



## 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)



# CHILD (0-18) HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_

Date of Birth \_\_\_\_\_

## IMMUNIZATIONS:

When was your last Tetanus shot? \_\_\_\_\_

When was your last Immunization? \_\_\_\_\_

What kind of Immunization was it? \_\_\_\_\_

Circle any or all you have had:

DAPT# 1 2 3 4 5 OPV# 1 2 3 4 5 MMR# 1 2

Hib Hep B# 1 2 3

When was your last Tb test? \_\_\_\_\_

## BIRTH HISTORY:

How long was your mother pregnant with you?

Weeks or Months \_\_\_\_\_

Any problems during the pregnancy? (circle)

Swelling, High Blood Pressure, Fevers

Other \_\_\_\_\_

How long was your mother in labor? \_\_\_\_\_

How were you born? (circle)

Vaginal delivery or C-Section

Birth Wt. \_\_\_\_\_ Length \_\_\_\_\_

How long did you stay in hospital? \_\_\_\_\_

Did you need? (circle)

ICU Care, Oxygen, Transfusions, Medicine

Other \_\_\_\_\_

## PAST HISTORY:

Have you had: (check and give year)

\_\_\_\_ Jaundice \_\_\_\_\_ Convulsions \_\_\_\_\_

\_\_\_\_ Pertussis \_\_\_\_\_ Whooping Cough \_\_\_\_\_

\_\_\_\_ Mumps \_\_\_\_\_ Chicken Pox \_\_\_\_\_

\_\_\_\_ Measles \_\_\_\_\_ Diphtheria \_\_\_\_\_

\_\_\_\_ Rubella \_\_\_\_\_ German Measles \_\_\_\_\_

\_\_\_\_ Tonsillitis \_\_\_\_\_ Scarlet Fever \_\_\_\_\_

\_\_\_\_ Otitis \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_

\_\_\_\_ Bronchitis \_\_\_\_\_ Hay Fever \_\_\_\_\_

\_\_\_\_ Allergies (please list) \_\_\_\_\_

## FAMILY HISTORY (check and list relation)

\_\_\_\_ Seizures \_\_\_\_\_ Mental Illness \_\_\_\_\_

\_\_\_\_ Allergies \_\_\_\_\_ Birth Defects \_\_\_\_\_

\_\_\_\_ Asthma \_\_\_\_\_ Retardation \_\_\_\_\_

\_\_\_\_ Ulcers \_\_\_\_\_ Liver Disease \_\_\_\_\_

\_\_\_\_ Colitis \_\_\_\_\_ Kidney Disease \_\_\_\_\_

\_\_\_\_ Goiter \_\_\_\_\_ Lung Disease \_\_\_\_\_

\_\_\_\_ Arthritis \_\_\_\_\_ High Bld. Pres. \_\_\_\_\_

\_\_\_\_ Cancer \_\_\_\_\_ Heart Attack \_\_\_\_\_

\_\_\_\_ Diabetes \_\_\_\_\_ Tuberculosis \_\_\_\_\_

How many brothers \_\_\_\_\_ Ages \_\_\_\_\_

How many sisters \_\_\_\_\_ Ages \_\_\_\_\_

Mother's Age \_\_\_\_\_ Father's Age \_\_\_\_\_

## SURGERIES IN A HOSPITAL?

Type \_\_\_\_\_ Month/Year \_\_\_\_\_

## HOSPITALIZATIONS FOR ILLNESS OR INJURY

Reason: \_\_\_\_\_ Month/Year \_\_\_\_\_

## CURRENT MEDICINES:

## MEDICATION ALLERGIES (list drug & reaction)

## GENERAL HEALTH: GOOD FAIR POOR

## SYSTEMS REVIEW: (circle if recurrent/current)

SKIN: eruptions, bleeding, bruising, moles, eczema, hives

LYMPH NODES: enlargement, pain, drainage

BONES/JOINTS/MUSCLES: pain, cramps, swelling

BLOOD: anemia, bleeding problems

GLANDS: goiter, growth problems, hunger, thirst, intolerance to heat or cold

HEAD: headaches, fainting, convulsions, injury

EYES: glasses, double vision, decreased vision

NOSE: runny, nose bleeds, snoring

MOUTH: pain, tooth trouble, sore throat, loss of voice

NECK: pain, swelling, decreased motion, sore glands

BREASTS: pain, swelling, discharge, lumps

LUNGS: wheezing, pain, cough, shortness of breath

HEART: abnormal beats, pain, turn blue, no energy

GI: appetite, large weight gain/loss, jaundice, vomiting, vomit blood, bowel problems

GU: urinary tract infections, stones, blood in urine, discharge, bed wetting

CNS: difficulties with smell, taste, touch, speech, chewing, hearing, balance, paralysis, sleep coordination, hallucinations, walking, swelling

OTHER: \_\_\_\_\_

*Sierra Family Care  
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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