Welcome to Complete Family Medicine

Office Use Only

Immunization _____ Preventative _____

Meds Reviewed: _____
(Circle One)

Brown bag List Verbal Pharmacy

Patient Name:_____

Why are you seeing us today?

_____
_____
_____
_____

Please Circle if you are experiencing any of these symptoms:

Constitutional:
Excess fatigue, fever, night sweats.

HEENT:
Eye discharge and vision loss.
Ear drainage, hearing loss and nasal drainage.

Respiratory:
Cough, shortness of breath and wheezing.

Cardiovascular:
Chest pain, pain in your legs while walking, and irregular heartbeat/palpitations.

Gastrointestinal:
Abdominal pain, constipation, diarrhea and vomiting.

Genitourinary/Reproductive:
Pain with urination, blood in your urination, increased urinary frequency.
Men: Penile discharge **Women**: Pain with menstruation, excessive bleeding, vaginal discharge

Metabolic/Endocrine:
Cold intolerance, heat intolerance, increased drinking and increased appetite.

Neuro/Psychiatric:
Trouble Walking.
Psychiatric symptoms.

Dermatologic:
Itch, rash.

Musculoskeletal:
Bone/joint symptoms and muscle weakness.

Hematology:
Bleeding and easy bruising.

Immunology:
Environmental allergies, drug allergies.

739.0 OA, F E, RR RL, SR SL
739.1 C 2 3 4 5 6 7, F E RR RL, SR SL
739.2 T 1 2 3 4 5 6 7 8 9 10 11 12 N F E, RR RL, SR SL
739.3 L 1 2 3 4 5, N F E, RR RL, SR SL
739.4 S L R on L R or L R Shear-sup, inf
739.5 P L R, ant post shear-sup
739.6 LE
739.7 UE
739.8 Rib L R, 1 2 3 4 5 6 7 8 9 10 11 12 inhaled exhaled
739.9 Other

HIPAA -23.A1

Office use only:

EPM _____

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of CFM's Notice of Privacy Practices (NPP). I also understand that CFM has the right to change its NPP and that I may contact the practice to obtain a current copy or I may access the notice via the CFM website.

I understand that I may refuse to sign this acknowledgement form or decline to receive a copy of CFM's NPP; and, if I refuse or decline, there will be no impact on the care or service I receive today.

_____ _____
Patient's Name (please print clearly) Date of birth

_____ _____
Signature of patient or guardian Today's date

_____
Guardian's name (please print clearly)

Office Use Only

CFM has made a reasonable attempt to obtain the patient's signature acknowledging receipt of the NPP; however, signature was not obtained for the following reason (check all that applies):

- ☐ Patient or representative refused to sign acknowledgement form
- ☐ Patient or representative refused copy of NPP
- ☐ Patient failed to sign the acknowledgement form but was presented with a copy of the NPP as a part of the new patient paperwork during today's visit.

_____ _____
CFM Staff Name (Print) Date

Disclosure Form

Office use only:
EHR ____
EPM ____

Today's Date_____

Patient's Name (printed)_____
Last First Middle

Date of Birth_____ SS#_____ Phone#_____

Legal Guardian (if patient is under 18)

_____
Last First Middle

Guardian's Relationship to the Patient _____

HIPAA privacy laws allow CFM to share medical information about its patients with others who are involved in the care of the patient or payment for services provided. I give CFM permission to share or discuss my health information with the following family, friends or others who will be involved in my care or payment for care. If releasing information to anyone, including those listed below, for purposes other than for care or payment, I understand I will be required to sign a separate Medical Record Release form.

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

Full Name: _____ Relationship to Patient _____

I understand that I have a right to revoke this permission at any time. I understand that if I revoke this permission, I must do so in writing and present my written notice to Complete Family Medicine, LLC. I understand that the revocation of permission will not apply to information that has already been released in response to this form. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that authorizing the disclosure of my medical information to the person(s) identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Signature of Witness Date

Complete Family Medicine
PO Box 295
Kirksville, MO 63501
PH: 660-665-7575 FX: 660-665-7576

COMPLETE FAMILY MEDICINE

Rev 1/2/2014 anc

Dear Patients,

Since the founding of this practice, we have always offered the best medical care possible. In order to continue to do so, we have implemented a Patient Financial Policy which is outlined in this document.

We send monthly statements to inform you of any balances due. We will also notify you of balances due when you check in at each appointment. We expect that patient due balances will be paid at the time of your appointment or upon receipt of our statement**. As of January 1, 2012 any balances that go over 30 days past due will accrue an interest of 1.5% every month after the initial 30 days.** In order to make it easier for you, we accept cash, checks, debit or credit cards.

As a courtesy to our patients, we offer payment plans for high balances due. If you are unable to pay your balance in the first 30 days you may set up a payment plan to avoid interest charges being added to your balance. **If you miss a payment on your payment plan, the interest will immediately begin accruing on the current balance.** Please see the billing office to inquire about setting up a payment plan.

We require a 24 notice for cancellation of an appointment. There will be a $15 fee added to your account if you fail to cancel you appointment 24 hours in advance. This fee is not payable by insurance and will be your responsibility to pay before your next scheduled appointment.

All balances and payment plans must be current at your next scheduled appointment or you may not be seen.

For Self-Pay Patients: We require a $20 copay before you are seen. We expect payment on the day of service for patients who have no insurance coverage. We will do our best to give you an estimate of the charges ahead of time. At the time of the visit, we will expect payment of the actual charges by one of the methods listed above. For large balances or necessary surgical procedures, we will work with you to develop a payment plan. Your balance must be **paid in full** in order to be seen at your next scheduled appointment. For more information please see our **Quick Pay Policy**.

For Commercial Insurance Patients: We require that you bring your insurance card with you to each appointment in our office so that we can be sure that we have correct insurance information on file. We scan all new insurance information into our system. As a courtesy to you, we will file a claim with your primary and secondary plans. **If your plan has a copay, we expect payment upon check in for visits.** When primary and secondary plans have paid their portion of the charge, the remainder will become the patient's balance and will be indicated on the statement you receive from our office. You may be responsible for a deductible or coinsurance depending on your policy. We are unable to offer a discount on your deductible or coinsurance amount due to contractual agreements with your insurance company.

If you choose to not have us file the claim with your insurance company, the balance of the visit becomes your responsibility and **must be paid on the date of service**, please see the **Quick Pay Policy. You must make this decision at the time of your visit; we cannot go back and bill your insurance for you after the date of service.** At the end of your visit you will be provided with a detailed receipt and a detailed insurance claim form marked PAID that you may then forward on to your insurance company if you so choose. This amount may still be applied towards your deductible.

While our billing office will do all they can to help your in communicating and negotiating with your insurance plan, we must inform patients that any questions regarding coverage, benefits, or payment for services provided, is your responsibility to resolve with your insurance company.

For Medicaid Patients: If the patient is nineteen or older we require your copay amount at the time of your visit. You will also be responsible for any spendown amount on the day of service. These are contractual rules we have to abide by in order to stay within Medicaid's guidelines. **If your Medicaid is not active on the date of your visit you will be considered Self- Pay**. For more information please see our **Quick Pay Policy**.

For Medicare Patients: As a courtesy to our Medicare patients, we submit claims electronically to Medicare on a regular basis as well as secondary coverages. We require that you bring your Medicare and secondary insurance cards with you to each appointment. If you have no secondary coverage we require a copay at the time of visit. Your copay will be dependent on the services rendered. Your copay is only an estimate and a balance may remain after the claim has been processed. If this is so, we will send you a statement for the remaining balance.

For Motor Vehicle Accident/Liability Claims/Worker's Comp Claims: **It is the patient's responsibility to give CFM the insurance information for their accident claims.** If this information is not given to CFM in a timely manner, the balance for the visits will become the responsibility of the patient. If the claim goes unpaid by the accident insurance for over 45 days or is rejected by the accident insurance, the patient may choose to bill their regular health insurance or the balance becomes the patient's responsibility. If the accident insurance pays the patient for the claims, the balance at CFM becomes the patient's responsibility to reimburse in full. Patients must fill out a medical record release form for CFM to release their records and claims to the accident insurance.

This financial document cannot predict every circumstance or question about our policy. As we continue to grow, and/or business needs and economic conditions change, we reserve the right to revise, supplement, or rescind any policy or portion of this document at anytime. You will be notified in writing of such changes to the Complete Family Medicine financial policy as they occur.

Any patient may be refused service for any reason, including a balance on their account or a delinquent payment plan status.

Questions regarding this financial policy should be directed to our Billing Office at 660-665-7575.

Sincerely,

The Staff at Complete Family Medicine

Office use only:

EPM _____

Quick Pay Policy

As a courtesy for our patients, we are now offering a quick pay option if you choose to pay in full for your visit the day of the service.

You will receive 50% off of the price of all services if you pay in full the same day of service.

You will not be eligible for the Quick Pay amount after the end of business hours on the day of service. If you are unable to pay in full on the date of service, you will be sent a statement for the full amount of the visit. Payment will then be due upon the receipt of the statement.

For your convenience we accept cash, check, debit or credit cards.

I have read and understand the above stated Quick Pay Policy.

I have read and understand the Complete Family Medicine Financial Policy. I understand my financial obligations regarding my visits at Complete Family Medicine.

_____ _____
Patient's Name (Print Clearly) Date of birth

_____ _____
Signature of Patient or Representative Date

_____ _____
CFM Witness Date

Rev 1/2/2014 anc

COMPLETE FAMILY MEDICINE

Date _____

Provider's Initials ____

Abstracted by _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

Name: *(Last, First, M.I.)* ☐ **M** ☐ **F**	**DOB** _____/_____/_____
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or Referring Doctor:	**Date of Last Physical Exam: ___**

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and Dates:

☐ Tetanus _____ ☐ Pneumonia _____

☐ Hepatitis _____ ☐ Chickenpox _____

☐ Influenza _____ ☐ MMR _____

Measles, Mumps, Rubella

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

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

Please turn to next page

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name the Drug	Strength	Frequency Taken

Allergies to Medications:

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise:

☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)

☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:

Are you dieting? ..... ☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? ..... ☐ Yes ☐ No
# of meals you eat in an average day?_____
Rank Salt Intake ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low

Caffeine:

☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol:

Do you drink alcohol? ..... ☐ Yes ☐ No
If yes, what kind?_____ How many drinks per week? _____
Are you concerned about the amount you drink? ..... ☐ Yes ☐ No
Have you considered stopping? ..... ☐ Yes ☐ No
Have you ever experienced blackouts? ..... ☐ Yes ☐ No
Are you prone to "binge" drinking? ..... ☐ Yes ☐ No
Do you drive after drinking? ..... ☐ Yes ☐ No

Tobacco:

Do you use tobacco? ..... ☐ Yes ☐ No

☐ Cigarettes - Pks/day_____ ☐ Chew - #/day _____ ☐ Pipe - #/day _____

☐ Cigars - #/day _____ ☐ # of Years _____ ☐ or Year Quit _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs:

Do you currently use recreational or street drugs? ..... ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ..... ☐ Yes ☐ No

Please turn to next page

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Sex:

Are you sexually active? ..... ☐ Yes ☐ No
If yes, are you trying for a pregnancy? ..... ☐ Yes ☐ No
If not trying for a pregnancy list contraceptive or barrier method used? _____
Any discomfort with intercourse? ..... ☐ Yes ☐ No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? .. ☐ Yes ☐ No

Personal Safety:

Do you live alone? ..... ☐ Yes ☐ No
Do you have frequent falls? ..... ☐ Yes ☐ No
Do you have vision or hearing loss? ..... ☐ Yes ☐ No
Do you have an Advance Directive and/or Living Will? ..... ☐ Yes ☐ No
Would you like information on the preparation of these? ..... ☐ Yes ☐ No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? ..... ☐ Yes ☐ No

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times.

While riding a motorcycle or bicycle, wear a helmet.

Always have functional smoke detectors and fire extinguishers in your home.

If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.

Keep the firearm and ammunition in separate locations.

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death		Age	Age at Death	Significant Health Problems or Cause of Death
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Brothers and Sisters	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F			**Grandparents (Mother's Side)**			
	☐ M ☐ F			***Male***			
	☐ M ☐ F			***Female***			
	☐ M ☐ F			**Grandparents (Father's Side)**			
	☐ M ☐ F			***Male***			
	☐ M ☐ F			***Female***			

MENTAL HEALTH

Is stress a major problem for you? ..... ☐ Yes ☐ No
Do you feel depressed? ..... ☐ Yes ☐ No
Do you panic when stressed? ..... ☐ Yes ☐ No
Do you have problems with eating or your appetite? ..... ☐ Yes ☐ No
Do you cry frequently? ..... ☐ Yes ☐ No
Have you ever attempted suicide? ..... ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ..... ☐ Yes ☐ No
Do you have trouble sleeping? ..... ☐ Yes ☐ No
Have you ever been to a counselor? ..... ☐ Yes ☐ No

WOMEN ONLY

Age at onset of menstruation: _____ Date of last menstruation: _____/_____/_____
Period every _____ days. Heavy periods, irregularity, spotting, pain or discharge? ..... ☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____
Are you pregnant or breastfeeding? ..... ☐ Yes ☐ No
Have you had a D&C, hysterectomy or cesarean? ..... ☐ Yes ☐ No
Any urinary tract, bladder or kidney infections within the last year? ..... ☐ Yes ☐ No
Any blood in your urine? ..... ☐ Yes ☐ No
Any problems with control of urination? ..... ☐ Yes ☐ No
Any hot flashes or sweating at night? ..... ☐ Yes ☐ No
Do you have menstrual tension, pain, bloating,
irritability or other symptoms at or around time of period? ..... ☐ Yes ☐ No
Experienced any recent breast tenderness, lumps or nipple discharge? ..... ☐ Yes ☐ No
Date of last pap and rectal exam? _____/_____/_____

MEN ONLY

Do you usually get up to urinate during the night? ..... ☐ Yes ☐ No If yes, # of times _____
Do you feel pain or burning with urination? ..... ☐ Yes ☐ No
Any blood in your urine? ..... ☐ Yes ☐ No
Do you feel burning discharge from penis? ..... ☐ Yes ☐ No
Has the force of your urination decreased? ..... ☐ Yes ☐ No
Have you had any kidney, bladder or prostate infections within the last 12 months? ..... ☐ Yes ☐ No
Do you have any problems emptying your bladder completely? ..... ☐ Yes ☐ No
Any difficulty with erection or ejaculation? ..... ☐ Yes ☐ No
Any testicle pain or swelling? ..... ☐ Yes ☐ No
Date of last prostate and rectal exam? _____/_____/_____

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin_____
☐ Head/Neck _____
☐ Ears_____
☐ Nose _____
☐ Throat _____
☐ Lungs _____
☐ Chest/Heart_____

☐ Back _____
☐ Intestinal _____
☐ Bladder _____
☐ Bowel _____
☐ Circulation _____

Recent Changes In:
☐ Weight _____

☐ Energy Level _____
☐ Ability to Sleep_____

Other Pain/Discomfort:

_____

_____

_____

_____

Do you take any supplements, herbs, or vitamins?

What other doctors, specialists or alternative healthcare providers do you currently see or have you seen in the past?