**NEW PATIENT INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Patient Information** | Name (Last, First, MI): | | | DOB: | Today's date: | |
| Street Address: | | | City: | State: | Zip: |
| Home Phone  ( )  Harvey Balls 0% with solid fillPreferred | Work Phone  ( )  Harvey Balls 0% with solid fillPreferred | Cell Phone  ( )  Harvey Balls 0% with solid fillPreferred | Gender:  Harvey Balls 0% with solid fillMale Harvey Balls 0% with solid fillFemale Harvey Balls 0% with solid fillOther\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Marital Status:  Harvey Balls 0% with solid fillSingle Harvey Balls 0% with solid fillMarried Harvey Balls 0% with solid fillDivorced Harvey Balls 0% with solid fillWidowed Harvey Balls 0% with solid fillSeparated Harvey Balls 0% with solid fillPartner Harvey Balls 0% with solid fillOther | |
| SSN: | Race: | Ethnicity: | Preferred Language: | | |
| Email Address: | | | Spouse's Name: | | |
| **Financially Responsible Party** | Is patient responsible party/guarantor? Harvey Balls 0% with solid fillYes Harvey Balls 0% with solid fillNo  (If you are over the age of 18 & not in the care of an institution you are the guarantor as you are the person responsible for any charges you may incur during your visit(s)). If yes you do not need to fill out this information. | | | | | |
| Name (Last, First, MI): | | | DOB: | City: | |
| Street Address:  City: | | | City: | State: | Zip: |
| Home Phone  ( )  Harvey Balls 0% with solid fillPreferred | Work Phone  ( )  Harvey Balls 0% with solid fillPreferred | Cell Phone  ( )  Harvey Balls 0% with solid fillPreferred | Occupation: | Employer: | |
| Email Address: | | | Relationship to patient: | | |
| **Emergency Contact** | Name: | | | Relationship to patient: | | |
| Home Phone  ( )  Harvey Balls 0% with solid fillPreferred | | Work Phone  ( )  Harvey Balls 0% with solid fillPreferred | Cell Phone  ( )  Harvey Balls 0% with solid fillPreferred | | |
| **PCP**  **Info**  **Referral**  **Info** | Referring Physician's Name: | | | Physician phone/fax:  ( ) | | |
| Physician Address: | | |
|  | Previous Primary Care Physician: | | | Physician phone/fax:  ( ) | | |
| Physician Address: | | |
| **Insurance Information** | Primary Insurance Company: | | Name of Insurance Holder: | Policy # | Group # | |
| Patient's Relationship to insured:  Harvey Balls 0% with solid fillSelf Harvey Balls 0% with solid fillSpouse Harvey Balls 0% with solid fillChild Harvey Balls 0% with solid fillOther\_\_\_\_\_\_\_\_\_ | |
| Insurer's Social Security #: | Gender:  Harvey Balls 0% with solid fillMale Harvey Balls 0% with solid fillFemale Harvey Balls 0% with solid fillOther\_\_\_\_\_\_\_\_ | Employer of Insurance holder: | Date of Birth: | Work Phone:  ( ) | |
| Secondary Insurance Company: | | Name of Insurance Holder: | Policy # | Group # | |
| Patient's Relationship to insured:  Harvey Balls 0% with solid fillSelf Harvey Balls 0% with solid fillSpouse Harvey Balls 0% with solid fillChild Harvey Balls 0% with solid fillOther\_\_\_\_\_\_\_\_\_ | |
| Insurer's Social Security #: | Gender:  Harvey Balls 0% with solid fillMale Harvey Balls 0% with solid fillFemale Harvey Balls 0% with solid fillOther\_\_\_\_\_\_\_\_\_ | Employer of Insurance holder: | Date of Birth: | Work Phone:  ( ) | |
|  | By signing below, I acknowledge that the information I provided is correct to the best of my ability.  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Guarantor Signature (if other than patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

Due to the increased control of health care by insurance companies, we explain the following services for your consideration

***Annual Physical/Well Women/Well child exam***

|  |  |
| --- | --- |
| Insurance coverage *usually* includes:  -Physician Orders for screening tests  -Screening lab work  -Preventative vaccinations  -Breast exam/ Pelvic exam -Pap testing | This does NOT include:  -Medical complaints  -Illnesses Concerns which include but are not limited to: Depression, anxiety, upper respiratory infection, fatigue symptoms, hormonal imbalance, problems urinating, birth control, skin lesion removal, vaginal infections, weight management. |

Your insurance company may **not pay 100% for your preventative visit or may bill you a co-pay** if you choose to discuss illness/non preventative complaints during your preventative visit. We are happy to address additional medical concerns at this visit as long as you are aware that you may potentially be billed by your insurance as a non-preventative visit.

I have read and understand the information stated above, and I understand that I am ***financially responsible*** for all services not paid by my insurance carrier.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Lab Information**

Your provider may feel it necessary for you to have lab testing done. It is ***your responsibility*** to check with your insurance regarding which tests will be covered under the diagnosis listed on the lab requisitions. LabCorp and other third-party labs routinely perform tests on specimens from our office. Therefore, you may receive a separate bill from one of these laboratories. It is ***your responsibility*** to know which laboratory your insurance will cover. If you have questions about lab prices or a bill you receive, please call number the listed on the bill, as we are not able to discuss outside accounts.

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

**Payment for Services**

Standard Cash Fee's (these prices are per visit)

\*Blood work, procedures & or medications may incur additional fees\*

|  |  |
| --- | --- |
| New Patient Family Practice Visit | $120 |
| Return Patient Family Practice Visit | $90 |
| Sport/Scout Physical | $25 |
| Initial weight loss appointment | $130 |
| Return weight loss appointment | $100 |

Fees may vary depending on insurance contracts or if arrangements have been made with the individual client or a third-party payer, such as clergy. *Payments are to be made at the beginning of each appointment*. Cash, and most major credit cards are accepted. There will be a 2% charge on all credit cards. NO CHECKS ACCEPTED.

**Insurance**

Some insurance companies will cover a portion of the costs associated with provider visits. Because policies differ regarding coverage and limitations, you are strongly encouraged to contact your insurance carrier to determine the limits of your coverage. In most cases, we will bill your primary insurance company and provide the necessary documentation required. Please remember that any charge **not covered** by your insurance will be **your responsibility. Your portion of the payment (co-pay, deductible or co-insurance) is required to be paid at the time of service.**

**Acknowledgement of financial responsibility and payment for services: (Please initial) \_\_\_\_\_\_\_\_\_**

**APPOINTMENT REMINDER INFORMATION**

**Cancelation Policy & Credit Card Information**

**Brandy Marie Tafoya, APRN-C & Brandy Marie Family & Aesthetic Care**

Appointment reminders are provided as a courtesy but are not a guaranteed service and may occur less than 24 hours before the scheduled appointment. Late Cancellation and No-show fees will still apply even if an appointment reminder is not provided or received.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like appointment reminders? Yes NO

If Yes, how would like the reminders delivered? (Please select one)

initial\_\_\_\_\_\_\_\_\_ Text (message rates and costs will be an expense to the patient): #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

initial\_\_\_\_\_\_\_\_\_ Phone Call: #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home or Cell (Circle which number this is)

**Late Cancellation of Appointments & No-Show Policy**

On occasion, a situation may arise which prevents you from keeping a scheduled appointment. It is required that you notify Brandy Marie Family & Aesthetic Care ***24 hours*** in advance of an appointment you cannot keep. If an appointment is cancelled with less than 24 hours' notice you will be expected pay a **Late Cancellation** fee of **$50.00**. If you do not come to a scheduled appointment and fail to give any notice *prior to the appointment* (phone call, email, text, etc.) you will be expected to pay a **No Show** fee of **$50.00**. Exceptions may be granted to waive the fee in emergency situations but must be approved by the provider, Brandy Tafoya, APRN-C.

The purpose of these fees is to encourage responsibility on the part of the patient and to ensure that the provider's time, which has been reserved for you, is utilized efficiently. Late Cancellations and No Shows prevent the provider from using the period reserved to assist other patients who may need the appointment time. In addition, Late Cancellations and No Shows affect the provider financially. Consequently, these fees are in place to resolve these issues and are not typically waived.

**Calls to reschedule in advance may be made *during business hours* (M-F, 9AM-5PM) at the main line at 801-866-5353. If rescheduling needs to take place *after hours or on weekends* calls/texts can be made directly to Brandy Tafoya, APRN-C at 801-866-5353.**

By initialing below, I accept the responsibility to come to scheduled appointments, cancel appointments with a minimum of 24 hours advance notice, or pay the **Late Cancellation** or **No-Show** fee.

**Acknowledgement/Acceptance of Late Cancellation/No Show policy: (Please initial) \_\_\_\_\_\_\_\_\_**

**Card on File Agreement**

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Cardholder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Billing address on card including zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card expires on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CCV Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Brandy Marie Family & Aesthetic Care, LLC. to keep my account information on file for payment and to initiate debit or initiate charge entries on this account, as amounts are owed for the Patient Account listed above. I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. I understand that a debit or charge may be made to my bank account or credit card account periodically to pay for amounts owed. If my bank account or credit card information listed above changes for any reason, I will notify Brandy Marie Family & Aesthetic Care. This authorization shall remain in effect until card expiration date as listed above or until Brandy Marie Family & Aesthetic Care has received a written notification from me of its termination. In the event of a returned ACH declined charge, my account will be charged a $25.00 service fee for each occurrence.

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Description of Services**

We welcome you to Brandy Marie Family & Aesthetic Care *and* hope that your visit will be worthwhile. The following information is important for your consideration. Your goals are more likely to be met when you understand the nature and limitations of each visit to your primary care provider.

**Goals and Outcomes**

Generally, well visits most useful tool in helping individuals improve themselves and their overall health when they are seen every 6 months. Therefore, this clinic has adopted a 6 month visit policy for any and all prescription medications, managed by this clinic, to be refilled, renewed or dose adjusted.

**Benefits and Risks**

Most people experience improvement with their overall health when being seen by their provider every 6-months. We do understand that there is a risk of infection, whether that being viral or bacterial in nature when traveling outside of their home to see their provider.

**Other Areas of Discussion**

We encourage you to ask about areas of concern. Please note that if this a routine health physical a secondary visit will be billed to your insurance. This may also be the case if a visit was made for a different reason and additional concerns are presented at the visit and not informed upon making such visit with scheduling. This is due to time is allotted per patient concern and when additional concerns arise time has not been allotted taking time from the following patients.

***Brandy Marie Family & Aesthetic Care - does not provide emergency care. In the event of an emergency, you should call “911” and/or proceed to the nearest emergency room.***

**Confidentiality**

We understand that the information you share with your primary care provider can be very personal and that you may not want us to disclose this information to others without your authorization. The *Notice of Privacy Practices* that you have received describes the ways in which we may use and disclose health information about you. It also describes your rights and our obligations regarding the use and disclosure of that information. All clients will be asked to sign an *Authorization for Release of Confidential Information* form Brandy Marie Family & Aesthetic Care and we will not release confidential information without this written authorization, unless such release is otherwise authorized or required by law. However, you hereby authorize release of information for insurance claim purposes. You also authorize any medical information to be released to your referring physicians. Potential self- harm or harm to others, subpoenas, and other child abuse or neglect are also exclusions to this confidentiality. In addition, medical records cannot be released to another provider or agency unless all outstanding accounts have been paid in full. All records are kept as secure as reasonably possible. No one will have access to your records without your knowledge and consent.

**Grievance**

You have every right to be treated with respect and dignity in a safe environment. Discrimination is not tolerated. If you have concerns about the services you receive, talk with your therapist.

**I have read the *Description of Clinical Services* and understand that I am working directly with *Brandy Tafoya, APRN-C & Brandy Marie Family & Aesthetic Care* not with *Breen Family Medicine.* I hereby release *Breen Family Medicine, the landlord and clinic spaced share with Brandy Marie Family & Aesthetic Care* from any and all liability. I understand that I am encouraged to ask questions and give input regarding the Provider-Patient Experience at any time. If there is anything in this form that I do not understand, it is my responsibility to seek clarification.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client’s Signature (or Legal Guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

**Notice of Privacy Practices & Reviews**

**Notice of Privacy Practices**

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Why We Are Providing You with This Notice**

We are required by the federal law known as the *Health Insurance Portability and Accountability Act* (HIPAA) to give you this notice. This Notice will tell you about the ways in which we may use and disclose health information about you and will inform you of your rights and our obligations regarding the use and disclosure of that information.

**Your Health Information**

This Notice applies to the information and records we have about your health, health status, and the health care services you receive from *Brandy Marie Family & Aesthetic Care.* This information and records relate primarily to primary care services you have received from us.

**How We May Use and Disclose Health Information About You**

**For Treatment**

We may use or disclose health information about you to facilitate counseling and other health treatment. For example, your provider might disclose information about you to another *provider* so that your provider might determine the most appropriate care for you.

**For Payment**

We may use and disclose health information about you so that we can be compensated by you, an insurance company, another party, including present or future ecclesiastical leaders if they are paying any portion of the fee for the services, we provide you. For example, we may need to provide your insurance company information about our services to you so that your insurance company will compensate us for these services.

**For Office Operations**

We may use and disclose health information about you in order to operate our office and to make sure that you and our other patients receive the best care possible. For example, we may use your health information to evaluate the performance of our staff or to contact you to remind you of your appointments.

***Please notify us in writing if you do not want us to contact you to remind you of your appointments.***

**Special Situations**

We may use or disclose your health information without your permission for several reasons. These reasons include:  
Disclosing your health information when we believe such disclosure is necessary to prevent a serious threat to your health and safety or the health and safety of another person.  
Disclosing your health information as required by federal, state, or local law.  
Disclosing your health information as required by law to prevent injury or suspected abuse or neglect.  
Disclosing your health information in response to a court order, subpoena, warrant, summons or similar process.

**Other Uses and Disclosures of Health Information**

Except where otherwise required or authorized by law, we will not use or disclose your health information for any purpose without your written authorization. If you authorize us to use or disclose health information about you, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons identified in your written authorization, but we cannot undo any uses or disclosures that have already occurred with your permission.

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**Your Rights Regarding Your Health Information**

You have the following rights with regard to your health information

* You may inspect and copy your health information, with certain exceptions.
* If you believe that your health information is incorrect or incomplete, you may request that the information be amended and/or updated.
* You may obtain an accounting of our disclosures of your health information. This is a list of all of our disclosures of your health information for purposes other than treatment, payment and health care operations.
* You have the right to request that we restrict or limit our use or disclosure of your health information to only treatment, payment or health care operations. We are not required to comply with your request.
* You may request that we communicate with you regarding your health matters in a certain way or at a certain location. For example, you can request that we only contact you at work or by mail.
* You have the right to receive a paper copy of this Notice.

If you want to exercise any of these rights, please notify Brandy Marie Family & Aesthetic Care in writing.

**Changes To This Notice**

We have the right to change this Notice. If we do so, the new Notice will apply to the health information we may already have about you and to the health information we receive in the future. We are required to abide by the most current Notice that is in effect. We will post a summary of the most current Notice in our office. You are entitled to receive a copy of the most current Notice.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with *Brandy Marie Family & Aesthetic Care and* please contact Brandy Tafoya, APRN-C, Owner & Provider of *Brandy Marie Family & Aesthetic Care @ 801-866-5353*. You will not be penalized for filing a complaint.

**Acknowledgement of Receipt of Notice of Privacy Practices**

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Brandy Marie Family & Aesthetic Care Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Brandy Marie Family & Aesthetic Care's Notice of Privacy Practices, please do not hesitate to contact a clinic representative.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Printed): Patient Representative and relationship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Date Notice Received:

**Release of Information**

□I authorize the release of information including the diagnosis, records; Examination rendered to me and claims information. This information may be released to:

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

□Child(ren): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

□Information is not to be released to anyone.  
This Release of Information will remain in effect until terminated by me in writing.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient/Responsible Party Signature Date

**Messages from Provider (Please call):**

□my home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □my work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□my cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If unable to reach me:**

□you may leave a detailed message  
□please leave a message asking me to return your call □do not leave a message

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Date Signed: