



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 Routh Medical Center Health Service District

Patient Name: _____

Primary Medical Insurance

Insurance Company

Name: _____ ID# _____

Policy Holder Name: _____ Social Security Number _____

Date Of Birth _____

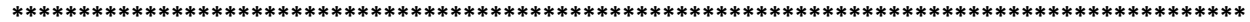


Secondary Medical Insurance

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.



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, hereby 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 Policy 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 Rouff 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 Rouff Medical Center.

X Signature _____ **Date** _____

Please initial: _____ I agree that South Rouff 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 Rouff Medical Center may disclose my health care information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____



South Routh Medical Center Health Service District

Patient Name: _____

Medications and supplements

Include anything you take over the counter. Please include dose and times per day.

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

Preferred Pharmacy (include city) _____

List any allergies to medications and reactions _____

Family History

Relative	Alive or Deceased	Age	Medical Problems
Mother			
Father			
Brother(s)			
Sister(s)			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Are there any questions you would like to address at your visit? If so, please list them here:

1. _____

2. _____



Patient Name: _____

Surgical History

Please list any surgeries you have had and what year (or write NONE).

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Social History

Do you smoke or chew tobacco? Yes ___ No ___ If yes, which one?

If yes, would you like help quitting? Yes ___ No ___

How many alcoholic drinks do you have per week? _____

Do you think you eat a healthy diet? Yes ___ No ___ I'd like more information ___

How many days per week do you exercise more than 30 minutes? _____

Health Maintenance When was your last (if relevant)?

Mammogram _____	Tdap _____	Pap smear _____
Colonoscopy _____	Flu shot _____	Prostate Exam (or PSA) _____
Bone Density Scan _____	Pneumovax/Prevnar _____	Eye exam _____
Dental Exam _____	Shingles shot _____	Blood work _____

Would you like to have any of these done if you are due? If yes, please circle above.

If relevant, do you perform a regular self-breast exam or testicular exam? Yes ___ No ___

If yes, do you have concerns? Yes ___ No ___

If yes, write here: _____

What do you use for contraception (if relevant)? _____

Do you have a Living Will or Power of Attorney? Yes ___ No ___ I would like information ___

Care team, Primary Care Physician, specialist _____



Patient Name: _____

Have you ever had any of the following? Describe the problem

Arthritis -----Yes No _____

Asthma-----Yes No _____

COPD-----Yes No _____

Cancer-----Yes No _____

Coronary Artery Disease-----Yes No _____

Depression-----Yes No _____

Diabetes-----Yes No _____

Diverticulitis-----Yes No _____

Fibromyalgia-----Yes No _____

Gout-----Yes No _____

Growth removed from the
colon or rectum (polyp or tumor)-----Yes No _____

Have you ever traveled or lived
outside the US or Canada-----Yes No _____

Heart Disease-----Yes No _____

High Cholesterol-----Yes No _____

Hypertension-----Yes No _____

Hyperthyroidism-----Yes No _____

Hypothyroidism-----Yes No _____

Kidney Disease-----Yes No _____

Kidney Stones-----Yes No _____

Liver Disease-----Yes No _____

Osteoporosis-----Yes No _____

Pulmonary Embolism-----Yes No _____

Reflux/GERD-----Yes No _____

Stroke or TIA-----Yes No _____

Tuberculosis-----Yes No _____