Chart#_____

Four Corners Health Care, Inc.
Registration/Insurance Information

Patient Name:_____ Date of Birth:_____
(Last) (First) (Middle)

Address:_____ Social Security #:_____

City:_____ State:_____ Zip:_____

List phone numbers in order of preference for calling: **May we leave a message?** **Circle One:**
#1-Area Code:_____ Number:_____ *Yes / No* *Cell / Home / Other*
#2-Area Code:_____ Number:_____ *Yes / No* *Cell / Home / Other*
#3-Area Code:_____ Number:_____ *Yes / No* *Cell / Home / Other*

E-mail address: _____

Male_____ Female_____ Marital Status: Single____ Married____ Divorced____ Widowed____

Employer:_____

Employer Phone : Area Code:_____Number:_____
May we leave a message at your place of employment? Yes / No

If patient is a minor:
Parent/Guardian Name:_____ Parent/Guardian Employer:_____
Work Phone: Area Code:_____Number:_____ Cell Phone: Area Code:_____Number:_____
SSN:_____ DOB:_____

Emergency Contact: *Name, home phone number, and cell number of a* ***local person that does not live with you****:*
Name:_____ Relationship: _____
Home Phone: Area Code:____Number:_____ Cell Phone: Area Code:____Number:_____

Name of person who is responsible for payment:_____
Phone: Area Code:_____Number:_____

Please note that we do not provide Workers' Compensation care at this time.

Insurance Information (you are responsible for any costs not covered by your insurance):
Allegiance____ Blue Cross/Blue Shield____ Health Info Net____; Policy name: _____
Healthy MT Kids____ Healthy MT Kids Plus____ Medicaid____ Medicare____ MUST____
Pacific Source____ Tri-Care____ United Healthcare____ No Insurance____
Other Insurance: *If you do not have a policy with one of the above insurance carriers, please see our financial policy page. Please list the name of your insurance carrier here:* _____

Policy holder:_____Policy/ID #_____
(Please present your card(s) to the receptionist)

Note: If you have Medicare, it is usually your primary insurance

I hereby acknowledge that I have been presented with a copy of the **Four Corners Health Care, Inc. Notice of Privacy Practices.**
Signature:_____ Date: _____

Four Corners Health Care, Inc.

Patient Financial Policy

The following is an explanation of our financial policy. Our fees are based upon the services provided and are competitive with other practices in the area for the same types of services. You are responsible for payment regardless of any insurance company's arbitrary determination of "reasonable, usual and customary" fees.

Patients must provide all information requested on the patient registration form. If we are filing your claim with your insurance carrier for you, please understand that the bill is your responsibility. Once your insurance carrier has processed your claim, the balance minus any insurance adjustments, will be expected within thirty (30) days. If your insurance carrier sends us a payment for charges your have already paid, we will reimburse your within thirty (30) days.

Blue Cross/Blue Shield, Allegiance, New West, Medicaid, and Tri-Care: As "providers" for these insurance companies, we will file your claim directly. You are responsible for any applicable co-payment and/or deductible at the time of service.

Medicare: Your services are always filed with Medicare. Medicare automatically transfers information to most supplemental insurances. If you are not sure about this transfer, please contact your insurance agent or call the Medicare office at 1-800-332-6146. Please keep all copies of your billing statement until you receive an explanation of payment from Medicare and your supplemental insurance.

Minor Patient: The adult accompanying a minor and the parents (or guardian) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless arrangements have been made prior to the minor's visit.

Workers' Compensation: We do not currently file Workers' Compensation claims.

Other Insurance: ***If we are not providers for your insurance company, payment will be expected at the time service is rendered***. We do not file other types of insurance claims. However, we will provide you with a statement at each visit that you can submit to your insurance company for reimbursement based on your policy plan and coverage. WE suggest that you make a copy of all items you are mailing to your insurance company in the event they are lost or misplaced. We do not negotiate our service costs with insurance companies (referred to most often in terms of "reasonable and customary" discounts). We do encourage you to contact them if you have questions concerning coverage, payments, hospital stays, and preauthorization of significant procedures (i.e., CT scan, MRI).

We accept the following forms of payment:
CASH, DEBIT CARD, CHECK ($30.00 return fee), VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER.

Any charges which are outstanding for thirty (30) days after a final payment by your insurance carrier are subject to a finance charge of 1.5% per month. In the event any action or litigation required to collect unpaid charges, Four Corners Health Care, Inc. shall be entitled to collect all costs and expenses incurred, including reasonable attorney's fees, and all costs or fees on appeal or in any bankruptcy proceeding.

_____ _____

Signature of Patient or responsible party Date

_____

Print name of Patient or responsible party

FOUR CORNERS HEALTH CARE, Inc.

Assignment of Benefits/Release of Information/Disclosure

Assignment of Benefits

I hereby assign to Four Corners Health Care, Inc. any insurance or other third-party benefits available for health care services provided to me. I understand that Four Corners Health Care, Inc. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Four Corners Health Care, Inc., I agree to forward to Four Corners Health Care, Inc. all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____

Date: _____

Authorization for Release of Information

I authorize Four Corners Health Care, Inc. to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Four Corners Health Care, Inc. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Four Corners Health Care, Inc.

I agree that these provisions will remain in effect until I provide written revocation to Four Corners Health Care, Inc.

Signature of Patient/Legal Guardian: _____

Date: _____

Disclosure

Four Corners Health Care, Inc.'s usual hours are Monday-Thursday, 9AM-5PM. We are closed in the evenings, weekends, and major holidays. There may be instances when the clinic closes early or is closed for an entire day or period of time. In this event, a reasonable effort will be made to contact patients with appointments and provide a recorded phone message as to when the clinic will next open.

Health care is provided by appointment. Walk-ins are welcome, based on provider availability. For after-hours care or when the clinic is closed, go to the nearest hospital emergency room or call 911.

During the course of health care visit, it may be determined that specialty care is needed. When necessary and feasible to do so, a reasonable effort will be made to assist patients who need to be referred for specialized care. However, Four Corners Health Care, Inc. is not responsible or liable if they cannot locate a specialty care physician who will accept such referral. Urgent concerns (including anticipation of hospitalization) will be referred to the Bozeman Deaconess Hospital emergency room.

Signature of Patient/Legal Guardian: _____

Date: _____

Four Corners Health Care, Inc.
Adult Past Medical History

Date:_____

Patient Name: _____ **Date of Birth:_____**

Where do you receive your routine health care?_____
What other health care providers have you seen in the past 6 months?_____

Any major accidents or injuries?: No / Yes (If yes, please explain)_____
_____

Any serious or chronic illnesses?: (Please circle as appropriate)
diabetes hypertension heart disease sickle cell anemia cancer seizure disorder Polio
Other _____

Hospitalizations/Operations?:

YEAR	REASON	YEAR	REASON

Women Only
Obstetric history:
number or pregnancies_____; number of live deliveries _____;
number of pre-term pregnancies_____; number of incomplete pregnancies_____.
Were there any problems with the postpartum course?: No / Yes _____
_____

Adult Immunizations:
Date of last pneumococcal vaccine (65 & older)_____;
Date of last tetanus immunization_____

Child Immunizations:
Are immunizations up-to-date? No / Yes
Where do you receive immunizations?_____

Approximate date of last examination for:
dental_____; vision_____; hearing_____; EKG_____;
Stress test_____; chest x-ray_____; colonoscopy_____; PSA_____;
mammogram_____; pap smear_____;
DEXA scan_____;

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File: My Computer > Local Disk (C:) > Office Manager > Front Desk > Office Organization Items > Forms > "Adult Past Medical History Form"

Four Corners Health Care, Inc.
Adult Social History

Date: _____

Patient Name: _____ **Date of Birth:** _____

Marital Status: Single Married Widowed Divorced Separated

Religious affiliation, (optional): _____

Family Members and significant others:

Name	DOB	Relationship	Live with you? Y / N

Home owner/renter: House Apartment/condo Mobile home Other_____

Pets: _____

Have you ever used tobacco? N /Y
Circle as appropriate: Cigars / Cigarettes / Chewing Tobacco
How much? _____ *How long?* _____ *When quit?* _____

Do you have a marijuana card? N / Y *If yes, for what?* _____

Caffeine use? N / Y *If yes, amount:* _____

Alcohol use? N / Y *If yes, amount:* _____

Occupation: _____

Work exposures you are aware of: _____

Recreation activities/exercise: _____

Hobbies/interests: _____

Sources for emotional support: _____

Four Corners Health Care, Inc.

Medications and Allergies List

Patient Name:_____Date of Birth: _____

Help us care for you better by telling us what prescriptions and over-the-counter medications you take and any allergies you may have.

Prescriptions						
Name of medicine	Dose (total milligrams)	How many times per day?	When do you take it? (Morning and night? After meals?)	Who prescribed it for you?	Why do you take it?	Do you have any side-effects? Describe them.
Over-the-counter medications, herbal remedies, vitamins, aspirin, etc.						

Form of Contraception used: _____

Allergies:

Medicines: Y / N _____
Foods: Y / N _____
Animals: Y / N _____
Environmental: Y / N _____
Latex: Y / N _____
Other: Y / N _____

Four Corners Health Care, Inc.
Patient & Family History

Date: _____

Patient Name: _____ Sex: M □ F □Date of Birth: _____
Was patient adopted? Y/N
If yes, from where?_____

Please circle as appropriate: N = no and Y = yes If yes, please check who condition relates to (parents, siblings, grandparents, aunts/uncles, first cousins).

Have you or a family member had any of the following?:

		You:	**Family Member (who?):**
No/Yes	Alcohol/Drug problems	_____	_____
No/Yes	Allergies	_____	_____
No/Yes	Anemia/ Low blood	_____	_____
No/Yes	Anxiety	_____	_____
No/Yes	AIDS/HIV	_____	_____
No/Yes	Asthma/Lung problems	_____	_____
No/Yes	Arthritis, Bone or joint	_____	_____
No/Yes	Autism/Neurological problems	_____	_____
No/Yes	Behavioral problems	_____	_____
No/Yes	Blood disorders/bleeding problems	_____	_____
No/Yes	Cushing's Disease	_____	_____
No/Yes	Diabetes	_____	_____
No/Yes	Ear/Hearing problems	_____	_____
No/Yes	Heart disease/Stroke (<60 years old)	_____	_____
No/Yes	High blood pressure	_____	_____
No/Yes	High cholesterol	_____	_____
No/Yes	Jaundice/Liver disease	_____	_____
No/Yes	Kidney disease/Bladder problems	_____	_____
No/Yes	Learning problems	_____	_____
No/Yes	MS	_____	_____
No/Yes	Obesity	_____	_____
No/Yes	Parkinsons disease	_____	_____
No/Yes	Psych. condition	_____	_____
No/Yes	Seizure disorders	_____	_____
No/Yes	Sickle cell	_____	_____
No/Yes	Skin Problems/Eczema	_____	_____
No/Yes	Stomach ulcers	_____	_____
No/Yes	Sudden death (infancy or childhood)	_____	_____
No/Yes	Thyroid problems	_____	_____
No/Yes	Tuberculosis	_____	_____
No/Yes	Unexpected sudden death (<60 years old)	_____	_____
No/Yes	Vascular problems	_____	_____

Other (Please explain): _____