Homewood Family Medicine
PATIENT INFORMATION SHEET

NAME: _____ _____
Last First MI DOB

ADDRESS: _____

CITY:. _____ STATE: _____ZIP: _____

PHONE (HOME):_____ (CELL):_____

EMAIL ADDRESS:_____ PREFERRED METHOD OF CONTACT: _____
MAY WE LEAVE A MESSAGE AT THE PREFERRED NUMBER OF CONTACT? ____YES ___ NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

DO YOU HAVE AN ADVANCED CARE DIRECTIVE? ____ YES ___ NO (If yes please provide us a copy)
(THIS INCLUDES: LIVING WILL, DO NOT RESUSCITATE, HEALTHCARE PROXY OR POWER OF ATTORNEY)

MARRITAL STATUS: ____MARRIED ___ SINGLE ___DIVORCED ___ WIDOW(ER)

RELIGION: _____ ETHNICITY _____ RACE--------
(THESE ARE REQUIRED BY THE FEDERAL GOVERNMENT FOR STATISTICAL PURPOSES)

SOCIAL SECURITY NUMBER:_____ *(THIS IS OPTIONAL HOWEVER, NUMEROUS INSURANCE COMPANIES STILL REQUIRE THIS FOR CLAIMS SUBMISSION AND VERIFICATION PURPOSES)*

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT RELATIONSHIP TO PATIENT:_____

PRIMARY INSURANCE: _____CARD HOLDER NAME:_____ DOB: _____

POLICY/ID #: _____ _____ GROUP# _____

PATIENT RELATIONSHIP TO INSURED: _____SELF _____SPOUSE_____CHILD OTHER

SECONDARY INS: _____CARD HOLDER NAME_____DOB_____

POLICY/ID:_____GROUP #_____

PATIENT RELATIONSHIP TO INSURED: _____SELF _____SPOUSE_____CHILD OTHER

EMPLOYER: _____EMPLOYER PHONE#: _____

PHARMACY NAME/ADDRESS: _____ PHONE:_____
(* You must provide us with specific pharmacy information to allow us to fill your prescriptions)

I hereby authorize Homewood Family Medicine to furnish the above insurance company all medical information necessary to process any claims. 1 also authorize payment of medical benefits to Homewood Family Medicine. I have read the no- show po licy and agree to provide the appropriate notice if I am unable to make my scheduled appointment.

I accept responsibility for all accrued charges, including those my insurance company may not cover at the anticipated level. Additionally, I understand I may be held responsible for charges should my insurance company delay payment. I also agree to pay all fees associated in collecting my balance including collection agency fees ranging from $12 to 40% of the balance if sent to collections.

Russell Homewood, DO is an owner in Red Mountain Medical Plaza.

PATIENT/PARENT OR GUARDIAN SIGNATURE:_____

NAME (PRINTED):_____ DATE:_____

PATIENT COMMUNICATION LOG

PATIENT NAME: _____DOB:_____DATE:_____

THE FOLLOWING INSTRUCTIONS PERTAIN TO THE ABOVE NAMED PATIENT:

OK TO CALL HOME AND LEAVE A MESSAGE? ____YES____NO

OK TO CALL WORK NUMBER? _____YES____NO

OK TO CALL CELL PHONE?____YES____ NO

CALL THIS NUMBER ONLY:_____

I AUTHORIZE HFM TO SPEAK WITH AND GIVE MY PERSONAL MEDICAL INFORMATION TO :

NAME: _____ PHONE:_____

NAME: _____ PHONE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES AND HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW IT.

CONSENT TO TREAT MINOR PATIENT

I AUTHORIZE HOMEWOOD FAMILY MEDICINE TO PROVIDE MY SON/DAUGHTER WHOM IS AT LEAST 16 YEARS OF AGE,MEDICAL CARE INCLUDING, BUT NOT LIMITED TO, .LAB TESTING, VERIFICATION AND/OR ADMINISTRATION OFIMMUNIZATIONS AND NECESSARY MEDICAL TREATMENT {INCLDUING MINOR SURGICAL PROCEDURES).

I GIVE MY PERMISSION FOR THE FOLLOWING INDIVIDUALS (*MUST BE 21 YEARS OR ODLER*) TO AUTHORIZE ANY MEDICAL TREATMENT FOR MY MINOR SON/DAUGHTER. I AUTHORIZE THESE INDIVIDUALS TO MAKE DECISIONS REGARDING PRESCRIPTIONS AND IMMUNIZATIONS IF I AM NOT AVAILABLE TO GIVE MY CONSENT.

NAME (PRINT):_____ RELATION TO PATIENT (PRINT)_____
NAME (PRINT):_____ RELATION TO PATIENT (PRINT)_____

PATIENT/PARENT OR GUARDIAN SIGNATURE:_____DATE:_____

HOMEWOOD FAMILY MEDICINE FINANCIAL POLICY

1. NO SHOW/CANCELLATION POLICY:
OUR GOAL IS TO BE ABLE TO ACCOMMODATE THOSE PATIENTS WHO NEED SAME DAY SICK APPOINTMENTS. WE ASK THAT IF YOU NEED TO CANCEL YOUR APPOINTMENT THAT YOU DO SO **24 HOURS IN ADVANCE** TO ALLOW ANOTHER PATIENT TO USE THAT TIME. CANCELLING YOUR APPOINTMENT ALSO HELPS SCHEDULING AND AIDS IN OUR PROVIDERS STAYING ON TIME . YOU WILL BE CHARGED A $75 FEE FOR MISSED APPOINTMENTS AND APPOINTMENTS THAT ARE CANCELED IN LESS THAT THE 24 HOURS BEFORE YOUR SCHEDULED APPOINTMENT TIME. CANCELLATIONS ON THE SAME DAY AS THE APPOINTMENT ARE NOT ACCEPTABLE AND WILL ALSO RECEIVE A $75 CHARGE AS WELL. *IF YOU HAVE TWO NO-SHOWS IN A CALENDAR YEAR YOU WILL BE DISCHARGED FROM THE PRACTICE.*

2. COPAYMENTS/CO-INSURANCE/DEDUCTIBLES:
ALL ARE DUE AT THE TIME OF SERVICE. PLEASE COME PREPARED TO PAY ANY COPAY, COINS OR DEDUCTIBLE.

3. INSURANCE:
YOUR INSURANCE SCHEDULE OF BENEFITS IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. FOR THIS REASON IT IS NOT OUR POLICY TO CALL YOUR INSURANCE IN ORDER TO PROVIDE YOU WITH A BENEFIT QUOTE. WE ENCOURAGE YOU TO REFER TO THE SCHEDULE OF BENEFITS PROVIDED TO YOU BY YOUR INSURANCE PLAN, AND/OR CALL YOUR INSURANCE TO CLARIFY ANY BENEFIT QUESTIONS YOU MAY HAVE BEFORE SERVICES ARE RENDERED. AFTER YOUR CLAIMS HAVE BEEN PROCESSED, IF YOU FEEL YOUR PLAN BENEFITS WERE NOT APPLIED TO YOUR CLAIM CORRECTLY, WE ENCOURAGE YOU TO CALL YOUR INSURANCE COMPANY TO WORK OUT ANY BENEFIT ISSUES, NOTATING THE DATE, CUSTOMER SERVICES REPRESENTATIVES NAME, CALL REFERENCE NUMBER (IF AVAILABLE), AND THE TIME FRAME YOUR INSURANCE NEEDS FOR REPROCESSING YOUR CLAIM. PLEASE THEN CALL OUR BILLING OFFICE WITH THIS INFORMATION, WE WILL NOTATE IT ON YOUR ACCOUNT. OF COURSE, IF A CLAIM ISSUE IS IN REGARD TO OUR NETWORK STATUS WITH YOUR INSURANCE, OR IS THE RESULT OF A CODING ERROR, WE WILL CONTACT YOUR INSURANCE OR APPEAL THE CLAIM TO RESOLVE THESE PROVIDER-RELATED ISSUES. YOU HAVE AN OBLIGATION TO PAY CHARGES THAT ARE NOT COVERED BY YOUR INSURANCE CARRIER. PLEASE VERIFY BENEFITS PRIOR TO ANY PROCEDURE AND PROVIDE US WITH CURRENT INSURANCE INFORMATION.

4. UNINSURED/SELF PAY:
WE ARE HAPPY TO OFFER DISCOUNTS TO OUR PATIENTS WHOM ARE UNINSURED. PLEASE NOTE WE DO NOT ACCEPT "DISCOUNT CARDS" BECAUSE WE DO NOT WANT TO ENCOURAGE YOU TO PAY FOR A DISCOUNT WE ARE HAPPY TO PROVIDE TO YOU FOR FREE. PAYMENT IS EXPECTED AT TIME OF SERVICE IF YOU ARE UN INSURED. IF YOU FIND YOU NEED A PAYMENT PLAN INSTEAD, PLEASE FEEL FREE TO DISCUSS THIS WITH US, PREFERABLY BEFORE SERVICES ARE RENDERED, AS WE CAN SUGGEST OTHER COST SAVING MEASURES WITH YOU .

5. DELINQUENT ACCOUNTS:
AN ACCOUNT IS DELINQUENT AND ELIGIBLE TO BE SENT TO AN OUTSIDE COLLECTIONS AGENCY WHEN IT IS 90 DAYS PAST DUE. AT THIS POINT, ALL COLLECTION AND LEGAL FEES WILL BE ADDED TO THE BALANCE DUE AND WILL BE YOUR RESPONSI BI LITY. (COLLECTION FEES START AT $12 AND GO UP TO 40% OF THE TOTAL COLLECTION AMOUNT)

6. PAYMENT ARRANGEMENTS:
IF YOU WOULD LIKE TO MAKE PAYMENT ARRANGEMENTS ON YOUR ACCOUNT, WE ARE HAPPY TO SET UP A PAYMENT PLAN TAILORED TO YOUR NEEDS AND BUDGET. CALL US, WE ARE HERE TO HE LP!

7. PERSONAL CHECKS:
WE ARE HAPPY TO ACCEPT YOUR PERSONAL CHECK FOR PAYMENT ON YOUR ACCOUNT. PAYMENT MADE BY CHECK ON THE DATE OF SERVICE WILL NOT BE ACCEPTED OVER $40. CHECKS WILL NOT BE ACCEPTED FOR URINE DRUG SCREENS. IF YOUR CHECK IS RETURNED TO US BY YOUR BANK AS NON-PAYABLE, YOU WILL BE CHARGED AN ADDITIONAL $50.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND I AGREE TO ABIDE BY ITS TERMS.

PATIENT NAME (PRINT):_____ DATE:_____

PATIENT/PARENT OR GUARDIAN (SIGN)_____

HEALTH HISTORY FORM

Name: _____ DOB: _____Age:_____Male:_____ Female:_____

Who do you currently live with? _____ Alone _____Family Friends _____Significant other
Do you feel safe at home? _____Yes ____ No Highest level of education: _____
Current job:_____ Previous job: _____

MEDICATIONS (Please include all prescriptions & over the counter vitamins and supplements)

NAME	DOSAGE (mg)	QUANTITY (# of pills)	HOW IS IT TAKEN (how many times per day)	WHY DO YOU TAKE IT (for what condition)

ALLERGIES: Any medications, x-ray dyes or other substances? _____YES _____NO
(If yes, please list name of medication and type of reaction)_____
_____

SURGERIES/HOSPITALIZATIONS (Please list date & details. Please indicate planned surgery or hospitalization)

DATE	SURG/ HOSP	DETAILS
	SURG/ HOSP	
	SURG/ HOSP	
	SURG/ HOSP	
	SURG/ HOSP	

SEVERE INJURIES (Please list dates and details of any injuries you have ever had)
_____
_____
_____

IMMUNIZATIONS:
Date of last TB screening?_____ ___ POS __ NEG Date of last Tetanus vaccine? _____
Dates of Hepatitis B series? _____ Date of Guardasil series?_____
Date of last Flu vaccine? _____ Date of last Pneumonia vaccine?_____
Date of chicken pox disease or shot?_____

HEALTH MAINTENANCE:
Date of your last colonoscopy?_____ Date of your last pap smear? _____
Date of your last mammogram?_____ Date of your last bone density test? _____
Date of your last eye exam?_____ Date of your last wellness exam?_____
Do you consider yourself : ____Underweight ____Normal ____Overweight ____Obese
What kind of exercise do you do?_____ How often?_____
Do you wear seatbelts? ___ Yes ___No Do you use sunscreen? ____ Yes ___ No
Do you feel safe at home? ___ Yes ___No Do you text while driving? ___ Yes ___ No
What type of birth control is used between you and your partner?_____

OB/GYN HISTORY:
Age of first Menes:_____ Date of last period:_____ Do you suffer from PMS? ____Yes ___No
Have you ever had an abnormal papsmear? ____Yes ___No (If yes, date &results) _____
Pregnancies: Total Number_____ Full Term_____ Miscarriages_____ Abortions_____ Premature_____ Tubal_____
Complications: _____

SOCIAL HISTORY:

Are you sexually active? ____Yes ____No (If yes, are your partners): ___Men ___Women ___Both
Have you ever had a sexually transmitted disease? ___Yes ___No / Diagnosis: _____
Do you smoke: ___Yes ___No How many per day? _____ Have you ever quit? ___Yes ___No
Do you use other tobacco products? ___Yes ___No (If yes, what)? _____ When?_____
Do you drink coffee/soda/tea? ___Yes ___No (If yes, how many cups/cans per day)? _____
Do you drink alcohol? ___Yes ___No How many per day?_____ How many per week?_____
Have you ever had a problem with alcohol in the past? ___Yes___No
Has anyone expressed concerns about your alcohol use? ___Yes___No
Do you use recreational drugs? ___Yes___No / (If yes, What types)?_____
Have you ever had a drug problem in the past (prescription or illegal drug use)? ___Yes____No
If yes, please explain: _____

Please check the following conditions are you currently being treated for or have been treated for in the past.

	Alcohol abuse		Coronary Artery Disease		Kidney Stones		**None**	
	Anemia, Iron Deficiency		Coumadin Therapy		Macular Degeneration			
	Angina, Stable		Cerebrovascular Accident		Migraines		**Other:**	
	Anorexia		Deep Vein Thrombosis		High Cholesterol			
	Aortic Stenosis		Depressive Disorder		Parkinson's Disease			
	Asthma		Diabetes Mellitus, Type I		Peripheral Vascular Disease			
	Atrial Fibrillation		Diabetes Mellitus, Type II		Prostate Cancer			
	Attention Deficit Disorder		Drug Abuse		PTSD			
	Bipolar Disorder		Gallbladder Disorder		Pulmonary Embolism			
	Breast Cancer		Glaucoma		Schizophrenia			
	Chronic Kidney Dis III		Headache		Sleep Apnea			
	Chronic Kidney Dis IV		Hepatitis		Transient Ischemic Attack (TIA)			
	Colitis		High Blood Pressure		Urinary Incontinence			
	Colon Cancer		Hyperthyroidism		Venereal Disease			
	Congestive Heart Failure		Hypothyroidism					

FAMILY HISTORY: (Please check all boxes that apply) Were you adopted? ___Yes__No

ILLNESS	**Father**	**Mother**	**Sibling**	**Child**	**Maternal Grandma**	**Maternal Grandpa**	**Paternal Grandma**	**Paternal Grandpa**	**Other**
Alcoholism/Drug Addiction									
Anemia									
Anxiety									
Asthma									
Bleeding/Clotting Disorder									
Breast Cancer									
Colon/Bowel Problems									
Depression									
Diabetes									
Epilepsy									
Heart Attack									
Heart Disease									
High Blood Pressure									
High Cholesterol									
HIV/Aids									
Kidney Disease									
Liver Disease									
Lung Cancer									
Ovarian Cancer									
Seizures									
Skin Caner									
Stroke									
Suicide									
Other:									