Gilbert Family Medicine, LLC

Patient Registration

Patient Information:

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____/_____/_____ Soc. Sec. No.: _____

Gender (M/F): _____ Marital Status: ___ Married ___Divorced ___Single ___Other

Home Ph. #: _____ Cell #: _____ Work #: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Guarantor Information/Responsible Party if Patient is a Minor:

Last Name: _____ First Name: _____ MI: _____

DOB: _____/_____/_____ Soc. Sec. No.: _____ Relation to Patient: _____

Treatment Consent of a Minor:

I _____ parent/guardian of _____ Authorize Gilbert Family Medicine, LLC to examine and treat him/her in the event I cannot accompany him/her for an appointment to the office.

Primary Insurance: _____ Policy #: _____ Group #: _____

Primary Insurance Policy Holder Information (If different from above):

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____/_____/_____ Soc. Sec. No.: _____ Relation to Patient: _____

Employer Name & Address: _____

Work Phone #: _____ Home Phone # (If different from above): _____

Home Address (If different from above): _____ City: _____ Zip: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Secondary Insurance Policy Holder Information:

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____/_____/_____ Soc. Sec. No.: _____ Relationship to Patient: _____

Employer Name & Address: _____

Work Phone #: _____ Home Ph. # (If different from above): _____

Assignment of Insurance Benefits / Financial Responsibility

Authorization to Release Information / Appointments Policy

I authorize Gilbert Family Medicine, LLC to release records pertaining to my treatment to my insurance company or to other third parties responsible for the payment of my medical charges, including review activities related to my physician's participation with my health plan

I understand that I am responsible for keeping any appointment scheduled with Gilbert Family Medicine, LLC. GFM has the right to reschedule my appointment if I am not on time for my appointment. I understand that Gilbert Family Medicine, LLC may charge a "No Show" fee for failure to keep appointments, without 24 hour advanced notice.

I hereby authorize direct payment to Gilbert Family Medicine, LLC for services rendered. I understand that I am financially responsible for any balance not recovered. If after 60 days the balance is not paid, a collection agency fee not to exceed 30% along with the outstanding balance will be due

Any balance outstanding past 60 days may be charged to the following credit card.

Card Type: _____ Card #: _____ Exp: _____

Signature: _____ **Date:** _____

We have provided you with a copy of our Notice of Privacy Practices. Please sign this form acknowledging that you have received a copy. In order to protect your privacy we need you to give us permission to leave a message or speak with other parties. Please indicate your answer with a yes or no response.

_____Yes _____No: It is OK to leave a message regarding an appointment time.

_____Yes _____No: It is Ok to leave a message regarding test results.

_____Yes _____No: It is Ok to speak with my spouse, caregiver, MPOA or guardian. NAME: _____

Signature of Patient or Guardian of Patient: _____ Date: _____

GILBERT FAMILY MEDICINE

Financial Policies and Arrangements

Insurance: Filing/Benefits/Payment

There are numerous insurance plans with which we have contracted to receive payment direct from the insurance company. With these plans, the patient is generally required to meet a deductible or make a co-payment. If you are covered by one of these plans, please show us your card. **Be prepared to make your co-payment or pay for your office visit if your deductible has not been met at the time of service**. For your convenience in addition to cash or check we also honor Visa and MasterCard.

With plans that we do not contract with, you will be asked to pay at the time of your visit. At the time of payment you will receive a super-bill containing all the information you will need to file your insurance claim.

It is your responsibility as a consumer to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover different types of services. Contraception (Depo-Provera), immunizations, and other services may not be covered on your particular plan. Services provided that are not a covered benefits are your responsibility, and payment is due at the time services are rendered. If you have questions as to what services are covered, contact member services at the number listed on your insurance card.

We will set aside the portion of the balance estimated to be paid by your insurance carrier for 30 days. Gilbert Family Medicine cannot accept responsibility for collection your insurance claims of for negotiating a settlement on a disputed claim. You will continue to receive statements until the account is paid in full.

Payment Arrangements

Payment is expected at the time of service. If you do not have your co-pay at the time of service, your visit will be rescheduled. Also, we recognize the need to set up payment plans for patients who require extensive treatment. Our business office will be happy to help you with these arrangements. Please be aware that any balance remaining after the first statements will be subject to a **$30.00 rebilling** fee each month until the original balance and added fees are paid in full.

Delinquent Accounts

Bills delinquent more than Sixty (60) days will be transferred to an outside collection agency unless prior arrangements have been made. If you have questions or think an error has been made, please discuss them with us prior to the 90 days in order that we may help you to resolve this. Delinquent accounts will responsible for any collection charges.

Returned Checks

There is a $30.00 service fee for checks returned for insufficient funds.

Cancellation of Appointments

If you find it necessary to cancel your appointment all we ask of you is to give us reasonable notice so that we may let another patient have your appointment time. We ask one (1) day prior for routine visits and two (2) for physicals and office procedures/surgeries. For your consideration in letting us know ahead of time, we do not charge for your cancelled appointment.

No Show Appointments

Should you not show or notify us in advance to cancel your appointment there is a **$75.00 No Show charge for routine visits and $135.00 NO-Show charge for physical and office procedure/surgeries** for the time that had been reserved for you. Payment will be required prior to being seen from any future appointments. **Two NO SHOW appointments will be considered grounds for dismissal from the office.**

Medical Records

There is NO CHARGE when records are sent to a physician for continuing care. A copying fee is charged when records are released to a patient or other non-physician recipients.

Multiple Family Member Appointments

Unless previously arranged when scheduling an appointment, other members of the family will not be seen at the time of your appointment. We cannot maintain our schedule nor is it fair to other patients who have scheduled time to be seen. Multiple appointments are available by appointment only. Please let the receptionist know of your specific family needs when scheduling with us.

Additional Help

Gilbert Family Medicine wants you to feel free to discuss any concerns you may have or any problems you may be experiencing with our office. Please help us to help you. Our entire staff is dedicated to making your visits with us as pleasant as possible.

*****It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by your insurance.*****

I have read and agree to the above policy of Gilbert Family Medicine.
I understand its contents and by signing below accept the aforementioned financial responsibilities.

Signature: _____ **Date:** _____
(Patient or Guardian/Responsible Party for Patient)

Review of Systems

Name: _____
Date: _____
Date of Birth: _____
Age: _____ **Occupation:** _____

Allergies to Medications: _____
_____
Current Medications: _____
_____

Past Medical History/Hospitalizations

_____
_____
_____

Surgery

Date_____**Reason**_____
Date_____**Reason**_____
Date_____**Reason**_____

Social History

□ Alcohol: Type_____
Amount _____
□ Caffeine: Type_____
Amount _____

□ Tobacco:
How Long? _____
Interested in Quitting? _____
□ Recreational Drugs
_____

□ Exercise:
How Often? _____
□ Married
How Long? _____
□ Children
How Many? _____

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	□	□	□	□	□	□
Asthma	□	□	□	□	□	□
Bleeding	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Glaucoma	□	□	□	□	□	□
Epilepsy	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Heart Attack	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□
Kidney Disease	□	□	□	□	□	□
Mental Illness	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□
Stroke	□	□	□	□	□	□
Thyroid Disease	□	□	□	□	□	□
Other	□	□	□	□	□	□

_____

Review of Systems: Circle what applies to you

General:	general good health	weight changes	fevers	fatigue	weakness
Skin:	changes in moles	easy bruising	bleeding	tattoos? _____	
Lymph Glands:	enlarged	painful			
Head:	convulsive disorder	dizzy spells	fainting	injury? _____	
Eyes:	glaucoma	double vision	visual disturbances	last eye exam _____	
Ears:	deafness	ringing in ears	pain	chronic infection	
Nose:	allergies	nasal discharge	nose bleeds		
Mouth:	sore mouth	sore tongue			
Throat:	hoarseness	voice change	sore throat	difficulty swallowing	
Neck:	goiter	enlarged glands			
Breasts:	masses	nipple discharge	skin changes		
	last mammogram_____	abnormal mammogram____	self breast checks_____		
Lungs:	wheezing	shortness of breath	cough	tuberculosis	asthma
Heart:	high blood pressure	heart attack	heart murmur	chest pain	
	rheumatic fever	shortness of breath with exercise			
Gastro/	change in bowels	blood in stool	dark stools	hemorrhoids	
Intestinal:	constipation	diarrhea			
	change in appetite	abdominal pain	pain with swallowing		Hepatitis____
Urinary:	burning	frequency	difficulty	leaking	kidney probs.
Men:	testicular pain	last prostate test_____	sexually transmitted diseases_____		
Women:	last menstrual period_____	length of flow_____	periods regular_____		
	last pap smear_____	abnormal _____	sexually transmitted diseases _____		
	pregnancies # _____	complete _____	incomplete _____		
Muscle/Bone:	arthritis	joint pain	bone density? _____		calcium? _____
Neurological:	dizziness	fainting	seizure		
Mental:	depression	anxiety	other _____		
Other:	diabetes	thyroid	blood clots	other_____	