LAKE CITY AREA MEDICAL CENTER

700 NORTH HENSON ♦ PO BOX 999 ♦ LAKE CITY CO 81235

PATIENT INFORMATION SHEET PATIENT #_____

Name of Patient (Last) (First) (MI)	Home Phone	Business Phone	Cell Phone
PERMANENT Address	City	State	Zip Code

IF MINOR, name(s) and DOB of Mother & Father	Their Home Phone
Their Social Security No. - -	Their Business Pone
Their Place of Employment & Address	

GENDER		MARITAL STATUS				Your Date of Birth	Your Social Security Number
Male	Female	Single	Married	Widowed	Divorced	/ /	- -

RACE (Circle one)		ETHNICITY	PREFERRED LANG.	REQUIRED INFO
White	Black	Latino or Hispanic	English	E-mail Address
Asian	Other	Not Latino or Hispanic	Other:	CIRCLE PREFERENCE FOR CONTACT: Mail - Email

IF EMPLOYED, Your Place of Employment	Would You Like to Have Electronic Access to Your Patient Record? ☐ Yes ☐ No (Details will be provided)

INSURANCE? ☐ Yes Give the card(s) to the receptionist for scanning. ☐ No

Name of Health Insurance Holder if Other Than Patient	Date of Birth
Social Security No.	Business Phone
Place of Employment & Address	

FAMILY CONTACTS

NAME	SEX	DATE OF BIRTH	PHONE NUMBER

LOCAL (TEMPORARY) ADDRESS:

Address / Lodging	Local Phone No.	
City	State	Zip Code

I hereby grant Lake City Area Medical Center permission to treat me or the above named patient(s).

I authorize the release of any medical records or other information necessary to process the claim(s). I authorize the sharing of records when necessary with QHN and PPRN. I also request payment of benefits either to myself, or the party who accepts assignment. I also agree to comply with this office's payment policy.

Signature of Patient or Responsible Party: _____ Date: _____ (12/15/11)

Would You Like To Receive Electronic Statements? Yes___ No___
Email address _____@_____

Please complete the following information: **PATIENT'S NAME:**_____

DIET: ☐ Balanced ☐ Meat / Potatoes ☐ Vegetarian ☐ Gluten Free ☐ High Protein ☐ High Carbohydrate ☐ High Fat

Are you a smoker? ☐ Yes ☐ No (If yes, number of packs per day: _____)

Exposure to second-hand smoke? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No Problem? ☐ Yes ☐ No

Do you use recreational drugs? If so, tell us about it.

VACCINE HISTORY
(Check all that apply)

☐ **Childhood (Provide copy)** ☐ **I do not use vaccines.** ☐ **Flu** ☐ **Tet-Tox (Tetanus)** ☐ **Td (Tetanus/ Diphtheria)** ☐ **Tdap (Tetanus\Diphtheria /Pertussis)** ☐ **Hepatitis A** ☐ **Hepatitis B**

☐ Tuberculosis Skin Test ☐ Pneumonia ☐ Shingles ☐ Other: **Provide dates, if possible.**

FAMILY HISTORY
(Check all that apply)

☐ High Blood Pressure ☐ Cancer (Breast) ☐ Cancer (Colon) ☐ Cancer (Prostate)

☐ Diabetes ☐ Strokes ☐ High Cholesterol ☐ Heart Attack

☐ OTHER: (Describe)

SOCIALHISTORY

Retired? ☐ Yes ☐ No

Current Occupation:

Previous Occupations:

Occupational Exposures:

Highest Level of Education: ☐ Some High School ☐ GED ☐ High School Diploma ☐ Some College

☐ College Degree ☐ Some Post-college or Graduate School ☐ Graduate Degree ☐ Masters Degree

☐ Other: (Describe)

Please complete the following information: **PATIENT'S NAME:**_____

MEDICAL HISTORY (Diabetes, High Blood Pressure, Cancer, etc.)		**SURGICAL HISTORY** (Appendix, Tonsils, Gallbladder, Cardiac, Shoulder, Hysterectomy, etc.)	
YEAR ONSET (Diagnosed)	**PROBLEM**	**DATE**	**SURGERY**

ALLERGIES (Medications and/or Environmental)	
Allergen (Penicillin, Sulfa, Grasses, Pollen, Dogs, Cats, etc.)	**Reaction (Rash, Hives, Swelling, Shock, etc.)**

MEDICATIONS (Prescriptions and Supplements)		
NAME	**STRENGTH (10 mg, etc.)**	**HOW IS IT TAKEN? (1 tablet twice daily, 1- 2mg tablet Mon-Wed-Fri, etc.…)**

Please complete the following information: **PATIENT'S NAME:**_____

MEDICATIONS (Continued)		
NAME	**STRENGTH (10 mg, etc.)**	**HOW IS IT TAKEN? (1 tablet twice daily, 1- 2mg tablet Mon-Wed-Fri, etc.…)**
FOR ADDITIONAL INFORMATION WE SHOULD KNOW, USE THE SPACE BELOW.		

LAKE CITY AREA MEDICAL CENTER

700 North Henson / PO Box 999
Lake City CO 81235
970- 944- 2331

-Notice Of Privacy Practices Acknowledgment-

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that ***Lake City Area Medical Center*** has the right to change its *Notice of Privacy Practices* from time to time and that I may contact ***Lake City Area Medical Center*** at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that ***Lake City Area Medical Center*** may restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand that ***Lake City Area Medical Center*** is not required to agree to my requested restrictions, but if ***Lake City Area Medical Center*** does agree, then ***Lake City Area Medical Center*** is bound to abide by such restrictions.

Patient Name (*Please Print*): _____

Patient Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date	Initials	Reason

Lake Fork Health Service District Financial Agreement

1. All copayments and unsatisfied deductibles must be paid at time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all copayments, co-insurance, or non-covered services. We cannot waive copayments, deductibles, co-insurance or non-covered services defined as patient responsibility under the terms of our contracts. **Your payment options are: Cash, Check, or Credit Card.**
2. For our patients with no insurance coverage, payment is expected at the time of your visit. You will be given a timely payment discount. Partial payments or payments made after the date of service are not subject to this discount. We do offer a sliding fee scale for those who are not able to obtain/afford health insurance.
3. Insurance: Your insurance is a contract between you and the insurance company, and it is your responsibility to know your benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If your insurance card is not supplied, you will be billed for services and payment in full will be expected within 30 days of receipt of statement.
4. No/show missed appointments: Broken appointments represent not only a cost to us, but also inability to provide services to others who could have been seen in the time set aside for you. **We require 24 hour notice of cancellation to avoid $50 cancellation fee for a new patient and a $25 for an established patient appointment.**
5. Collection Accounts: All unpaid charges over 90 days will receive a letter for a final collection attempt. If you do not respond your account will be turned over to an outside collection agency. You are responsible for all legal fees, court costs, and any collection agency fee. If your mail is returned to us, we will make one attempt to correct the address. If we are unable to reach you this will be forwarded to a collection agency.
6. Returned checks: All returned checks will have a $30 NSF fee applied to your account.
7. <u>If you have made an appointment for a wellness visit/physical only and your doctor treats you for an illness or counsels you regarding a medical condition on during this visit, there could be a separate charge and co-pay that is your responsibility.</u>
8. Medicare patients: We participate in the Medicare program. You are responsible for your co-pay, deductible, co-insurance and NON COVERED SERVICES. We may ask you to sign an ABN (Advanced Beneficiary Notice), which lists our fee and notifies you of your financial responsibility for certain medical services.
9. Special arrangements may be made for patients having more costly procedures. We understand financial problems arise from time to time. Please let us know if you are interested in setting up a payment arrangement on your account.

Patient Name: _____

List Other Family Members: _____

Signature of Acknowledgement: _____

Date: _____