Sierra Family Care
Patient Information Sheet

Date:_____

Referred by:_____

Mr./Mrs./Miss/Ms./(circle one) Male or Female (circle one)

Patients name _____
(first) (m.i) (last)

Age_____ Date of birth_____ Social Security#_____

Home phone_____ Cell Phone_____

Mailing address:_____
City State Zip

Physical Address:_____

Patients Occupation_____Work Phone #_____

Employers Name and address_____

Marital Status:_____ (single, married, divorced, widowed, separated)

Spouse's Name_____Cell#_____

Person to notify in emergency and relationship to patient:

_____

Financial Responsibility:_____
Name Date of birth Social security #

Address:_____
Relationship to patient

Home phone_____ Cell phone_____

Employer:_____
Name of employer work phone address

If patient is a minor other parent or guardian:

_____
Name Date of birth Social security number relationship

_____
Address Home phone Cell phone Employer

I consent to treatment necessary for the care of the above named patient.
I allow fax and electronic transmittal of my records, if necessary.
I understand that I will receive 3 statements for each balance after that my account will be sent to collections.
I understand that payment of charges incurred is due at the time of service unless other authorized financial arrangements have been made prior to treatment.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I further authorize and request that my insurance payments be made directly to Sierra Family Care.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

_____
Date Signature

Sierra Family Care - Payment Policy

Name: (print) _____ Date____/____/____

Thank you for choosing us as your primary care provider. We are committed to the provision of superior and personalized care.

This payment policy outlines our expectation for payment for services we render. **It is required that you read and sign this agreement in order to be a patient of Sierra Family Care.**

1. **No Insurance:** If you do not have health insurance or have a plan we do not accept we will gladly care for you for cash at the time of service.

2. **Insurance:** If you have an insurance plan that we are contracted with we will follow our contractual obligations. It is imperative that you know the limits and coverage of your insurance as well.

3. **Co-payment and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from clients can be considered fraud against your insurer.

4. **Non-Covered Services:** Please be aware that some and perhaps all of the services you receive may be considered by your insurance company or Medicare to be "non-covered" services or even considered to be "not reasonable or medically necessary" as outlined by their own standards for coverage of service. Be assured that **we only provide services in agreement with you** and that we feel are indeed necessary for your physical or mental well being. As such, **any services deemed not coverable by your insurance will be your responsibility to pay for.**

   Examples:
   1. **Vaccines and Tests:** Some vaccines and screening tests at certain ages although advised, may not be considered covered services by your insurance plan.
   2. **Timing:** Payers often deny certain services because they perceive the service as medically unnecessary if it is performed sooner than expected by the payer.
   3. **File/Form Fees:** Expenses incurred for the processing of patient's, pharmacy, governmental, or insurance requests that require medical record review and documentation with or without a change in care plan are not billable to payers.

   File/Form Fees range from $3 per event that requires medical record review and documentation between office visits (including prescription requests) to $25 or more for the completion of a wide variety of special forms related to ones state of health, disability, retirement, school, travel, and specialized

examination and documentation, beyond that which is usually covered at an office visit for your health care.

5. **How to Avoid Fees:** You don't like paying them and we don't like charging them. The vast majority of file fees are for prescription refill requests made between office visits. Your participation in your care will result in avoiding these fees if you would simply **bring all your medications to every visit** and make sure you have enough refills to get you through to your next scheduled office visit.

6. **Claims Submission:** **Synapse** is our contracted billing service. We will submit your claim via Synapse and assist you in getting your claims paid, if we are contracted to do so with your insurance provider. Your insurance company may require you to submit some information directly. It is your responsibility to comply with their request(s). **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company. We will also abide by any agreement we may have in place with your insurance company.

7. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you maintain you benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. **Non-payment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please immediately contact our office manager if you need to arrange partial payments. **Please be aware that if a balance remains unpaid, we will refer your account to a collection agency** and you and your immediate family members for whom you are the guarantor may be discharged from the practice. If this does occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care after which time we will not longer provide any services to you.

The policies outlined above are designed to allow us to work together more efficiently for the benefit of our patients. Thank your for your understanding in this matter.

I have read and understand the payment policy and agree to abide by this payment policy.

Name: (print) _____ Date____/____/____

Signature:_____

(rev: 12/13)

Sierra Family Care History form

Name:_____Age____ Birth Date:_____ Todays Date_____

Hospital or Out Patient Surgery/ Procedure
Year/ Type of Surgery/ Procedure

_____
_____
_____
_____
_____

Hospitalization for Illness:
Year Type of Illness

_____
_____
_____
_____
_____

Medication Allergy/Intolerance:_____

Medications you take:_____

_____

When was your last **Colonoscopy?** _____ Last Mammogram_____ Last Menstrual Period _____
Date **Date** **Date**

Do you have or have you had any of the following illnesses or conditions: (Circle)

Diabetes / Thyroid Disease / Anemia / Blood Clots / Blood Transfusions / Bleeding Disorder

High Blood Pressure / Heart Attack / Heart Disease / Stroke / Seizure / Brain Injury

Asthma / COPD / Emphysema/ Pneumonia / Lung Disease / Acid Reflux / Ulcer / Colitis / Irritable Bowel

Liver Disease / Gall Bladder Disease / Gall Stones / Kidney Disease / Kidney Stones/ Colon Polyps

Anxiety / Depression / Nervous Disorder / PTSD / Other_____

Are You Disabled? Why: _____

Spinal disk or joint problems? Cervical / Thoracic / Lumbar /Other_____

History of Cancer of : _____

Other or additional information _____

_____

Family History:

Have any relatives had any of the following?

If So Whom?

Anemia _____ Hi or Low Thyroid _____
Blood Clots_____ Heart Trouble _____
Allergies_____ Lung Disease _____
Asthma _____ Kidney Disease_____
Lupus_____ Mental Health issues_____
Cancer_____ Colon Polyps_____
Diabetes_____ Depression_____
Stroke_____ Birth Defects_____
Seizure_____ Tuberculosis_____
Other_____

Social History:

Are you: **(Circle)**

Married / Widowed / Divorced
Single/ Separated / Living together

Do you use:

Tobacco: NO Yes Daily /Occasional /Rare/Never
Chew or Smoke / Packs per day ____ Years ____
Alcohol: No Yes Daily / Occasional / Rare
Beer / Wine / Liquor How much:_____
Other:_____

Do you :

Have **Children** No Yes How many_____
Have Pets No Yes ____ What Kind_____

Occupation:_____

rev 12/13

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The federal government recently published regulations designed to protect the privacy of my health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans.

I _____ received and read a copy of the Notice of Privacy Practices from Sierra Family Care.

_____
Signature

_____
Date Signed