Patient Information/Demographics

Bolton Family Medical Clinic, P.C.

PATIENT INFORMATION

Patient Name: _____ Marital Status: [] S [] M [] W [] D

Date of Birth: _____ Social Security Number: _____ Sex: [] Male [] Female

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Numbers: Cell: _____ Home: _____ Work: _____

E-mail Address: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

If Student School Name: _____ Grade: _____ [] Full-Time [] Part-Time

Parent or Spouse: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Numbers: Cell: _____ Home: _____ Work: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____ City: _____ State: _____ Zip Code: _____

How did you hear about our office? _____ Name of Friend /Relative, Phone Book, Newspaper _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ **Relationship:** _____

Address: _____ **Phone number:** _____

PRIMARY INSURANCE INFORMATION

Insurance name: _____ Company: _____

Group number: _____ Identification number: _____

Address: _____ Phone number: _____

Insured's name: _____ Relationship: _____

SECONDARY INSURANCE INFORMATION

Insurance name: _____ Company: _____

Group number: _____ Identification number: _____

Address: _____ Phone number: _____

Insured's name: _____ Relationship: _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT: Signature: _____

Date: _____ If under 18 years old, relationship to patient: _____

** We must have permission from a parent or legal guardian to treat a patient under 18 years old

Office Use Only: Information Verified By: _____ *Date:* _____

BOLTON FAMILY MEDICAL CLINIC, P.C.

PATIENT QUESTIONNAIRE/ MEDICAL HISTORY

DATE_____

NAME_____ Male □ Female □ DATE OF BIRTH_____

OCCUPATION_____ □ Retired? □ Disabled? □ Unemployed? Other _____

□ Married? □ Divorced? □ Widowed? □ Single? □ Separated? □ Partner? □ Live alone? □ Caregiver?

Date last seen by a doctor? _____ Doctor's name_____ Reason?_____

PLEASE LIST ALL CURRENT/CHRONIC MEDICAL PROBLEMS, MEDICATIONS, AND ALLERGIES:

MEDICAL PROBLEMS	MEDICATION	DOSE	TIMES/DAY
	DRUG ALLERGIES: □ NONE		REACTION:

CURRENT/PAST MEDICAL HISTORY:

Check each item	Now	Past	Check each item	Now	Past	Check each item	Now	Past
Weight loss or gain			Chronic cough/emphysema			Diabetes		
Headaches/ Migraine			Difficulty breathing			Neurological problems		
Seizures/ Epilepsy			Chest pain			Anemia		
Eye disease/problems			Heart problems/ murmur			Arthritis		
Hearing problems/ loss			Heart surgery- valve/stent			Osteoporosis		
Fainting/ Dizzy spells			High blood pressure			Back pain/injury		
Head injury			Stroke			Bleeding disorder		
Allergies/ Hay fever			High cholesterol			Cancer		
Sinus problem/ infection			Circulation problems			Urinary problems		
Nosebleeds			Thyroid disease			Sexually transmitted diseases		
Ear infection/ drainage			Stomach problems/ulcer			Skin problems-eczema, etc.		
Swallowing problems			Liver disease/ hepatitis			Sleeping problems		
Asthma			Kidney disease/ stones			Depression/ Anxiety		

Other problems: _____

FAMILY HISTORY:

If anyone in your close family has/had cancer, diabetes, heart attack, stroke, high blood pressure, high cholesterol, migraine, depression, suicide, alcoholism, or other serious medical problems, please list who & what they have/had:

_____

_____

HOSPITALIZATIONS:

If you have been hospitalized for illness or surgery (except childbirth), please list dates and circumstance:

Date	Illness/Operation	Date	Illness/ Operation

SOCIAL HISTORY:

Cigarette smoker? □ Yes □ No □ Past

Packs/day _____ # years_____

Drink alcohol? □Yes □ No □ Past

How often _____ How much _____

Use other tobacco products? □ Yes □ No

Use illegal drugs? □ Yes □ No □ Past

Type: _____

IMMUNIZATIONS DATE

Flu vaccine _____

Pneumonia shot _____

Tetanus _____

*CHILDREN: CURRENT? □YES □NO

Last eye exam: _____

Last colon test/type: _____

Last blood work/type: _____

FOR WOMEN ONLY:

Last PAP_____ Normal? □Yes □No

Last mammogram_____Normal □Yes□ No

Last period_____ Normal □ Yes □ No

Birth control? □ Yes □ No Type:_____

Miscarriages/Abortions? □ Yes □No #__

Total number of pregnancies: _____

Number of living children: _____

LIST ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS:

_____

BOLTON FAMILY MEDICAL CLINIC, P.C.

Notice of Policy and Procedure

THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER!

***We encourage you to make an appointment, because we are not a walk-in clinic!**

***We require AT LEAST a 24-hour notice for cancelling an appointment. We will charge a $20.00 fee if you fail to cancel your scheduled appointment or "no-show."**

*We request a copy of all insurance cards and a photo I.D. **Please inform us of any changes in insurance, address, phone number, etc.** You may receive a bill if you fail to give us current or correct insurance information, or if your insurance fails to pay within 60 days or longer.

*If you do not have any insurance, we will expect payment before services are provided. We accept cash, credit, debit cards, and checks. However, if we are unable to verify checking funds, we have the right to refuse a check. **There is a $30.00 fee on all returned checks,** and will result in us not accepting any further payments from you by check.

*Most insurance plans have a co-pay and/or deductible. This is your responsibility, and payment is expected at the time of service. We do not extend credit. **We expect payment of at least 10% of any balance over $100.** We will be glad to work out a payment plan, but if a balance remains unpaid, we have the right to refuse service.

*Unpaid balances greater than 120 days will be turned over to a collection agency (Franklin Collections) unless you have established a payment plan with us. You will be responsible for paying the collection agency before we will see you again.

*All patient account balances will accrue a 5% finance charge and a $10.00 service charge monthly.

***Telephone messages and requests for refills may require up to a 24 hour response.** If the problem is urgent, please state the nature of urgency, and it will be given priority.

***Any controlled medication refill MUST be picked up at the office, between 9:30-11:30 a.m., Mon.- Fri., or 2:30-4:30 p.m., Mon.- Thu.** We charge $10.00 per prescription for this service, or you have the option of an office visit. If it has been over 90 days since your last office visit, or at the physician's discretion, an office visit may be required before receiving any medication refills.

*The physician is NOT accepting any new chronic pain patients requiring narcotics, patients requesting anxiety medications like Xanax, or new adult ADHD patients requesting amphetamines, but will be glad to refer you to a pain management specialist or psychiatrist.

*New and established patients taking any controlled medications will be required to sign a controlled medication policy and submit a urine sample or oral swab for random drug testing, at the physician's discretion. If your insurance doesn't pay for this, you will be responsible for the $30.00 charge.

*You may be asked to sign an Advanced Beneficiary Notice (ABN), which holds you responsible to pay for any services, lab, or procedures that are not paid by your insurance.

*Please be aware that we use Pathgroup Lab, for lab tests not done in the clinic, and LabSolutions for drug testing. You may receive a bill from them if your insurance denies payment.

*Your insurance policy is an agreement between you and the insurance company. We file all insurance claims as a courtesy to you, but charges for services rendered by this office are ultimately your responsibility. If your insurance company pays you directly, it is your responsibility to pay the clinic. Failure to do this is illegal and reportable to the federal government.

*Finally, we ask that you respect our office and others around you, who may be ill. We ask that you do not bring food or drink (we have a water cooler). **All cellular phones must be turned off prior to entering the exam room.** Please supervise children closely. Patient information is free to take, or read and replace. Please notify the staff with any problems or questions.

By signing below, you acknowledge that you have:

1. Read and understood the above information and agree to abide by our policies.
2. Received a copy of the Notice of Privacy Practices to review.

Signature: _____ Date: _____

Patient name if under 18 years old: _____

Parent or legal guardian is authorized signature above.

This can also serve as legal consent to treat a patient under 18 years old.

Bolton Family Medical Clinic
2781 Highway 145
Saltillo, MS 38866
662-869-0033

This signature page is to verify that I have received, read, and, understood the forms given to me by Bolton Family Medical Clinic regarding their obligation and compliance concerning the privacy acts stated in HIPPA regulations. I am fully aware of my rights to privacy under this policy. I am aware of the limited exceptions to disclose information in my medical record. I understand that upon signing, there will be no expiration date.

Signature: _____

Date of Signature: _____

Bolton Family Medical Clinic Consent For Treatment

Consent for Treatment

I desire to be seen at the Bolton Family Medical Clinic and hereby give my consent for the Clinic, its' physician, employees, and contractors to see and treat me, as they deem necessary and appropriate, for diagnoses such as Hepatitis and HIV (including testing where healthcare professionals have been exposed to my blood or body fluids), anesthesia, and other services, treatments, and procedures rendered or performed at the Clinic and/or such persons to report certain positive test results such as, but not limited to, Hepatitis and the antibody for HIV, to the Health Department as required.

I understand that I have the right to ask questions and to receive information regarding my care and treatment, and the right to withdraw, in writing, my consent to treatment or testing. **Initials**_____

Statement of Financial Responsibility

I understand that I am financially responsible for payment for all services rendered to, or for, my family or me. Although the clinic will bill, or arrange for billing, to my insurance carrier, I understand and agree that I am responsible for payment of all charges for services provided, regardless of the availability of any insurance coverage(s). I agree to pay all co-pays and deductibles. In the event that I fail to pay any charges and the account is turned over to a collection agency or attorney, I agree to pay all collection fees incurred, including, but not limited to, reasonable attorney fees and court costs.

Initials_____

Release from Liability for Refusing Medical Care and Leaving Against Medical Advice

I agree that if I refuse treatment recommended by the clinic, its' physician, employees, or others, or if I leave the clinic against that advice of such physician or clinical personnel, then the clinic, its' physician, employees, and all other persons, are released from any responsibility or liability for any injuries or damages which may result from my refusal of treatment or my acting against such advice.

Initials_____

Consent for Bolton Family Medical Clinic to Seek Medical Information

I understand that I am obligated to inform the physician if I receive medical treatment from another medical provider. I am aware that it is the responsibility of my treating physician to give me adequate medical care, which may include seeking medical records from another medical provider or medication records from pharmacies. This information will only be used for Bolton Family Medical Clinic to treat my medical needs appropriately, and will be kept strictly confidential.

Initials_____

Release of Medical Information, Insurance Authorization, and Benefit Assignment

I hereby authorize the release of any and all medical information requested by, or otherwise necessary, to process my claims with my insurance company, the Social Security Administration and its' intermediaries, Medicare, Medicaid, or any other organization responsible for payment of charges for, or related to, any services provided to me or my family. I hereby assign and authorize payment to the clinic of any insurance, managed care, or other benefits that are filed by the clinic for services provided for my family or me.

Initials_____

Medicare and Medicaid Lifetime Consent

I hereby authorize and request that payment of authorized Medicare and/or Medicaid benefits be made to Bolton Family Medical Clinic for any services rendered to me.

Initials_____

I have read and understood the above consent.

Signature: _____

Date: _____

Bolton Family Medical Clinic, P.C.
2781 Highway 145
Saltillo, MS 38866
Phone: (662) 869-0033
Fax: (662) 869-0053

Authorization for Use, Disclosure, or Release of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip Code: _____

I authorize _____

_____

(previous healthcare providers and/or pharmacies)
to disclose the information from my record **TO Bolton Family Medical Clinic.**

I authorize Bolton Family Medical Clinic to disclose information **FROM** my medical records to the following individuals or entities:

_____

_____

_____

I authorize the disclosure of medical records, progress notes, list of medications, lab/X-ray/test results, psychiatric evaluations, and any other medical information, for the purpose of continuity of care, for the time period of:
Dates: _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, including HIV/AIDS. It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this authorization has not been revoked, it will terminate on the following date, event, or condition: _____
If I fail to specify an expiration date, event, or condition, this authorization will automatically expire in 12 months.

I understand that I can refuse to sign this authorization. I do not need to sign this form to obtain treatment, payment, or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may then no longer be protected by federal confidentiality rules.

_____
Signature of Patient or Representative

_____
Printed Name of Patient or Representative

_____
Date

_____
Relationship to Patient (if under 18 years old)