Star Family medicine
Pediatric registration form

Patient information: (children under age 18)

Last name____ First Name____

Street address: ________________________________City: _________________ State: ______ Zip code:______________

Home phone: _____________________________Date of birth: ____/____/______ Sex: M__ F__ Student? Yes__ No__

Responsible Party Information: (the person who accompanies the child to the visit)

Last name: ____ First name: __________________________________

Street address: ____ Same as patient______

City: _________________________ State: ___________________________ Zip code: ________________

Last name(other parent): ____First name_______________________________

Street address: ____ Same as patient_______

City: ___________________________ State: _________________________ Zip code: _______________

Primary Insurance Information:

Subscriber's name: ____ ID #: ______________________ GR #:_____________

Subscriber's DOB: _____/_____/______ Relation to patient: __________________________

Insurance carrier name: ____ Effective date: ______________________

Subscriber's address:____

Secondary Insurance Information:

Subscriber's name: ____ ID #: ______________________ GR #:_____________

Subscriber's DOB: _____/_____/______ Relation to patient: __________________________

Insurance carrier name: ____ Effective date: ______________________

Subscriber's address:____

I authorize my insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to STAR FAMILY MEDICINE, PC, or any of its affiliates or agents, lenders, or any third party services acting for FPPC, PC, or any of its affiliates.

I agree to promptly pay for the services rendered for me or the patient named above. If I fail to meet my financial commitment to STAR FAMILY MEDICINE and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. I further agree to pay for any missed appointments of which I did not notify the medical office within a reasonable amount of time.
I authorize STAR FAMILY MEDICINE to test my blood for hepatitis and/or the AIDS virus, if in their opinion; an employee has suffered an exposure incident as a result of my treatment, as defined by the Occupational Safety and Health Administration.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician for services.

Signed____ Date:____

STAR FAMILY MEDICINE

BILLING AND PAYMENT AGREEMENT

Welcome to Star Family Medicine. We are happy that you have chosen us as your primary care medical office. Finances are always a sensitive subject to address; however, we believe that it is important to address insurance and payment issues at the onset of our relationship so that there are no issues for either of us once we begin. In order to facilitate a beneficial experience for you, let us explain how a primary care medical office operates and provide some tips on how to utilize your insurance benefits to your maximum advantage.

- Most people chose a doctor who is approved by their insurance company. Therefore, all initial paperwork must be completed correctly in order for us to receive third party insurance payment and so that you do not incur any unnecessary costs.
- Your individual insurance company sets your co-pay. You may also have a deductible that has to be met before the insurance will begin to pay for services. You pay this directly to your doctor's office and then when the deductible, (if any) is met, the insurance will begin to pay. This varies from company to company, so it is to your advantage to check with your company's benefit coordinator before you come in for your visit.
- Many companies require that you see a pre-selected primary care physician. Make sure you check with your insurance company to make sure the doctor you wish to see is on their list of approved physicians or the insurance company may refuse to pay for your visit.
- Our practice doesn't participate with Medicaid. If Medicaid is your secondary insurance and there will be a left over balance after your primary insurance payment, you will be responsible for this balance as we won't be reimbursed by Medicaid.
- We cannot charge the insurance company for missed appointments; therefore it is our policy to charge $25.00 for cancellations of less than 24 hours prior to a scheduled appointment or for no show. Remember that you have committed for that time and have blocked out a physician's time to others. There will also be a $45.00 service charge for all returned checks.
- If you should change insurance companies let us know so that we can check to see if your coverage is the same. Should you change insurances and not inform us, you may become individually liable for visits that could have otherwise been covered under your new insurance. It is important that you let us know whether more than one insurance company covers you, and if so which insurance is primary and secondary so that we can bill the primary company first or your second insurance will be null and void.
- We hope that this will clear up any questions you may have about the clerical end of your visit with us. Please feel free to ask any questions you have
- Unpaid insurance balances over 60 days will become patient responsibility. So, please make sure we have your current information on file.

By your signature it is understood and agreed that you are directly responsible for payment for the services rendered whether or not your insurance is involved. If it becomes necessary to go outside of the office to any agency for the collection of fees, you will be charged for the additional expenses.

Signature:____ Date: ______________________

STAR FAMILY MEDICINE

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day health care operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Statement of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry our treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: ____________________________________

Print Patient Name: ____

Relationship to Patient: ____

Signature: ____

STAR FAMILY MEDICINE MONICA MIHALACHE, MD

INITIAL PATIENT HISTORY	NAME
	DOB/AGE:
	INFORMANT:

PAST MEDICAL HISTORY/DIAGNOSIS

____ ____

____ ____

____ ____

SURGERIES/PROCEDURES	DATE	HOSPITALIZATIONS	DATE
1______________________	__________	1 ______________________	__________
2______________________	__________	2 ______________________	__________
3______________________	__________	3 ______________________	__________
4______________________	__________	4 ______________________	__________

FAMILY MEDICAL HISTORY	MEDICATION ALLERGIES	REACTION
MOTHER:______________________	**1** ______________________	__________
FATHER:______________________	**2** ______________________	__________
SIBLINGS:______________________	**3** ______________________	__________
CHILDREN:______________________	**4**______________________	__________
OTHER:______________________	**5**______________________	__________

CURRENT MEDICATION, DOSAGES AND INSTRUCTIONS

1______________________________ 5______________________________

2______________________________ 6______________________________

3______________________________ 7______________________________

4______________________________ 8______________________________

SOCIAL HISTORY CIRCLE ONE: SINGLE MARRIED SEPERATED DIVORCED WIDOWED SIGNIFICANT OTHER

WITH WHOM DO YOU LIVE? ________________________ RELIGIOUS PREFERENCE:________________________

ARE YOU EMPLOYED? NO____ PART TIME______ FULL TIME_____ JOB TITLE: __________________ DISABLED (REASON)____________________________

TOBACCO: NEVER SMOKED___ QUIT _____YEARS AGO #YEARS SMOKED___ #PACKS PER DAY_____ OTHER FORM OF TOBACCO _____ DO YOU WANT TO QUIT? ______

ALCOHOL: NEVER___ QUIT____YEARS AGO 1DRINK /MONTH_____ 1 DRINK/WEEK_____ 1 DRINK/DAY_____ OTHER_____ DO YOU WANT TO QUIT ?______

RECREATIONAL DRUGS: NEVER_____ QUIT_____YEARS AGO CURRENTLY USE______ HISTORY OF IV DRUGS_____TYPE_________________________ DO YOU WANT TO QUIT ? _________ DO YOU HAVE AN ADVANCED DIRECTIVE? ____ DO YOU WEAR A SEAT BELT? ALWAYS____ SOMETIMES____NEVER______

MOST RECENT VACCINES: TETANUS______________(Date) PNEUMOVAX_________________(Date) FLU SHOT ___________(Date) TB TEST___________(Date)**+OR-**PATIENT/INFORMANT

SIGNATURE____**DATE**______________________________

Physician Signature ____