Demographics

All information is kept strictly confidential.

HERITAGE
FAMILY MEDICINE

PATIENT FULL NAME:_____DATE OF BIRTH__/___/____

STREET: _____CITY:_____STATE____ ZIP: ____

EMAIL:_____@_____HOME PHONE: _____CELL: _____ WORK: _____

SOCIAL SEC #: _____ PREFERRED PHARMACY: _____ TOWN: _____

HOW DID YOU HEAR ABOUT US? PERSON: _____ ☐SIGN ☐ONLINE ☐DRIVE BY ☐AD

FOR EMERGENCY

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

PHONE: _____ CELL: _____ CITY: _____ STATE: _____

INSURANCE

RESPONSIBLE PERSON ON CARD: _____ THEIR DATE OF BIRTH __/__/____

EMPLOYER NAME: _____ PHONE NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

It is very important to understand the following insurance terms:

Deductible: The amount you pay for covered health care services ***before*** your insurance plan starts to pay. (They don't pay anything until you have padi this amount.)

Co-Insurance: The percentage of costs of a covered health care service you pay, (example 20%), ***after*** you've paid your deductible.

Co-Pay: A fixed amount (example $30) you pay for a health care service ***after*** you've paid your deductible.

Before we can accurately charge your insurance, we need to know these numbers. Please take a moment to call your company (1-800 number on back of insurance card) and ask them about your responsibility for these three things.

Deductible: **$_____ per year**
Co-Insurance: **_____ % of charges**
Co-Pay: **$_____ per visit**

(No Blanks! We must have these numbers before continuing. Only put "Zero" if insurance says zero.

Special Cases:

Are you here for a car crash or worker's comp issue?	☐ yes ☐ no
Are you paying yourself for the visit?	☐ yes ☐ no
Are you here for DOT/CDL only? (you're on the wrong form)	☐ yes ☐ no
Will you submit bills to a health sharing account?	☐ yes ☐ no
Will you submit bills to an employer?	☐ yes ☐ no

Privacy

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RELEASE OF INFORMATION

I would like Heritage Family Medicine to share my private medical information with the following people listed below. This may be a spouse, family member, or friend. I understand this will allow the staff at the clinic to communicate with my chosen representative(s) and pass on information to me, including, but not limited to appointments, results, diagnoses, labs, tests, and other important information.

NAME	RELATIONSHIP	PHONE

In accordance with Alaska Stale Law and the Privacy Rule of the Health Insurance Portability and Accountability Act ot 1996 (HIPAA), I understand that: 1. This authorization may include disclosure of information relating to alcohol, drugs, HIV or other health information. I specifically authorize release of such information to the person(s) indicated. *2.*1 have the right to revoke this authorization at any time by writing to the clinic. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. 4.1 understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. 5. Information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law. I release and hold harmless Heritage Family Medicine, LLC. and members and employees thereof, from any and all consequences of this release.

PATIENT SIGNATURE: _____ DATE: ____/____/_____

Payment Policy

Billing Practices:

Heritage Family Medicine contracts R&R Billing Service to handle all billing. Their offices are off site from the clinic. Because of this, only known co-pays or outstanding bills received in the mail are collected at the office. Charges from the day's visit will be sent promptly in the mail. For patients without health insurance, we require payment at the time of service. If you are a new patient and uninsured, we will collect a deposit of $300 dollars cash or credit before your visit. Any refundable portion will be returned after your visit. In some cases, we may collect an amount less than the full charge for the visit and you will be billed accordingly. Overcharges will be refunded in a timely manner. If you need to make payment arrangements, please let us know. Any balance over 90 days will be charged a 20% service fee.

A Word about Insurance

Please understand that your health insurance policy is an arrangement between you and your insurance company. You have a separate relationship with our office, and are responsible for full payment of your account, regardless of the status of your insurance claim. Unfortunately, insurance companies are paying less each year, but our costs continue to rise. We cannot be expected to understand all the particulars of hundreds of plans, so please read your policy. As a service to you, we will file insurance claims for each of your insurance policies. You will need to furnish the clinic with all necessary information. If you are expecting payment from a car insurance policy, you will need to pay for your visits up front. We will reimburse you if, and when, the car insurance pays on the claim. *Note - Many insurance companies do not pay for some physicals. Because of this, at the time of the visit, Heritage Family Medicine will collect $50.00 for sports physicals and $150.00 for DOT/CDL physicals. If your insurance policy covers them you may be entitled to a refund if you have met the requirements of your insurance company.

Fees for Services

Fees for medical services are based on the cost of procedures performed, the amount of professional skills involved, the amount of administration and record review required, and the amount of time-spent. Our office fees for professional services are determined in the same manner as those of other various physicians' offices throughout Alaska and the United States. Appropriate charges for the completion of various forms will apply. R&R Billing will be glad to speak with you about our fees at the number below. We will be happy to estimate your charges; however, due to the nature of diagnosing medical problems, it is difficult to be precise concerning total charges. If at any time you have questions about your charges, please let us know.

No Show Fee

Not showing up for an appointment or failing to call to cancel significantly affects our ability to provide flexible appointment times and same day appointments. Because we respect your time and we want you to respect ours, we have a "no-show" policy. There is a token administrative fee of **$100 for each "no-show".** Please call 24 hours in advance, if possible, to cancel an appointment.

Payment Options

We accept cash, personal checks, Visa, and MasterCard. Payments can be made over the phone, through the mail, or in person. R&R Billing is happy to assist you with any questions and can be reached at 745-6440.

What if the account is not paid?

We want to be understanding and cooperative with everyone. Our staff will work with you in setting up payment arrangements if necessary. However, for those patients who do not fulfill their obligations after 90 days, it will be considered in everyone's best interest for those accounts to be referred to a collections agency. If a patient has been referred to a collection agency, future visits may be paid at the time of service with cash or credit while back debt is being paid.

Acceptance of Responsibility

"I understand that I am financially responsible for all charges whether or not paid by an insurance company. I know that it is my responsibility to notify Heritage Family Medicine of any changes to my account. This includes changes in insurance, address, telephone numbers, emergency contacts, etc."

Patient Name: _____Signature: _____ Date: ___/___/_____

Medical History

Adult Personal Medical History

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Patient Name:_____
Past Medical History: (Please check any medical problems you've had and note active or inactive problems, or the year occurred or started).

☐Acne	☐Allergies	☐Anemia	☐Asthma
☐Back Problems	☐Cancer/Type	☐Depression	☐Diabetes
☐Drug/Alcohol Problem	☐Eating Disorder	☐Gall Bladder	☐Heart Attack or Disease
☐Heart Murmur	☐High Cholesterol	☐High Blood Pressure	☐Kidney Stones
☐Liver Disease/Hepatitis	☐Migraines	☐Multiple Sclerosis	☐Pre-Cancer Skin
☐Rheumatoid Arthritis	☐Seizures	☐Stroke/TIA	☐Suicide Attempts
☐Thyroid Problems	☐Ulcers	☐Other:	☐Other:
☐Other:	☐Other:	☐Other:	☐Other:

Women Only:
# of Pregnancies _____ # of Deliveries ____ # of Miscarriage/Abortion ____
Last Menstrual Period (first day): __/__/____ Abnormal Pap Smear: ☐yes ☐no
Sexually Transmitted Disease: _____

Past Surgical History: (write the **date** next to the surgery)

Appendix	Bariatric	Bypass	Cataracts
C-Section	Gallbladder	Fracture Repair	Hernia
Knee Replacement	Hip Replacement	Shoulder	Sinus
Skin Cancer	Tonsils or Adenoids	Other:	Other:

Family History: **If Living** **If Deceased**

	Age	Major Health Problem	Age	Reason Died
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				

Social History:
Ethnicity: ☐ Prefer Not to Answer
☐White ☐Black ☐Asian ☐Pacific Is ☐N. American ☐ White Hispanic ☐Black Hispanic

Occupation/Job/Career: _____
Status: ☐ Single ☐ GF/BF or SO ☐ Married ☐ Divorced ☐ Widowed ☐ Single

Tobacco Use:
☐Never Smoker ☐Former Smoker (Quit Year):___ ☐Smoker (Packs per Day):___ Want to Quit? ☐

Recreational Drugs:
☐None ☐Cannabis ☐Cocaine ☐Meth ☐Heroine ☐Other IV Drug ☐Other _____

Alcohol: ☐ None ☐ Occasional *1-2/wk ☐ Moderate 3-5/wk ☐ Heavy >5/wk
☐ Beer ☐ Wine ☐ Hard Liquor ☐ Need to cut back?
*(1 drinks is 12 oz beer, 5 oz wine, 1.5 oz liquor)

Exercise:
☐ Sedentary ☐ 1-2 times/week ☐ 3-4 times/week ☐ 5-7 times/week

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Health Care Maintenance: Have you had the following tests done?

Exam:	**Date:**	**Results:**
Colonoscopy		
Eye Exam		
Mammogram		
Pap Smear		
Prostate Exam/PSA		

Vaccines: I've been vaccinated against or continue to protect myself against:
☐ Flu ☐ Covid-19 Moderna ☐ Covid-19 Pfizer ☐ Covid-19 J&J ☐ Tetanus ☐ Shingles ☐ Pneumonia
☐ All Childhood Vaccinations (MMR, Hepatitis, Chicken Pox, etc)
☐ I don't believe in vaccines

Medications

Important Medications and Allergies

***Please bring your medications to each visit when wanting refills or medication changes.**

Medication Allergy: _____ ☐ No Known Drug Allergy (NKDA)

Medications:

	Drug	**Dose (mg)**	**Times per Day**
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			

Thank you for taking the time to fill this out.
It will help us in your health care!