

**\*\*Please review and update the information below to the best of your ability.\*\***

**Patient Registration**

**CURRENT PATIENT INFORMATION – PLEASE PRINT**

**Guarantor Information (to whom statements are sent)**

Last Name:  
First Name:  
Middle Name:  
Address:  
City: State:  
Zip:  
Home Phone:  
Work Phone:  
Mobile Phone:  
Sex:  
Date of Birth:  
Social Security No.:  
Patient email:  
Required by government mandate [although you may refuse]:  
Language:  
Race:  
Ethnicity:  
Marital Status:

Name:  
Address:  
Relationship to patient: \_\_\_\_\_  
Date of Birth:  
Social Security No.:  
Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Emergency Contact Information**

Name:  
Relationship:  
Phone:  
Mobile Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Employer information**

Employer:  
Address:  
Phone:

Other

**Pharmacy Information:**

Patient Referred by:  
Primary Care Provider:  
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Name:  
Crossroads:  
Phone:

**Primary Insurance Information**

**Secondary Insurance Information**

Insurance Plan Name:  
Last Name:  
First Name:  
Middle Name:  
Address:  
City: State: Zip:  
Date of Birth: Sex (please circle): M or F  
Employer Name:  
Patient's relationship to policy holder:

Insurance Plan Name:  
Last Name:  
First Name:  
Middle Name:  
Address:  
City: State: Zip:  
Date of Birth: Sex (please circle): M or F  
Employer Name:  
Patient's relationship to policy holder:

**To the best of my knowledge the above information is complete and accurate.**

**Signed** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*Please sign and date each item below\*\***

**ACKNOWLEDGEMENT AND AUTHORIZATION:**

- I have read and understand the HIPAA/Privacy Policy for HARRISONVILLE FAMILY MEDICINE INC

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I authorize HARRISONVILLE FAMILY MEDICINE INC to release medical information required to process my claim

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I have read and understand the Financial Policy for HARRISONVILLE FAMILY MEDICINE INC

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I authorize HARRISONVILLE FAMILY MEDICINE INC to obtain/have access to my medication history

Signed \_\_\_\_\_ Date: \_\_\_\_\_

- I authorize my provider's office to contact me by mobile phone

Signed \_\_\_\_\_ Date: \_\_\_\_\_

**Harrisonville Family Medicine, Inc,**  
**Privacy Consent Form**

(Check all that apply)

Myself

Spouse: \_\_\_\_\_

Family Member:

ALL Adult Family Members

ONLY: \_\_\_\_\_

Parent or Family Member ( For Minor Child)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

May leave a detailed message on answering machine / voicemail

NO Details on answering machine / voicemail – Only to call office

Email: \_\_\_\_\_

Consent to text (i.e. appt reminders, office closure due to weather or holidays, etc.)

Other: \_\_\_\_\_

**Note: It is your responsibility to notify HFM of any changes that need to be made to this form.**

I acknowledge that by signing below, that I authorize Harrisonville Family Medicine, Inc. to disclose any information related to my / my child's care, with the choices I have indicated above. I also acknowledge that I have received and read a copy of HFM Notice of Privacy Practices.

\_\_\_\_\_  
Patient / Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

# Past Medical History Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

DOB: \_\_\_\_\_

## Past Medical History

<b><u>Gastrointestinal</u></b>	
Ulcer	_____
Colon Polyps	_____
Colon Infections	_____
Diverticulosis	_____
Diverticulitis	_____
Acid Reflux	_____
Hepatitis	_____
Liver Disease	_____
Irritable Bowel Disease	_____
Crohn's Disease	_____
<b><u>Endocrine</u></b>	
Elevated Thyroid Levels	_____
Low Thyroid Levels	_____
Diabetes Type I	_____
Diabetes Type II	_____
<b><u>Pulmonary</u></b>	
Environmental Allergies	_____
Chronic Lung Disease	_____
Chronic Bronchitis	_____
Chronic Sinusitis	_____
Asthma	_____
Sleep Apnea	_____
<b><u>Musculoskeletal</u></b>	
Low Back Pain	_____
Gout	_____
Rheumatoid Arthritis	_____
Osteoporosis	_____
Osteoarthritis	_____
Fibromyalgia	_____
<b><u>Cardiovascular</u></b>	
Coronary Artery Disease	_____
Atrial Fibrillation	_____
Previous Heart Attack	_____
Elevated Blood Pressure	_____
High Cholesterol	_____
Blood Clot	_____
Congestive Heart Failure	_____
<b><u>Genitorinary</u></b>	
Kidney Stones	_____
Chronic Kidney Disease	_____
Urinary Tract Infections	_____
<b><u>NeuroPsych</u></b>	
Seizure Disorder	_____
Stroke	_____
Attention Deficit Disorder	_____
Depression	_____
Anxiety	_____
Dementia	_____
Alzheimer's	_____
Bipolar Disorder	_____
Migraine Headache	_____

## Misc.

Smoking	_____
Alcohol Use	_____
Anemia	_____
Glaucoma	_____
HIV Infection	_____

## Male

Elevated PSA	_____
Erectile Disorder	_____
Prostate Enlargement	_____

## Female

LMP	_____
Last Pap Smear	_____
H/O Abnl Paps	_____
# of Pregnancies	_____
Contraception	_____
Sexually Active	_____

## Personal History of Cancer

Brain Cancer	_____
Thyroid Cancer	_____
Breast Cancer	_____
Colon Cancer	_____
Lung Cancer	_____
Prostate Cancer	_____
Leukemia	_____
Lymphoma	_____
Ovarian Cancer	_____
Cervical Cancer	_____
Uterine Cancer	_____
Kidney Cancer	_____

## Family History

Heart Attack	_____
Hypertension	_____
Heart Disease	_____
Heart Failure	_____
Blood Clots	_____
Asthma	_____
Chronic Lung Disease	_____
Cancer	_____
Diabetes	_____
Depression	_____
Anxiety	_____
Mental Illness	_____
Alcoholism	_____
Alzheimer's	_____
Seizure Disorder	_____
Migraine Headaches	_____
Stroke	_____
Kidney Disease	_____

## Past Surgical History

<b><u>Cardiovascular</u></b>	
Aneurysm Repair	_____
Heart Bypass Surgery	_____
Carotid Artery Surgery	_____
Heart Valve Replacement	_____
Pacemaker	_____
Defibrillator	_____
Stent Placement	_____
<b><u>Musculoskeletal</u></b>	
Hip Replacement	_____
Knee Surgery	_____
Knee Replacement	_____
Shoulder Surgery	_____
Rotator Cuff Repair	_____
Carpel Tunnel	_____
Lower Back Surgery	_____
Neck Surgery	_____
<b><u>Genitourinary</u></b>	
Kidney Removal	_____
Kidney Stone Surgery	_____
Vasectomy	_____
Prostate Surgery	_____
<b><u>Gastrointestinal</u></b>	
Appendix Removed	_____
Gallbladder Removed	_____
Colon Resection	_____
Colostomy Bag	_____
Ileostomy Bag	_____
Weight Loss Surgery	_____
Hemorrhoid Surgery	_____
Pancreas Removal	_____
Spleen Removal	_____
<b><u>Hernia Repair</u></b>	
Incisional	_____
Inguinal (groin)	_____
Umbilical	_____
Abdominal	_____
<b><u>Other</u></b>	
Lung Surgery	_____
Thyroid Surgery	_____
Cataract Surgery	_____
Ear Tubes	_____
Tonsils Removed	_____
Adnoids Removed	_____
<b><u>OB / GYN</u></b>	
Total Abd. Hysterectomy	_____
with ovary removal	_____
Vaginal Hysterectomy	_____
Tubal Ligation	_____
Cesarean Section	_____
Mastectomy	_____
Lumpectomy	_____
Breast Augmentation	_____
Breast Reduction	_____

# HARRISONVILLE FAMILY MEDICINE

2820 E. Rock Haven Road, Ste 100

Harrisonville, MO 64701

Phone (816) 380-3582 Fax (816) 380-6964

Patient Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Releasing records **FROM:** \_\_\_\_\_  
(physician or organization name)

\_\_\_\_\_  
(mailing address, phone and fax number)

Releasing records **TO:** \_\_\_\_\_  
(physician or organization name)

\_\_\_\_\_  
(mailing address, phone and fax number)

*Please select only ONE of the following: I give my permission to release the following records to the above stated entity: (include dates where appropriate)*

\_\_\_\_\_ Confined to records for the time period  
of: \_\_\_\_\_

\_\_\_\_\_ Confined to records regarding the specific  
information: \_\_\_\_\_

\_\_\_\_\_ All records without regard to limitations placed on dates, history of illness, or diagnostic  
and therapeutic information, including AIDS testing or diagnosis, information or  
treatment for alcohol, drug abuse, and testing and diagnosis of psychiatric illness.

**For the purpose of:** \_\_\_\_\_

This authorization is voluntary. This authorization will expire \_\_\_\_\_ (e.g. 60 days) from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the office in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. I agree to waive all claims against the office for the release of the requested information. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the office if the recipient of the information is not a health plan, health care provider, health clearinghouse, or a business associate that has a contract with the office. I understand that I must provide the office with at least twenty-four (24) hours notice before coming to the facility to review records. I understand that after I have reviewed the records, I must provide the office with two (2) working days advance notice of any copies of the records that I would like to pick up at the office. I understand that if I request that records be copied and sent to me that the office will send those records to me within thirty (30) days. I understand that if I wish to have copies of records made, then the office will assess a fee for copying the records. The facility will notify me of the total amount due for copying and shipping of the requested records. I agree that the office will only send me the requested information once payment has been received in full for those costs. I understand that once the requested records leave HFM, they are the responsibility of the patient/ recipient. I understand that I have the option to have these records copied to a data disc, or an electronic copy can be made. The patient/ recipient will be responsible for providing a flash drive for the electronic copy.

Signature of Patient or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

If Signed by Legal Representative, Relationship to Patient \_\_\_\_\_ Signature of Witness \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date

## Wellness Update

**Do you experience any of these symptoms?**

	Yes	No
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

**How often do you experience these symptoms?**

- Occasionally (2-3 times per year)
- Over 3 times a year
- A few long periods of time per year (Spring, Summer, Fall, Winter)
- Most of the year

**Do you take prescription or over-the-counter (OTC) medications for the management of your allergy symptoms?**  Yes  No

If yes, name of medication and last date taken: \_\_\_\_\_

**Please indicate below symptoms/conditions you've experienced during the last 1 - 2 years**

- Sinus related issues (sinus pressure/pain, headaches, sinusitis)
- Re-occurring Seasonal Colds
- Chronic colds (lasting longer than 2 months)
- Migraine Headaches
- Restless sleep, challenges sleeping through the night, snoring
- Consistent or Re-occurring coughing
- Feeling of fatigue, irritability, & restlessness
- Asthma
- Skin conditions (dry and/or itchy skin, etc...)

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Phone: \_\_\_\_\_

**FOR PROVIDER USE ONLY:**

Order Allergy Test:  Yes  No

Date of last ENT exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# Harrisonville Family Medicine, Inc.

## Financial Policy

Effective Date: 7/1/2019

Thank you for choosing Harrisonville Family Medicine as your healthcare provider. Due to the changes in insurance reimbursements and high deductible health plans we are revising our financial policy to ensure we can continue to take care of your health needs and provide you with the best possible care. Please read the following information carefully.

This is an agreement between Harrisonville Family Medicine, Inc., as creditor, and the patient / debtor / responsible party. By executing this agreement, you are agreeing to pay for all services that are received.

**Contracted Insurance:** You are expected to pay deductibles and co-payments at the time of service. You must also pay outstanding balances prior to being seen in the office. **If you are not able to resolve an outstanding balance or pay the copay due before your next appointment, please be aware that your appointment will need to be rescheduled until your balance is paid in full or reasonable payment arrangements are made. If your appointment is rescheduled due to non-payment at time of check in there will be a \$40 no show fee applied.** The deductible will be collected until your yearly deductible has been reached. It is your responsibility to know what is and what is not covered under your plan. It is the insurance company that makes the final determination of your eligibility and coverage. **You will be responsible for any and all charges not covered by your insurance company.**

**Self-Pay Patients:** Payment is expected at the time of service. If you cannot pay at the time of service, your appointment will be rescheduled.

**Monthly Statements:** If you have a balance of \$10.00 or more on your account, we will send a monthly statement. **Please remember when you receive our statement you have already received quality care from your physician, your insurance has been filed and any payment or adjustment from your insurance company has been applied. The balance on your account is due and payable when the statement is issued.**

**Past Due Accounts:** Balances that remain on your account past 45 days are considered overdue and full payment will be expected at future appointments unless a payment plan has been arranged and approved by our billing department. Accounts over 90 days in arrears will be sent to our collection agency. At that point, for any new charges to be added to your account our office will require a credit card on file. Once an account has been placed in collections, the physician/patient relationship could be terminated and your records will be transferred to a physician of your choice.

**Forms & Fees:** Your portion of any form must be filled out completely before submitting it to us. A fee will be charged and collected when your form is returned to you or submitted on your behalf.

**No Show Policy:** A \$40 fee will be charged for any missed appointment without 24 hour notice. This is not covered by insurance and must be paid prior to your next appointment. Multiple no shows in any 12 month period could result in termination from our practice.

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_