CIRCLE OF LIFE FAMILY MEDICINE

CHARITY MOSES, FNP

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REGISTRATION FORM
(Please Print and send these in as soon as possible to set up appointment)

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____/_____ Cell Number: _____/_____

Email address for appointment reminders: _____

Date of Birth: _____ Sex: Male / Female Marital Status: S M D W

SSN#: _____

Race: ___ White ___ Black or African American ___ Asian ___ Other

Employer: _____ Employers Phone Number: _____/_____

INSURANCE INFORMATION:

Insurance Carrier: _____

Policy #:_____Group #: _____

Primary policy holder: _____

Date of Birth: _____ SS#: _____

****CANCELLATION, NO SHOW, AND LATE APPOINTMENT POLICY****

You must notify us (not on voice mail) within 24 hours should you choose to cancel or change your appointment.

If you do not show for a confirmed scheduled appointment (which may be left on voice mail or with a family member) without prior notification, you will be charged a $30.00 fee which will need to be paid before another appointment will be made.

If you are more than 20 minutes late for a scheduled appointment, it will be necessary to reschedule. In many cases this can be for later the same day.

We hope you understand this policy is meant to reduce your waiting time and to be fair to the staff and your fellow patients.

Signature: _____ Date: _____

(**We're not kidding**)

MEDICATION REFILL POLICY

All patients are **REQUIRED** to bring in **ALL MEDICATION AND VITAMIN BOTTLE** to every appointment. Failure to do so may result in delay of medication refills.

Please do not wait the day before your prescription runs out to call for a refill. Prescriptions are being electronically sent so this will give us **24-48 hours** to get approval and send to pharmacy.

GENERAL CONSENT FOR TREATMENT

We look forward to treating you as a patient; however, we need your permission for our physician to examine you, provide treatment, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

I GIVE GENERAL CONSENT TO BE TREATED:

Name: _____ Date: _____

FINANCIAL POLICY/ASSIGNMENT OF BENEFITS

PATIENT/PATIENTS REPRESENTATIVE: As a courtesy to our patients, the practice accepts assignment from most commercial insurance programs. ***I understand that it is my responsibility as the insurance carrier to be aware of your in and out of network benefits and lab companies, co-pays, and deductibles.*** We will file your primary insurance claim for you. Once the primary insurance has paid, we will also file your secondary insurance, if you have provided us with that information. However, insurance is a contract between YOU and YOUR INSURANCE COMPANY. Therefore, we ask that you acknowledge your responsibility for notifying staff of insurance changes and payment of our services. Also, your insurance company may ask us to provide information concerning your treatment before they will pay for the services.

If the insurance denies coverage, disallows a service, or otherwise does not pay the claim, you are still responsible for the fees at your next appointment. Balances not paid within 30 days after your first treatment will be subject to a 1 ½% service charge per month. In addition, if the fees for our services are not paid, we may turn the account over to a collection agency. Attorney fees and court costs will be added to the outstanding balance if it becomes necessary to take legal action to collect past due amounts. You will then be dismissed from practice.

I ACKNOWLEDGE IT IS MY RESPONSIBILITY TO ENSURE PAYMENT OF FEES FOR SERVICES PROVIDED BY THE PRACTICE AND AUTHORIZE THE PRACTICE TO RELEASE ANY MEDICAL INFORMATION, IF NECESSARY, TO MY INSURANCE COMPANY. THE UNDERSIGNED, GIVE AUTHORIZATON TO TREAT AND ASSIGN DIRECTLY TO CIRCLE OF LIFE FAMILY MEDICINE, ALL MEDICIAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. *I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE.* I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS AND AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

Signature: _____ Date: _____

NOTIFICATIONS AND RELEASE

It is our desire that every aspect of your service at our clinic meets or exceed your expectations. If you have any questions or concerns, suggestions for improvement in our services, or any comments, please do not hesitate to speak with a member of our staff.

PATIENT CONSENT & CLINICAL TESTING NOTIFICATION

We are thankful to be a partner with you in your healthcare. To keep you informed about your health, we will notify you about the results of clinical testing. Please tell us how you would like to be contacted by initializing the appropriate response:

_____ Please call me at this number _____ or _____
If I am not available at one of the numbers listed above, I authorize you to leave a message on my answering machine (and /or voice mail).

_____YES _____ NO

_____ I authorize you to leave a message with my spouse or family member.

_____YES _____ NO

I understand that it is my responsibility to notify CIRCLE OF LIFE FAMIY MEDICINE in writing if this information changes.
Signature: _____ Date: _____

PRIVACY RESTRICTION

New federal regulations require physician practices to keep your medical information private. Our practice has always guarded the privacy of our patients. We only share medical information with our healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will keep your record as long as you are a patient of the practice and seven years after your last visit.

I acknowledge that I am informed about the privacy of my medical records, and the practice's Privacy Policy has been made available to me.

Name: _____ Date: _____

As your healthcare provider, I want you to understand that everything you tell me is confidential. Our practice has always guarded the privacy of our patients. We only share your medical information with other healthcare providers that are participating in your care, your insurance company to provide your benefits, or for medical management issues. We will not discuss your condition with anyone else (i.e. parents/guardian, spouses, children) without approval in writing.

I understand the above statement and (check on below):

_____ I do not mind that my medical information is shared with my parent/guardian/spouse/adult child.

_____ I want my medical information to remain confidential. My protected health information should not be shared with any other individual. I realize that unless I pay cash for all services provided, there is a chance that an insurance company may request information and must be approved by Circle of Life Family Medicine, Privacy Officer.

Signature: _____ Date: _____

Emergency Treatment EXCEPTION: If the Privacy Officer agrees to a restriction. HIPAA privacy regulations provide an exception in emergency treatment for a hospital or physician to use and disclose necessary information to treat the patient

Circle of Life Family Medicine is a wellness practice. We strive for whole body fitness. Many of our services are CASH pay.

THEY ARE NOT COVERED BY INSURANCE.

These include:

Aesthetics including Botox and Fillers

Diet Supplements

IV Vitamins

Some Injections

Some Lab Work

Vitamins and Supplements

Weight Loss Program

Please be aware these services are **not covered by insurance** and payment is expected at time of services rendered. Payment will be collected before treatments. You will be notified in advance before these services are provided.

We have Quest Lab in-house. They do their own billing for Questions about your Quest Bill please call 1(800) 366-6635.

I have read the above statement. I am aware that I am responsible for any cash pay services and will pay before treatments are rendered.

Signature: _____ Date: _____

ALLERGIES/ADVERSE REACTIONS

____ No known allergies
____ Yes

MEDICATION	REACTION	MEDICATION	REACTION

MEDICATIONS

List any medications you are currently taking.

NAME	DOSE	FREQUENCY	30 OR 90 DAYS

SUPPLEMENTS

NAME	DOSE	FREQUENCY

PAST MEDICAL HISTORY

Have you had the following?	Yes	No	When?
Alzheimer's Disease			
Anxiety			
Asthma			
Anemia			
Arthritis			
Back Pain			
Atrial Fibrillation			
Blood Clots			
Cancer - Breast			
Cancer - Colon			
Cancer - Lung			
Cancer - ELSEWHERE			
COPD			
Colon problems			
Depression			
Diabetes			
Endometriosis			
GERD			
Glaucoma			
Gout			
HIV			
Headache			
Hepatitis			
Hernia			
Hypertension			
Heart Attack			
Kidney Stone			
Kidney Problems			
Liver Disease			
Migraine			
Osteoporosis			
Peptic Ulcer			
Postpartum Depression			
Prostate Problem			
Stroke			
Seizures			
Thyroid Disease			
Tuberculosis			

PAST SURGICAL HISTORY

Please list all surgeries	Date performed

SCREENING

Chest X-Ray	
Cholesterol screen	
Colonoscopy	
EKG	
Heart Disease	
High Cholesterol	
High Blood Pressure	
Mammogram	
PAP	

FAMILY HISTORY

Have any of your relatives had the following?	Yes	No	If yes, which relative?	If deceased, cause and age at death?
Diabetes				
Congenital Heart Defect				
Epilepsy				
Glaucoma				
Heart Disease				
High Cholesterol				
Hypertension				
Immunodeficiency				
Osteoporosis				
Pulmonary Embolism/DVT				
Stroke				
Thyroid Disorder				

Please give a brief description of the reason(s) you would like to see Dr. Tinney:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Tobacco: Do you now, or have you in the past used tobacco products? (check one)

____Never
____ In Past
- When did you quit? _____
- How much did you smoke? _____
- How long did you smoke? _____

____Current
- How much do you smoke? _____
- How long have you smoked? _____
- Have you ever tried to quit? _____
- What method(s) have you used? _____

Other Tobacco use:

Dip_____ Chew_____ Other _____

Recreational Drugs: Do you now, or have you in the past used recreational drugs? ___yes ___ no, what kinds? _____
- How long did you use it (them)? _____
- How often? _____

Alcohol: How many alcoholic drinks do you drink weekly? _____
What type of alcohol do you drink? _____

Caffeine: How many servings of caffeine do you have daily?
Coffee _____ Tea _____ Soft drinks _____

Diet Plan: Do you follow any certain diet plan? ___Yes ___ No
If yes, what type? _____

Depressed: Do you feel depressed? Yes ____ No_____, If yes, how _____
_____

Stress: On a scale of 1 to 10, with 10 being the worse stress, what is your normal everyday stress level? 0 1-2 3-4 5-6 7-8 9-10

Sleep: How many hours per night are you sleeping? _____
Do you have difficulty falling asleep? ____yes ____ no
Do you have problems waking up in morning? ____yes ____ no
Do you snore or hold your breath while sleeping? ____yes ____ no
Do you have difficulty staying awake while sitting quietly? ____yes ____ no