	☐ No	☐ Yes	Who?
Cystic Fibrosis	☐ No	☐ Yes	Who?
HIV/AIDS	☐ No	☐ Yes	Who?
Suicide Attempts	☐ No	☐ Yes	Who?
Heart Disease	☐ No	☐ Yes	Who?
Sudden Cardiac Death	☐ No	☐ Yes	Who?
High Blood Pressure/Stroke	☐ No	☐ Yes	Who?
High Cholesterol	☐ No	☐ Yes	Who?
Blood Disorders	☐ No	☐ Yes	Who?
Sickle Cell	☐ No	☐ Yes	Who?
Anemia	☐ No	☐ Yes	Who?
Thalassemia	☐ No	☐ Yes	Who?
Clotting Disorders	☐ No	☐ Yes	Who?
Diabetes	☐ No	☐ Yes	Who?
Seizures	☐ No	☐ Yes	Who?
Mental Illness	☐ No	☐ Yes	Who?
Depression	☐ No	☐ Yes	Who?
Suicide Attempts	☐ No	☐ Yes	Who?
Cancer	☐ No	☐ Yes	Who?
Breast	☐ No	☐ Yes	Who?
Cervical	☐ No	☐ Yes	Who?
Colorectal	☐ No	☐ Yes	Who?
Other _____			
Birth Defects	☐ No	☐ Yes	Who?
Hearing Loss	☐ No	☐ Yes	Who?
Speech Problems	☐ No	☐ Yes	Who?
Kidney Disease	☐ No	☐ Yes	Who?
Alcohol/Drug Abuse	☐ No	☐ Yes	Who?
Hepatitis/Liver Disease	☐ No	☐ Yes	Who?
Thyroid Disease	☐ No	☐ Yes	Who?
Learning Problems	☐ No	☐ Yes	Who?
Attention Deficit Disorder	☐ No	☐ Yes	Who?
Mental Retardation	☐ No	☐ Yes	Who?
Family Violence	☐ No	☐ Yes	Who?

Other Concerns:

Has any family member ever had an unexplained, unexpected death before age 50?
☐ No ☐ Yes (If yes, describe on back)

Date of Review:

continued >

Medical History Questionnaire

Pediatric/Family (Birth-12 years)

PREGNANCY AND BIRTH HISTORY

Adopted	☐ No	☐ Yes
Prenatal care	☐ No	☐ Yes
Illnesses during pregnancy	☐ No	☐ Yes
Medications during pregnancy	☐ No	☐ Yes
Alcohol/drug abuse	☐ No	☐ Yes
Tobacco use	☐ No	☐ Yes
Problems at birth	☐ No	☐ Yes
Mom		
Miscarriage	☐ No	☐ Yes
Toxemia	☐ No	☐ Yes
Baby		
Jaundice	☐ No	☐ Yes
Heart Murmur	☐ No	☐ Yes
Infection	☐ No	☐ Yes
Breathing Problems	☐ No	☐ Yes
Birth Defects	☐ No	☐ Yes

Other:

Name of Hospital: _____

Month of gestation when child was born: _____

Type of delivery: ☐ Vaginal ☐ C-section ☐ VBAC

Birth Weight _____

Discharge Weight _____

Newborn Hearing Screen	☐ No	☐ Yes
Did baby receive Hep B vaccine	☐ No	☐ Yes

Date of Hepatitis B Immunization: _____

FEEDING AND DIGESTION

Breast fed ☐ Formula ☐

Severe colic in first 3 months	☐ No	☐ Yes
Feeding problems	☐ No	☐ Yes
Good appetite	☐ No	☐ Yes
Takes vitamins	☐ No	☐ Yes
Eats balanced diet	☐ No	☐ Yes
Constipation problems	☐ No	☐ Yes
Food allergies/issues	☐ No	☐ Yes

PSYCHOSOCIAL HISTORY

Who lives in household: _____

☐ Rent ☐ Own ☐ Shelter

Who cares for child: _____

Is child in daycare: ☐ No ☐ Yes

Type: ☐ Center

☐ Private home

☐ Family member home

Date of Birth:

Mother _____

Father _____

Parents divorced/separated: ☐ No ☐ Yes

Parents working:

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes

Parents use tobacco:

Mother	☐ No	☐ Yes
Father	☐ No	☐ Yes
Child use tobacco (12 yrs +)	☐ No	☐ Yes
Sleep Problems	☐ No	☐ Yes

Foster Care

Dates: _____ _____

Other Languages _____

MEDICAL HISTORY

Broken bones	☐ No	☐ Yes
Serious accidents	☐ No	☐ Yes
Operations	☐ No	☐ Yes
Hospitalizations	☐ No	☐ Yes
ER visits/Urgent Care	☐ No	☐ Yes

Explain: _____

Additional Information: