NORTHWEST FAMILY PHYSICIANS

Date: _____

Check your preferrd provider:

☐ Timothy M Koehler, DO ☐ Tana L Goering, MD ☐ Joseph D Baalmann, MD ☐ Robin A Walker, MD ☐ Kimberly L Hébert, PA-C

Please Print ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Dr. Other _____

Legal Name - Last Name _____ First Name _____ (MI) _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address *(if different)* _____

Home # _____ Cell Phone _____ Email _____

Date of Birth _____ Age _____ Sex _____ Social Security # _____

Student _____ Where _____ Occupation _____

Employer's Name _____ Telephone # _____ Ext. # _____

Employer's Address _____

In Case of an Emergency Contact _____ Relationship _____

Address _____

Telephone # _____ Cell # _____

Spouse's Name _____ Social Security # _____

Telephone # _____ Cell # _____

Spouse's Employer _____ Spouse's DOB _____

Responsible Party of Patient *(if other than self)* _____

Relationship _____ Social Security # _____

Home Address _____ Home Telephone # _____

Employer _____ Work Telephone # _____

Primary Insurance _____ ☐ Insurance Card to be provided at check-in

Policy Holder _____ DOB _____ Relationship to Patient _____

Secondary Insurance _____ ☐ Insurance Card to be provided at check-in

Policy Holder _____ DOB _____ Relationship to Patient _____

Other Insurance _____ Group Number _____ ID Number _____

Address _____ Telephone # _____

City _____ State _____ Zip _____ Effective Date _____

Policy Holder _____ Relationship to Patient _____

Auto Insurance - MVA ☐ Additional Form to be completed

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

NORTHWEST FAMILY PHYSICIANS

ADULT HEALTH HISTORY

Name_____ Date of Birth_____ Date_____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. **Thank you!**

Age: ____ How would you rate your general health? ❑Excellent ❑Good ❑Fair ❑Poor

Main Reason for today's visit: _____
Other concerns: _____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates)

❑ Heart Disease	❑ Asthma/Lung Disease	❑ High Blood Pressure	❑ Seizures
Type: _____	❑ Diabetes	❑ Thyroid Problem	❑ Cancer (specify) _____
❑ Obesity/Overweight	❑ High Cholesterol	❑ Kidney Disease	❑ Depression/Anxiety
❑ Anemia	❑ Other (specify): _____		

SURGICAL HISTORY: Please list all prior operations (with dates):

❑ Wisdom Teeth_____	❑ Tonsillectomy_____	❑ Appendectomy_____	❑ Gall Bladder_____
❑ Heart (specify)_____		❑ Hysterectomy_____	❑ Prostate_____
❑ Joint (specify)_____		❑ Other (specify):_____	

HEALTH MAINTENANCE SCREENING TESTS:

Colonoscopy: Date_____ Abnormal? ❑Yes ❑No Mammogram: Date_____ Abnormal? ❑Yes ❑No
Pap Smear: Date_____ Abnormal? ❑Yes ❑No DEXA (bone density): Date_____ Abnormal? ❑Yes ❑No

CURRENT MEDICATIONS: ❑Separate List Provided

_____

_____

ALLERGIES or reactions to Medications: ❑Separate List Provided

_____

IMMUNIZATIONS: (Date of your most recent): Varicella (chicken pox)_____ ❑Illness ❑Shot

Pneumovax (pneumonia) _____	Meningitis _____	MMR _____	Hepatitis A _____
Influenza (flu shot) _____	Tetanus _____	HPV _____	Hepatitis B _____

SOCIAL HISTORY:

Work History: Occupation: _____ Employer:_____
Years of Education/Highest degree: _____ Marital Status: ❑Single ❑Married/Partner ❑Divorced ❑Widowed ❑Other
Spouse's name: _____ Number of children/ages: _____

Tobacco Use:

Cigarettes: ❑Never ❑Quit Date_____ ❑Current Smoker: packs/day_____ # of years _____
Other Tobacco: ❑Pipe ❑Cigar ❑Snuff ❑Chew Are you interested in quitting? ❑Yes ❑No

Alcohol Use:

Do you drink alcohol? ❑Yes ❑No # drinks/week _____ Is your alcohol use a concern for you or others? ❑Yes ❑No

Drug Use:

Have you ever used recreational drugs? ❑Yes ❑No Have you ever used needles to inject drugs? ❑ Yes ❑ No
Do you currently use any recreational drugs? ❑Yes ❑No: Type of drug_____ # times/week_____

Sexual Activity:

Sexually active: ❑Yes ❑No ❑Not currently Current sex partner(s) is/are: ❑Male ❑Female
Birth Control Method:_____ None needed
Have you ever had any sexually transmitted illness? ❑Yes ❑ No
Are you interested in being screened for sexually transmitted illness? ❑Yes ❑ No

~ See Other Side of Form~

OTHER CONCERNS:

Caffeine Intake: ❑None ❑Coffee/tea/soda _____cups/day

Weight: Are you satisfied with your weight? ❑ Yes ❑ No

Diet: How do you rate your diet? ❑Good ❑Fair ❑Poor

Do you eat or drink four servings of dairy or take calcium supplements? ❑Yes ❑No

Exercise: Do you exercise regularly? ❑Yes ❑No What kind of exercise? _____

How Long? (minutes)_____ How often? _____ If you do not exercise, why? _____

Safety: Do you use seatbelts consistently? ❑Yes ❑No Do you wear a helmet? ❑YES ❑NO

Is violence at home a concern for you? ❑Yes ❑No Have you ever been abused? ❑YES ❑NO

Have you completed a living will or durable power of attorney for health care? ❑YES ❑NO

FAMILY HISTORY: Please indicate the current status of your immediate family members:

Mother: ❑Living ❑ Deceased: Age and cause of death:_____ Other illnesses: _____

Maternal Grandmother: ❑Living ❑ Deceased: Age and cause of death:_____ Other illnesses: _____

Maternal Grandfather: ❑Living ❑ Deceased: Age and cause of death:_____ Other illnesses: _____

Father: ❑Living ❑ Deceased: Age and cause of death:_____ Other illnesses: _____

Paternal Grandmother: ❑Living ❑ Deceased: Age and cause of death:_____ Other illnesses: _____

Paternal Grandfather: ❑Living ❑ Deceased: Age and cause of death:_____ Other illnesses: _____

Sibling: B/S ❑Living ❑Deceased: Age and cause of death:_____ Other illnesses: _____

Sibling: B/S ❑Living ❑Deceased: Age and cause of death:_____ Other illnesses: _____

Sibling: B/S ❑Living ❑Deceased: Age and cause of death:_____ Other illnesses: _____

Child: S/D ❑Living ❑Deceased: Age and cause of death:_____ Other illnesses: _____

Child: S/D ❑Living ❑Deceased: Age and cause of death:_____ Other illnesses: _____

REVIEW OF SYMPTOMS: Please check any CURRENT symptoms you have.

Constitutional
___fatigue
___weight loss ___ gain
___fever/chills
___night sweats

Eyes
___vision change
___blurry vision
___double vision
___eye discharge
Last eye exam:_____

Ears
___hearing loss
___ringing in ears
___ear pain
___ear drainage

Nose/Mouth/Throat
___nasal drainage
___sinus congestion
___sinus pain
___sore throat/mouth
___hoarseness
___seasonal allergies

Respiratory
___persistent cough
___coughing up phlegm
___coughing up blood
___shortness of breath
___wheezing

Cardiovascular
___chest pain / heaviness
___difficulty breathing while lying flat
___ankle swelling
___palpitations

Gastrointestinal
___poor appetite
___heartburn/indigestion
___belching/gas
___difficulty swallowing
___nausea/vomiting
___diarrhea
___constipation
___abdominal pain
___rectal bleeding
___hemorrhoids
___black sticky stools

Musculoskeletal
___joint pain
___muscle pain
___muscle weakness
___back pain

Neurological
___numbness/tingling
___seizures
___headaches
___dizziness
___fainting

Skin
___new skin lesions
___breast discharge
___breast mass
___jaundice
___skin, hair, nails

Endocrine
___increased thirst
___sensitivity to heat
___sensitivity to cold

Blood/Lymph
___unusual bruising
___unusual bleeding
___enlarged lymph nodes

Genitourinary
___frequent urination
___urination at night
___x per night
___inability to hold urine
___burning on urination
___blood in urine

Women:
___vaginal discharge
___irregular periods
___painful periods
___pain with intercourse
Last period:_____

Men:
___penile discharge
___testicular lump
___erectile problems

Psychiatric
___depression
___anxiety
___excessive worry
___difficulty sleeping
___stress

WOMEN'S HEALTH HISTORY:

pregnancies____ # deliveries _____ # abortions _____ # miscarriages _____

Age at start of periods: _____ Age at end of periods: _____

Are your periods? ❑Regular ❑Irregular ❑Heavy ❑Painful

Provider Signature:_____Date:_____

NORTHWEST FAMILY PHYSICIANS

Notice of Privacy Practices Summary/Acknowledgment

Maintaining privacy of your health information is very important to us. Attached you will find our *Notice of Privacy Practices.* The following is a brief summary of the content of the attached notice. We encourage you to read the entire Notice and ask any questions you may have regarding its contents.

How We May Use and Disclose Health Information About You. This section describes the different ways we may use or disclose your health information without first obtaining a specific authorization from you. These types of uses and disclosures are specifically permitted by law because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the functioning of our health care system.

Your Rights Regarding Your Health Information. This section describes the following rights you have with respect to your health information and tells you how you may exercise these rights.

- Right to inspect and copy
- Right to request amendment
- Right to an accounting of disclosures
- Right to request restrictions on certain uses and disclosures
- Right to request alternative means of communication
- Right to receive a paper copy of our Notice of Privacy Practices

How to File Complaints Concerning Our Privacy Practices. This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing a complaint.

We ask you acknowledge your receipt of this Notice by signing below. You should keep the copy of the attached Notice; however, if you wish to receive another copy you may request a copy at any time. Also, the most current copy of our Notice will be posted in our office. If there are material changes to this Notice at a later date, you will be provided a copy of the revised Notice and asked to sign another acknowledgment.

I acknowledge that I received a copy of The Notice of Privacy Practices with the effective date of April 14, 2003.

_____ _____

Signature of Patient/Patient Representative *Date*

_____

Relationship to Patient

Original to be maintained in patient's permanent medical record.

NORTHWEST FAMILY PHYSICIANS

HIPAA RELEASE OF INFORMATION AND DISCLOSURE FORM

Permission To Disclose Information To Those Involved In My Care
Either In Person, By Telephone, Voice Mail Message or Answering Machine Message

I hereby authorize:
Northwest Family Physicians to disclose my own protected health information in person, by telephone conversation, voice mail message, or answering machine message to the individuals and telephone number(s) listed below. I authorize the release of any of my protected health information, EXCEPT:

- ❑ Name
- ❑ Address
- ❑ Telephone Records
- ❑ Enrollment Information
- ❑ Claims Information
- ❑ Payment Information
- ❑ Managed Care Information
- ❑ Pharmaceutical Information
- ❑ Consultation Reports
- ❑ X-Ray Reports
- ❑ Discharge Summary
- ❑ Progress Notes
- ❑ Explanation of Benefits
- ❑ History and Physical Examination
- ❑ Laboratory Tests
- ❑ Complete Health Record(s)
- ❑ Other (please specify): _____

This authorization provides for use and disclosure of only that protected health information as provided on this form and only for the purpose of communicating medical information to/about me.

By signing below, I represent that I understand the following:

- I have the right to revoke this authorization at any time.
- I have the right to refuse to sign this authorization.
- That Northwest Family Physicians will not condition my treatment on whether I provide authorization for the requested use or disclosure.

By signing below, I authorize my physician to release my protected health information to/about me in person by telephone call, voice mail message or answering machine message to those listed below:

Those Authorized: ❑ Self Only ❑ Other _____

❑ Spouse _____ ❑ Parent(s) _____

❑ Child _____ ❑ Child _____ ❑ Child _____

Patient Names (Please Print) | Date of Birth | Today's Date

Signature | Telephone Number(s)

NORTHWEST FAMILY PHYSICIANS

PATIENT FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please sign below to indicate that you have read, understand and agree to the policies outlined below.

INSURANCE

It is the patient's responsibility to provide current insurance information. We will obtain a copy of your insurance card at your initial visit. Please bring your insurance card every time you visit the office, as we may occasionally request a copy to update our records. If current insurance information is not on file at the time of service, the patient is responsible for paying all charges for the services.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, disputes with your insurance company regarding deductibles, co-payments, non-covered charges, and 'usual and customary' charges. We will supply, upon request, reasonably necessary information to support our charges. It is your responsibility to fully understand your plan and any health saving accounts you may have. You are ultimately responsible for the timely payment of our charges.

CO-PAYS , DEDUCTIBLES & CO-INSURANCE

Our patients use a variety of insurance plans. A large number of these plans now have high deductibles. We query your insurance company to confirm eligibility, co-pays, and outstanding deductibles. If you have NOT met your deductible for the plan year we will estimate your financial responsibility and ask you to pay the balance before you are seen by your provider. We require all patients to pay their estimated deductible, co-pay, co-insurance, and patient account balance before services are furnished in our office. We will bill you for any remaining balance after your insurance has processed our claim.

METHOD OF PAYMENT

We accept cash, checks, Visa or MasterCard. Subject to the previous paragraph, you may pay in person at our office, by mail, or with a credit card on our online patient portal. Any unpaid balance past 90 days will be automatically charged to the credit card on file (see Credit Card on File Policy If the credit card is declined, you will be assessed a $30.00 late fee. The charge for a returned check is $30.00 plus any bank fees incurred. This will be applied to your account in addition to the insufficient funds amount. If any check of yours is returned, we may place you on a "Cash Only" basis. Absolutely no post-dated checks will be accepted.

UNINSURED OR NON-COVERED INSURANCE PLANS

If our clinic does not participate with your insurance policy or you have no insurance, payment for your office visit is due in full before you are seen by your provider. Payment for any additional services rendered during your office visit is due upon rendering of the services.

PAYMENT ARRANGEMENTS

If your balance due is more than you are able to pay, our billing office will consider accepting a reasonable payment plan for your account. It is your responsibility, however, to contact our billing office at 316-462-6200 to request a payment plan. Any request for a payment plan will be accepted or rejected in our sole discretion.

UNPAID BALANCES

Past due balances are due before we will schedule a new appointment. We ask that full payment be made at the time of service unless prior arrangements have been made through the billing office. If your insurance company has not paid the balance in full, you will be notified through the explanation of benefits that you receive from your insurance company. Any account with a balance that is more than 120 days past due may be turned over to a collection agency for further collections. Any account that is turned over to collections will be assessed a one-time late fee of 25% of the past due amount and will be considered for dismissal from our practice.

MINORS

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. We may require a signed release to treat unaccompanied minors.

MEDICAL RECORD COPIES

Northwest Family Physicians, LLC utilize a medical records copy service. Their fees are set by the Federal Government Omnibus Rule. We reserve the right to charge a reasonable fee for copying your medical records.

CREDIT CARD ON FILE POLICY

We require a valid credit card, debit card or HSA card be kept on file for all patients. The card information is stored electronically in an encrypted form and cannot be viewed by our office staff. Your signature below authorizes us to charge your card with your consent or when your balance becomes 90 days past due.

By signing below, I acknowledge that I have or may in the future give Northwest Family Physicians, LLC a credit card, debit card, or HSA card to be saved on my family's account. I authorize Northwest Family Physicians, LLC to charge my card with my consent or when my account balance becomes 90 days past due.

Signature of patient/responsible party	Date	Patient DOB

Printed name of patient/responsible party	Relationship to patient

Chart Number _____