HOMETOWN HEALTHCARE

New Patient Form

This for needs to be completely filled out in accordance to the federal HIPAA. Please print legibly. Thank you!

Patient Information

Last Name:	First Name:	MI	D.O.B	SSN
Mailing Address:		City:	State	Zip Code
Can we leave a voicemail? ☐ Yes or ☐ No	Email address:		Contact Number ☐ cell ☐ Home	

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Other	Gender: ☐ Male ☐ Female	Advance Directive/ Living will ☐ Yes ☐ No You may provide us a copy at your discretion.	Emergency Contact: Relation:	Emergency Contact Phone:

*Race ___ Black/African American ___ American Indian ___ Native Hawaiian ___ Hispanic ___ Pacific Islander ___ White ___ Asian Other _____	Referred by: Preferred Language:
*Release of Information: List names of those who may receive your Protected Health Information: (medical records,prescriptions,labs etc.)	

Patient Insurance

Insurance Name:	ID#	Group#	Insurance Phone Number	
Policy Holder Name	D.O.B	SSN	☐ Male ☐ Female	Relationship to patient
Policy Holders Address (if different then above)		Employer Name (if insurance is through work)		

Secondary Insurance

Insurance Name:	ID#	Group#	Insurance Phone Number	
Policy Holder Name	D.O.B	SSN	☐ Male ☐ Female	Relationship to patient
Policy Holders Address (if different then above)		Employer Name (if insurance is through work)		

Pharmacy Information

Name:	Address:	Phone Number:	Fax number:

Responsible Party Information

Name (if other than patient)	Relationship to Patient	Date of Birth
Signature	Today's Date	
FOR OFFICIAL USE ONLY	Accepted & Checked by:	**Account ID:**

HOMETOWN HEALTHCARE

Patient Name: _____ **Date of Birth:** _____

Medical Information

Allergies to Medications & Reactions

_____

_____

_____

_____

Surgery History (procedure, reason & date)	Pregnancies (# of pregnancies, # of births, # of miscarriages)
_____	_____
_____	_____
_____	_____

Menstrual History : Age of Onset _____ Painful Periods: YES / NO Irregular Periods: YES / No

Past Medical History (Check if you have or had the following)

□ **Asthma**	□ **Tuberculosis**	□ **HIV/ARC/AIDS**
□ **Angina**	□ **Kidney Stones**	□ **Bleeding Tendency**
□ **Gout**	□ **Osteoporosis**	□ **High Cholesterol**
□ **Stroke**	□ **Endometriosis**	□ **Diabetes age _____**
□ **Ulcers**	□ **Degenerative Arthritis**	**Type _____**
□ **Thyroid**	□ **Rheumatoid Arthritis**	□ **Heart Attack/ at age _____**
□ **Valley Fever**	□ **Venereal Disease**	□ **Cancer/ Type _____**
□ **Heart Failure**	□ **High Blood Pressure**	□ **Erectile Dysfunction**
□ **COPD**	□ **Emphysema**	□ **Migraines**
		□ **Other _____**

Have you had a Blood Transfusion? YES / NO If yes, what year? _____

Family History

Mother's Age _____ If deceased, age and cause of death: _____
Father's Age _____ If deceased, age and cause of death: _____
Indicate which family member, has the family:
(F)Father (M) Mother (S) Sister (B) Brother (GM) Grandmother (GF) Grandfather
____Stroke ____ Diabetes ____High Cholesterol ____ Rheumatoid Arthritis ____ Cancer ____ Alcoholism
____ Hearth Attack ____ High Blood Pressure ____ HIV

Social History

Type of work: _____ Stressful ____ Hazardous ____ Heavy Lifting ____
Exercise: YES / NO # _____ times per week
Alcohol: YES / NO # _____ drinks per day *If you used to, when did you quit? _____
Do you smoke? YES / NO Did you ever? YES / NO How Many Daily? _____
When did you quit? _____ Are you Left Handed _____ or Right Handed _____ ?

Immunizations

All immunizations up to date? YES / NO	Tetanus with in last 10 yrs.? YES / NO

Current Medication ** (List name, dosage and frequency)**

_____

_____

_____

_____

HOMETOWN HEALTHCARE

Thank you for choosing HOMETOWN HEALTHCARE as your healthcare provider. We are committed to providing quality medical care. We ask that you read, sign, and return this form to us prior to your treatment.

CONSENT FOR MEDICAL TREAMENT

Patient, or patient's legal representative, agrees to the following terms of treatment:
I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding any illness, injury or health concern affecting me at any time I am present at HOMETOWN HEALTHCARE. These services may include, but not limit to, laboratory procedures, x-ray examinations, and medical or surgical treatment or procedures. I have read and understand this treatment agreement. I am the patient, the parent of minor child, or the legally authorized representative of the patient and an authorized to act on behalf of the patient to sign this agreement.

X_____ _____ _____
Signature Relationship to patient Date

X_____
Print Name

Financial Policy

- All patients must provide accurate and complete personal and information prior to being seen by the doctor.
- Payment is required at the time of service and may be in the form of cash, check, debit, or credit card**.**
- HOMETOWN HEALTHCARE may disclose all or part of a patient's medical or financial records (including information related to alcohol and drug abuse, mental health diagnosis and treatment, HIV related or other communicable disease related information) to third parties to obtain payment for services provided.
- We will gladly file your claim with your insurance. It is your responsibility to comply with any per-determination or notification requirements of your insurance plan. Many of the services provided may be covered and paid for by your insurance company. Unfortunately, insurance companies do not pay for all services that the provider may deem appropriate.
- In all cases we require the guarantor, the person who is financially responsible, to be personally liable for all balances.
- The Guarantor agrees to pay any and all applicable fees should the account be referred to an outside collection agency, including, and not limited to 33% of the account balance at the time it is sent to collections.
- HOMETOWN HEALTHCARE may charge reasonable fees for services related to your account including, but not limited to, interest on unpaid accounts, and medical record copies.
- Your personal information will be verified/updated at each visit, to ensure information on file is accurate.
- We will collect a deposit on the charges you incur today toward your balance (e.g. copay, deductible, coinsurance, self pay) and bill you for any remaining balance.
- Federal laws require that we submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. We are not allowed to change information just so insurance company can pay a claim.

I certify that the information provided is true and accurate. I assign any payable benefits to be paid directly to HOMETOWN HEALTHCARE and authorize them to submit a claim on my behalf. I understand that I am financially responsible for any non-covered service. I authorize HOMETOWN HEALTHCARE to release any information required to process claims for my care and treatment. I have read and understand the financial policy and agree to abide by it.

Signature: _____ Print: _____ Date:_____

HOMETOWN HEALTHCARE

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information"(PHI) by HOMETOWN HEALTHCARE in in order to carry out treatment, payment, or health care operations. The patient should review Premier Health's Notice of Privacy Practices for Protected Health information for a more complete description of the potential uses and disclosures of such information and patient has the right to review such Notice prior to signing this consent form.

HOMETOWN HEALTHCARE reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at the any time. If HOMETOWN HEALTHCARE does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice requesting a copy.

I understand that, and consent to, the following appointment reminders that will be used by HOMETOWN HEALTHCARE, by email, a telephone call at designated number and leaving a message on a voice mail or with a person answering the phone.

This consent is valid for seven years. At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the facility in writing. The revocation shall be effective except to the extent that HOMETOWN HEALTHCARE has already taken action in reliance on the Consent.

Health Current
I acknowledge that I received and read the notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the (HIE) unless I complete and return an OPT out form to my healthcare provider.

I have read and understand this information. I am the patient or am authorized to act no behalf of the patient to sign this document verifying consent to the above stated terms.

Signed this _____ day of _____, 20 _____.

X_____
(Patient Signature)

X _____
(signature of Guardian if applicable)

X_____
(please print patient name)

HOMETOWN HEALTHCARE

3001 N. Main street Suite 1B Prescott Valley, AZ 86314 * Phone (928) 259-5506 * Fax 1 (888) 494-0749

Medical Record Release

Authorization for Disclosure of Protected health information

Patient Name:_____ **Date of Birth** _____ **SSN:** _____
****PLEASE OBTAIN RECORDS FROM:**
Name of organization/provider/clinic_____

Street address _____

City,state,zip code _____

Phone # _____Fax # _____
**** PLEASE SEND RECORDS TO:**
Name of organization/provider/clinic **HOMETOWN HEALTHCARE**
Street Address **3001 N. Main Street Suite 1B**
City,state, zip code **Prescott Valley AZ, 86314**
Phone # **(928)259-5506** Fax # 1 **(888) 494-0749**

This information is to be disclosed to HOMETOWN HEALTHCARE for the purpose of medical care. I understand this authorization may be revoked in writing at any time, except to extend that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from today.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized here in. I am aware that this information may be sent via fax and or carrier agency (i.e. US Mail, Federal Express, UPS, etc.).

I understand the medical records may include information relating to:

- Acquired immunodeficiency Syndrome (AIDS) or infection with Human immunodeficiency virus (HIV)
- Psychiatric Care
- Treatment for Alcohol and/ or Drugs Abuse
- Communicable Disease

Signed:_____ Date _____
(patient/parent/guardian/ other-please specify)

IF RECORDS ARE RELEASED DIRECTLY TO PATIENT:

I, _____ acknowledge receipt of the above directed records. I confirm that this release of records was only valid for records that I have.

Signed:_____ Date _____
(patient/parent/guardian/ other-please specify)

Request for records completed by:	**Date:**

Policies and Agreements Form
Patient Copy

We appreciate you for choosing HOMETOWN HEALTHCARE (HTHC) as your primary care provider! Certain guidelines are out in place to ensure that we can give our patients outstanding medical care. Please take note of the following:

Payment Policy:
Payment is required when services are rendered. This allows us to offer quality medical care while keeping costs under control. You may pay by CASH, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. We do not accept personal checks as a form of payment. Insurance co-payments and outstanding balances (if any) must be paid at the time of service.

Appointment Time/No-Show Appointments/Same Day Cancellations:
New patients are expected to check in 30 mins prior to their scheduled appointment. **Established patients** are expected to check in 10 mins prior to their scheduled appointment time. If a patient checks in 6 mins. After their scheduled appointment time, patient may not be seen depending on the provider's schedule. Please mindful of the appointment that we have reserved for you. We charge a $50.0 NO-SHOW FEE. If you arrive 10 mins. After your appointment time, this is also considered a no-show. Rescheduling for a no-show does not replace patient no-show charge of $50.00.

Co-payments, Deductible & Coinsurance:
Under contractual obligations, we are required to always collect co-pays from the patient. A co-pay does NOT guarantee full payment of service from your insurance carrier. If you have not met your deductible, a $100.00 will be collected at time of service to be applied toward your deductible. It is your responsibility to know your insurance benefits. We only verify primary insurance courtesy to our patents.

Denial of Insurance Coverage:
If HTHC is given incorrect patient or insurance information resulting to a denial of coverage, than the patient (or whoever is the responsible financial party) will be responsible for the full payment of denied coverage.

Use of Electronic Communication:
As we strive to make our office efficient, we'd like to give you the option to receive documents (radiology or lab results, billing statements, etc.) through patient portal. This is done per HIPAA accordance. You may request to review our Notice of Privacy for Policy for protected Health information (PHI) from our front office staff.

Advanced Beneficiary Agreement:
For patient insured under Medicare, please note that your insurance does not pay for all of your health care costs.
When you receive an item or service that is not a Medicare Benefit, you are responsible to pay for it personally or through any other insurance that you may have.

Cash Discount Prices:
We understand that not everyone has access to health insurance. We offer cash discounts only for non-insured patients who pay the full amount at the time of service. We have adjusted our cash prices to reflect the increasing cost of our medical supplies.

Changes to Office Policies and Agreements:
HTHC reserves the right to change the contracts of this Policies and Agreements Form at any time. As our patient, you agree to abide by the most recent version of this form. You may ask for the revised copy from our office staff.

Comment and/or Concerns:
We welcome any helpful suggestions and constructive criticism. Send us an email: office.hometownhealthcare@gmail.com