Woodland Park Family Medicine
PATIENT FINANCIAL RESPONSIBILITY FORM

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services rendered.

- Prompt payment allows us to control costs. Outstanding accounts cost both the patient and the practice time and money; therefore, all patients will be required to establish financial arrangement for payment of their account.
- It should be noted that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your carrier, and to ensure your carrier remits payment for your account.
- As a courtesy to you, we will file claims with your primary and possibly secondary insurance companies. If we do not have a signed contract with your insurance company and they fail to pay your claim or we are unable to file a courtesy claim the account balance will be transferred to your responsibility. It is then your responsibility to contact the insurance company about processing your claim. You will be required to make payments on your account during this time. If the insurance company does pay, you receive any necessary refund.
- Each month, you will receive a statement for services which is due and payable within thirty days of the statement date, unless our records indicate insurance is still pending on that claim. If your payment is late or if you have not made financial arrangements we will mail you one reminder notice. It is imperative that you contact us immediately regarding delinquent accounts.
- If you are experiencing a set of financial circumstances beyond your control, please call our practice and we will be happy to make special payment arrangements, if warranted.
- If it is necessary for you to undergo surgery, we will work with you to determine which services your insurance may cover and which fees may be your responsibility; however, benefit checks are not a guarantee of coverage and may not reflect all charges. Hospital, anesthesia and lab/pathology charges are separate. Payment options may be discussed prior to scheduling your surgery to alleviate unnecessary concerns.
- Failure to adhere to the above policies could result in your account being turned over to an outside collection agency and possible dismissal from the practice.
- Payment is due at time of service for self-paying patients.
- There is a $25.00 service charge on any returned checks.
- There is a $15 charge for the completion of forms which include but are not limited to physical forms, disability forms, DOT, durable medical equipment or FMLA paperwork.
- If you require a copy of your medical records you will be charged $15 for the first 50 pages. $1 for every 10 pages after initial 50 pages.

Woodland Park Family Medicine firmly believes that a good doctor/patient relationship is based upon understanding and open communication. Our staff has been instructed to make every effort to assist you in managing your account. We hope to avoid any disagreement over payment for professional services by clearly defining our policies at the onset. If you have any questions concerning this policy or need any assistance with your account in the future, please contact us immediately.

I have read the above financial agreement and agree to abide by the terms set forth in it.

_____ _____

Signature of Patient/Guarantor Date

HEALTH HISTORY

Confidential

Patient Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason of visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual Period _____

Date of last pap smear _____

Have you had a mammogram_____

Are you pregnant_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

_____

_____

_____

Pharmacy Name:

ALLERGIES To medications or substances

_____

_____

_____

_____

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✔) if your blood relative had any of the following: Disease		Relationship to you
Father					☐	Arthritis, Gout	
Mother					☐	Asthma, Hay fever	
Brothers					☐	Cancer	
					☐	Chemical Dependancy	
					☐	Diabetes	
					☐	Heart Disease, Strokes	
Sisters					☐	High Blood Pressure	
					☐	Kidney Disease	
					☐	Tuberculosis	
					☐	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for hospitalization and outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, Please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex	Complications, if any

HEALTH HABITS Check (✔) which substances you use and describe how much you use.

☐	Caffeine	
☐	Tobacco	
☐	Street Drugs	
☐	Other	
☐		

OCCUPATIONAL CONCERNS

Check (✔) if your work exposes you to the following:

☐	Stress
☐	Hazardous Substances
☐	Heavy Lifting
☐	Other

Your Occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Date

WOODLAND PARK FAMILY MEDICINE

PHONE MESSAGE CONSENT

From time to time caring for our patients, it may be necessary or desirable to contact patients by phone. When you are not available for us to speak to directly, we like to leave messages where possible.

In order to protect your privacy, we have developed a policy on leaving messages.

We will not discuss any medical information with anyone except the patient or legal guardian.

We will not leave any medical information on an answering machine.

We will not leave any medical information on a voice mail system.

We will attempt to, as a courtesy, leave a reminder message regarding an upcoming appointment.

UNLESS

We have your written permission to leave messages for you. Please read the information below and consider carefully whom you want to have access to your medical information, such as test results. Please fill out only ONE of the following sections below to make your preference known.

A. I DO CONSENT TO LEAVE DETAILED MESSAGES:

I, _____, give Woodland Park Family Medicine and their staff my permission to leave phone messages regarding my medical care with the following: *Initial for each one you wish to have your messages.* This consent will remain in effect until rescinded in writing.

_____My home phone answering machine/voice mail
_____My work phone voice mail
_____My spouse (name)_____
_____Other (name)_____Phone #_____

Signature:_____

B. I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I, _____, wish to be contacted personally and I do not authorize detailed messages regarding my medical care be left on an answering machine, voice mail or with others.

Signature:_____

C. REVOCATION OF PRIOR CONSENT:

I, _____, wish to rescind the above authorizations.

Signature:_____

WOODLAND PARK FAMILY MEDICINE

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____have been made available a copy of Woodland Park Family Medicine,
(Patient Name)
LLC's Notice of Privacy Practices.

_____ _____
Signature of Patient/Guarantor Date

IF THE PATIENT IS *YOUNGER* THAN 21, PLEASE FILL THIS FORM OUT

Patient Eligibility Screening Record
Vaccines for Children Program

1. Initial Screening Date: (__ __/__ __/__ __ __ __)
   M M D D Y Y Y Y
2. Child's Name: _____ _____
   Last Name First MI
3. Child's Date of Birth: (__ __/__ __/__ __ __ __)
   M M D D Y Y Y Y
4. Parent/Guardian/Individual of Record: _____ _____
   Last Name First MI
5. Is your facility a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)?
   _____ Yes ___X____ No
6. Primary Physician's Name: _____ _____
   Last Name First
7. Does this patient qualify for immunization through the VFC program because he/she (check only one box):
   a) Yes, is enrolled in Medicaid ☐
   b) Yes, does not have health insurance ☐
   C) Yes, is an American Indian or Alaska Native ☐
   d) Yes, is underinsured (has health insurance that does not pay for vaccinations) ☐
   f) No, this child does not qualify for immunizations through the VFC program because he/she does not met the eligibility criteria. ☐

Eligibility Changes					
Date	Is enrolled in Medicaid	Does not have health insurance	Is an American Indian or Alaska Native	Is underinsured (has health insurance that does not pay for vaccinations)*	Does not meet eligibility criteria

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider' s office. The record may be completed by the parent, guardian, or individual of record or by the health care provider. VFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child' s eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine