Holmes Family Care

2564 NW Edenbower BLVD Ste 126
Roseburg, OR 97471
Phone: (541) 672-7718 Fax: (541) 315-7125
Email: office@holmesfamilycare.com

Please note: we must maintain the most up to date and accurate information on our patients. In addition to the face sheet present to you at every visit, we will request that you review and update this form at least once a year.

Date: _____

Patient Information

First Name: _____ MI: _____ Last Name: _____

SS#: _____ DOB: _____ Sex: _____ Preferred Pronouns: _____

Parent/Legal Guardian Name (if patient is a minor) Name: _____ DOB: _____

Address: _____ APT #: ___ City: _____ ST: ___ ZIP: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____ Would you like to be signed up for the portal? O Yes O No

Please check the boxes below:

Best Contact Method: O Home O Cell O Work O E-mail O Mail O Portal
By checking one of the boxes for best contact method, I agree to receiving correspondence from HFC.

Material Status: O Single O Married O Divorced O Widowed O Separated O Life Partner

Employment Status: O Full-time O Part-time O Unemployed O Student O Disable O Retired

Race: O White O African American O Asian O American Indian/Alaska Native O Native Hawaiian/Pacific Islander O Declined O Other: _____

Ethnicity: O Not Hispanic/Latino O Hispanic/Latino O Declined Preferred Language: O English O Spanish O Other: _____

Do you have any communication difficulties/special needs? O No O Hearing loss O Interpreter required O Reading difficulty O Sight impaired O Other: _____

Financially Responsible Party

O Same as patient information (if different, please complete section below):

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Relationship: O Spouse O Parent O Guardian O Other: _____

Address: _____ APT #: ___ City: _____ ST: ___ ZIP: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____ Employer: _____

Emergency Notification

Name: _____ Relationship: _____

Phone: Home: _____ Cell: _____

Name: _____ Relationship: _____

Phone: Home: _____ Cell: _____

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Contact Information

How would you like to be notified of normal/negative lab/imagining results? O Phone (voicemail okay) O Portal O Letter

How would you like to be reminded about appointments? O Text O Phone Call

Do we have permission to leave a detailed voicemail? O Yes O No

Insurance Information

Primary Insurance: _____

ID: _____ Group #: _____

Policy Holder Name: _____ Policy Holder's DOB: _____

Relationship: O Self O Spouse O Parent O Other: _____

SS#: _____ Employer: _____

Secondary Insurance: _____

ID: _____ Group #: _____

Policy Holder Name: _____ Policy Holder's DOB: _____

Relationship: O Self O Spouse O Parent O Other: _____

SS#: _____ Employer: _____

Medication Refill

Please contact your pharmacy for medication refills. Your pharmacy will fax us a medication refill request. Refill authorization may require 48-72 hours. Please allow sufficient time for us to process your refill request.

Initials: _____

Primary pharmacy name: _____ City: _____

Secondary pharmacy name: _____ City: _____

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Pediatric History Form:

Patient Name: _____ DOB: _____

Parent/Guardian Name: _____

Previous PCP: _____ Date of last physical: _____

Do you vaccine your child? O Yes O No Which lab do you prefer? O Mercy O Quest

How did you find out about our office? _____

Birth History:

O Boy O Girl Birth weight: ____lbs ____oz Birth Hospital/State: _____

O Full-term (37wks and up) O Premature (less than 37wks) # of weeks _____

O Vaginal O C-section O Forceps O Vacuum

Special interest/hobbies/activities:

_____

Care/Education:

O At home O Day Care O Pre-School O Elementary O Middle School O High School O Homeschool

Medical History

Medications:

Medications:	Dose:	Times Per Day:

Personal Medical History:

Does your child have any history of any medical conditions listed below? (if yes, check next to the condition)?
O None

Genetic:
O Chromosome Abnormality

Growth:
O Short Stature
O Overweight

Learning:
O Special Education
O Dyslexia

Behavior/Mood:
O ADHD
O Anxiety
O Obsessive-compulsive
O Depression

Development:
O Delay-speech/language
O Delay-motor skills
O Autism

Vision:
O Strabismus
O Amblyopia
O Myopia
O Astigmatism
O Cataract

Hearing:
O Multiple Ear Infection
O Ear Tubes
O Hearing Loss

Other medical conditions not listed: _____

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Specialty Care:

Has your child ever seen a medical specialist? O Yes O No

If yes, please describe: _____

Please describe any specific concerns you would like to discuss regarding your child:

_____

Surgeries

Type (specify left/right):	**Date:**	**Location/Facility:**

Hospitalizations:

Reason:	**Date:**	**Location/Facility:**

Household Information:

Please list all those living in the child's home:

Name:	**Relationship to Child**	**DOB:**

Smokers in the household? O Yes O No
Guns in the house? O Yes O No
Pets in the house? O No O Yes. What kind? _____

Parents: O Married O Live Together O Divorced O Single Parent O Remarried

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

_____
_____
_____

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Family History:

Name:_____ DOB: _____

Family Members	Statues: (Alive or Deceased)	Year of Birth	Diabetes	Hypertension	Heart Disease	High Cholesterol	Cancer	Mental Illness
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Brother (s)								
Sister (s)								
Son (s)								
Daughter (s)								

Other: _____

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Agreement of Financial Responsibility

Clinic Responsibilities:

- Provide accurate and timely billing
- Provide your bill to you in a paper statement

Patient Financial Responsibilities:

- Provide your **insurance card** at each visit to ensure that we bill your insurance correctly
- Please be familiar with your insurance coverage and limitations. This is a contract between you and your insurance company, and it is your responsibility to know your benefits. We do not have control over your coverage or co-pay rates. It is also your responsibility to determine whether the plan is 'in network' with the physician. Out of network plans will accrue higher costs.
- **Co-payments** are to be paid at each visit
- We will bill you primary and secondary insurance company first; any remaining balance will be billed to you. Patient due balances noted on your monthly statement are due within 30 days of receipt.
- Some insurance plans do not cover certain procedures, such as newborn circumcisions, employment exams, sports physicals and treatment of cosmetic skin lesions. In such cases, you will be asked to sign a waiver agreeing to pay for the visit at the time of service. You may want to call your insurance company ot determine coverage for a procedure that is being considered.
- For our self-pay patients, we require payment in full at the time of your service.
- We require at least 24-hour notice if you are unable to keep your appointment. Missing an appointment without notice and/or arriving too late to be seen is considered a no show and is subjected to a $50.00 penalty.
- Accounts delinquent beyond 60 days will be subject to transfer to an outside collection agency at the patient's expense. Repeated failure to pay may results in patient dismissal from the clinic.

Updates to this policy can be found on our website. Please let us know if you have any questions. Call our Billing Department at **541-672-7718 option 1.**

I have read, understand, and agree to the above Agreement of Financial Responsibility. I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

Patient Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

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No Show and Late Arrival Policy

Thank you for choosing Holmes Family care for your medical needs. We schedule our appointments with the aim to provide each patient the right amount of time to receive the highest quality of care. While we understand that life is unpredictable, any time a patient misses an appointment another patient is prevented from receiving care. These policies are in place to give us time to schedule other patients who may be waiting for care and to ensure that patients who arrive on time do not wait longer than necessary to see the provider.

Rescheduling:

If a patient needs to cancel or reschedule an appointment, please contact our office as soon as possible and no later than 24 hours prior to the scheduled appointment time. Office phone number is: 541-672-7718. **If the office doesn't answer, please leave a message with name of patient, date of birth and appointment time.**

No Show Policy:

Patients that no show their appointment without cancelling at least 24 hours prior to appointment time will be considered a **"No Show."**

After the second no show, patient will be charged a fee of $50.00. This fee **must** be paid before a patient can be seen.

After the third no show and/or cancellation/reschedule without 24-hour notice, patient may be dismissed from the practice.

Late Arrival Policy:

If a patient is more than 10 minutes late from the scheduled appointment time, the appointment will be rescheduled. Patient will be given the option to wait for a later appointment time on the same day if one is available.

If patient arrives more than 10 minutes late for their new patient appointment or arrive at the scheduled appointment time without completed registration forms, patient may be asked to reschedule.

Insurances **will not** reimburse for these fees therefor it will be assessed directly to the account guarantor.

By signing below, I am acknowledging having read and understanding the Polices and Fee's outlined above and agree to its terms.

Patient Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

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Protected Health Information Disclosure

Please provide a list of all individuals **(including parent/guardian)** we may speak with in regards to the patient's medical information including; leaving a message in regards to medical care, appointment scheduling or confirming, and payment information or account balances.

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This undesigned patient or patient representative agrees as follows:

1. Authority is granted to Holmes Family Care to render needed treatment to the patient.
2. I authorize release of information about my medical history, lab/imagining results, billing questions, confirming and scheduling appointments to the individuals above.
3. I authorize Holmes Family Care to release information regarding my treatment to my insurance company for billing purposes.
4. I authorize payment of medical benefits to Holmes Family Care for services rendered.
5. I understand that I am responsible for all charges incurred through Holmes Family Care.
6. Authorization Period: O One year **OR** O Lifetime

Please provide a list of individuals that are able to **bring** patient to their appointments, aside from parent or guardian.

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____

I request that payment under the medical insurance program be made to Holmes Family Care on any bills for services furnished me during the effective period of this authorization and I authorize the above name Holmes Family Care to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If this becomes necessary to effect collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

You may receive an additional bill from our office if you received additional services during your visits. This may be but is not limited to: injections, immunizations, urine test, etc.

Patient Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

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Patient Rights and Responsibilities

Patient Rights:

- To receive care that is considerate and respectful, without discrimination of any kind based on race, color, sex, language, religion, political, national or social origin, disability, age, martial and family status, sexual orientation and gender identity, health status, place of residence or economic and social situation.
- Get up-to-date, complete and honest information
- Have things explained in the language you want to use.
- Know all the facts we have about your illness, treatments and what may happen.
- Know the name and specialty of the people taking care of you.
- Agree or disagree to treatment options (as allowed by law)
- Take part in planning and carrying out your care.
- Have privacy with all your records, when your provider examines you and talks with you (as allowed by law)
- Know how your doctor works with the other places that take care of you.
- Be evaluated and treated for pain
- Be treated right away if you might die, even if you don't have insurance or cannot pay.
- To agree to an Advance Directive, such as a health care proxy.
- Get a detailed explanation and a copy of your bill.
- If you have a complaint, we must respond to you in a reasonable amount of time.
- See, copy, correct or restrict use of the information in your medical record (as allowed by law)
- Decline to being examined, observed or treated by a student or staff member. If so, you will still be treated.
- Get quick responses to questions or concerns.

Patient Responsibilities:

- Be seen in clinic at **least once a year** per insurance requirements.
- Show respect, consideration and dignity to all clinic employees.
- Communicate completely and honestly about current health and past medical history, includes medications, past illnesses or hospitalizations.
- Ask questions when something is unclear with your care.
- Notify us if there might be a problem with your care.
- Notify the clinic if you believe we did not respect your rights, if you have a complaint or an idea how we can improve our practice.
- Help the clinic be a safe place. If you see an unsafe situation or unsafe behavior, notify us.
- Try to follow the treatment plan that was discussed during your appointment. If unable to do so, please let the provider know.
- Pay your co-pay and balance when you are here. If unable to, contact our office to discuss payment options.
- If unable to make appointment, please notify the clinic within 24 hours of appointment time.
- Do not carry weapons of any kind into the clinic.
- Notify the clinic if there is any change to address, telephone number, or insurance plan.
- Notify the clinic if there is change to make to your Advanced Directive or Health Care Proxy forms. (Advance Directive notifies us what kind of care you want if, in the future, you're unable to discuss this. Health Care Proxy notifies us on who can make decisions about your care, if someday patient is unable to make decisions of themselves.

I have received a copy of and have read all my rights and responsibilities, or they have been read to me, and I understand them.

Printed Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

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Acknowledgement & Consent

I understand that Holmes Family Care will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Holmes Family Care may use and disclose my health information in order to:

- Make decisions about the plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I understand that I have the right to receive and review a written description of how Holmes Family Care will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of Holmes Family Care, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Holmes Family Care Notice of Privacy Practices is available at the front desk.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Holmes Family Care is not required by law to agree to such request.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered my own personal copy of the Notice of Privacy Practices.

Printed Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

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Authorization for Release of Protected Health Information

Holmes Family Care is committed to protecting the privacy of information about you and your health. This means that in many cases, we must obtain you authorization in order to disclose protected health information about you. Please read the information below carefully before signing this form.

Patient Name: _____ DOB: _____ Phone: _____

Records request from:

Name of Facility: _____

Adress: _____

Phone: _____ Fax: _____

Records to use or disclose to:

Holmes Family Care Phone: 541-672-7718 Fax: 541-315-7125
2564 NW Edenbower BLVD Ste 126 Roseburg, OR. 97471

_____ I authorize the release of my **compete** medical records. This authorization for release of information covers the period of health care from: Start Date: _____ to _____

Please initial beside the options below to authorize the release of sensitive information pertaining to:

_____ Mental Health
_____ Drugs or Alcohol
_____ Genetic Testing
_____ HIV/AIDS/other infectious diseases

This information may be used by the person I authorize to receive this information for medical treatment or consultations, billing, or claims payment, or other purposes as I may direct.

- **I understand that this authorization is voluntary, and that I may results to sign it.**
- **I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.**
- **I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.**
- **I understand that I have the right to receive a copy of this authorization.**
- **I understand that I have the right to inspect or copy the information to be disclosed.**
- **I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on the authorization.**

By signing below, I acknowledge that I have read and accept all of the above.

_____
Signature of Patient or Representative

_____
Printed Name of Patient or Representative Date: