

Patient Demographics

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____
(Last) (First) (Middle)

AGE: _____ SOCIAL SECURITY NUMBER: _____ RACE: _____

ETHNICITY (check one): Hispanic or Latino Not Hispanic or Latino Prefer to not specify

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

E-MAIL ADDRESS: _____

May we contact you regarding lab results via e-mail? Yes _____ No _____ Preferred Pharmacy: _____

MARITAL STATUS (check one):

Married Single Divorced

Separated Significant Other

SPOUSE / PERSON RESPONSIBLE FOR PAYMENT INFORMATION:

Person responsible for payment: _____ Birth Date: ____/____/____

Social Security Number: _____ Relationship to patient: _____

Employer: _____ Primary Phone: _____ Home Phone: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy ID#: _____ Group #: _____

Policyholder's Name: _____ Relationship to Patient: _____ SSN: _____

Secondary Insurance: _____ Policy ID#: _____ Group #: _____

Policyholder's Name: _____ Relationship to Patient: _____ SSN: _____

EMERGENCY CONTACT:

Name: _____ Phone #: _____ Relationship: _____

I acknowledge that Jeanne Hebl may release to third party payers requested medical and/or other information necessary to process my claim(s). I hereby assign to Jeanne Hebl all benefits which are or shall become payable from any third party payer who is responsible for payment of my Jeanne Hebl expenses. I authorize and direct all third party payers to pay all benefits directly to Jeanne Hebl.

Patient and/or person legally and financially responsible for patient's medical bills agree to pay patient's account regardless of the existence of insurance or other third party liability. Full payment will be made promptly unless other credit arrangements are made. Jeanne Hebl is free to declare the entire balance to be due and payable if any scheduled payments are missed. The undersigned agrees to pay all costs of collection, including reasonable attorney's fees, if the account is not paid in a timely manner.

I authorize treatment of the person named above and agree to pay all fees and charges for any services.

PATIENT'S SIGNATURE: _____ DATE: _____

LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

Patient Compliance Policy

Please Initial All Sections Below:

- _____ 1. We expect payment on the day of service. This reduces our billing costs and allows us to keep costs down for you. We require full payment of expected patient responsibility at the time of service based on your insurance coverage.
- _____ 2. By accepting Medicaid and private insurance we are mandated by law and the terms of the contracts we have signed with Medicaid and private insurance to collect your co-pay at the time of service. If you are unable to make the co-payment that is due at the time of your appointment we will need to reschedule your appointment until such time as you are able to make the payment.
- _____ 3. We will submit charges to your insurance carrier when complete information has been received. If Insurance payment is delayed over 60 days you will be expected to pay the balance. If non-payment from your carrier is due to documentation needed to support service we will make all efforts to supply the needed information. We will not fraudulently change diagnoses from the supporting documentation in order for a better outcome from your insurance company. We do supply some services that insurance carriers do not consider a covered benefit of contracts such as infertility testing and IUD devices. For any non-covered services we will require payment in full on the day of services. Any payments received from your insurance carrier after you have paid on your balance will be refunded to you within 30 days of receipt of overpayment.
- _____ 4. We will bill secondary insurance. Carrying primary and secondary policies does not alleviate all patient responsibilities; deductibles, co-pays and patient co-insurances still apply. After receipt of insurance payments, the amount that is remaining as patient responsibility is due in full within 30 days. We recommend that you review your insurance carrier explanation of benefits (EOB's). It is your responsibility to know what you owe on your accounts.
- _____ 5. If arrangements for payment are needed, an agreement will be completed and signed with our office staff. A confidential meeting will allow for questions and explanation of our policies. You will receive copies of all signed financial agreements.
- _____ 6. We require 24 hour notice for cancellations on scheduled appointments. Failure to comply with this policy can result in additional fees and dismissal from our practice. In addition, if you miss three appointments without providing our office with notice of cancellation, or by rescheduling an appointment, you will be imposed a \$75.00 fee and possible dismissal from our practice.
- _____ 7. In the event we are unable to collect payment directly from you, your account will be sent to a collection agency. You acknowledge and agree you will be responsible for any and all collection agency fees and reasonable attorney's fees and costs which may be incurred as a result of your non-payment. These charges are the sole responsibility of the patient and will not be billed to any insurance carrier.

Patient Responsibility:

- _____ 8. I have been offered the Notice of Privacy Practices document and received a copy of the philosophy and mission statement.
- _____ 9. I understand failure to comply with any of the above policies can result in dismissal from care at this facility.
- _____ 10. There will be a 1% interest charge per month on all accounts over sixty days.

Print Patient Name

Relationship to Patient

Date

Signature of Patient or Responsible Party

NOTICE OF PRIVACY PRACTICES

Jeanne Hebl, CNM, PLLC dba The Birth Center

THIS NOTICE IS REQUIRED BY LAW (FEDERAL REGULATION 45 CFR PARTS 160&164) AND DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTICE IS IN EFFECT ON AND AFTER FEBRUARY 3, 2009. PLEASE REVIEW IT CAREFULLY.

USAGE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

We use health information about you for treatment (diagnostic testing, medical prescription, referral, etc.), to obtain payment (submit claims to and/or encounters with billing services and/or clearinghouses, and/or collection agencies, etc.), for healthcare operations (reporting, utilization management, etc.) and to evaluate the quality of care that you receive.

We may use or disclose identifiable health information about you without your authorization for other purposes such as auditing and research studies when the research has been approved by an institutional review board. As required by law, we may disclose your health information to public health or legal authorities charged with prevention or controlling disease, injury, or disability.

YOUR HEALTH INFORMATION RIGHTS

- You have the right to inspect and obtain a copy of your health record with a signed authorization as provided in 45 CFR 164.524
- You have the right to request in writing that we restrict and/or not use or disclose your protected health information as provided in 45 CFR 164.522 *but we do not have to agree to accept your restrictions.*
- You have the right to request in writing that your physician amend your protected health information as provided in 45 CFR 164.528
- You have the right to request in writing to receive confidential communications from us by alternative means or at an alternative location as provided in 45 CFR 164.522
- You have the right to obtain a list of instances (accounting of disclosures) where we have disclosed your protected health information for purposes other than treatment, payment or health care operations as provided in 45 CFR 165.528
- You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken as provided in 45 CFR 164.508

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy of your health information.
- We are required by law to provide you with this notice about our privacy practices
- We are required by law to follow the privacy practices that are described in this notice; however, we reserve the right to change or modify our practices and to make the new provisions effective for all protected health information (PHI) we maintain. Should our information practices change, we will post the revised privacy notice.

QUESTIONS/COMPLAINTS

If you have questions or if you are concerned that we have violated your privacy rights, you may contact the privacy officer. You may also file a complaint with the US Secretary of Health and Human Services. There will be no retaliation against you for filing a complaint.

Privacy Officer: Jeanne Hebl (406) 541-7115

Mailing Address: PO Box 699, Missoula, MT 59806

EMR PRACTICE TO PATIENT MESSAGING

Patient Name: _____ DOB: _____

As our patient, we may need to communicate with you when you are not in the practice office. To assure your privacy we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care.

Please Indicate Your Preferred Method of Communication: (initial below)

_____ I give permission to send reminders and messages pertaining to me through the **EMR** (Electronic Medical Records) System at the numbers listed below:

Method	Yes	No	Area Code/Number/Email
Email: Reminders & Messaging			
SMS Mobile Text: Reminders & Messaging			
Voice: Reminders & Messaging			

MEDICAL INFORMATION PREFERENCES

Please Indicate Your Preferences: (initial below)

_____ I give permission to leave a message with medical information pertaining to me at the numbers listed below:

Method	Yes	No	Area Code/Number
Home			
Work			
Cell			
Other			

Without specific permission we will not release your medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify below those individuals and their relationship to you (i.e. spouse/partner, parent etc.)

Personal Medical History

Date: _____ Name: _____ Date of Birth: _____ Age: _____

Marital Status: S M D W Sexual Orientation: _____ Gender Identity: _____

Husband/Partner Name/Date of Birth: _____ Years Together: _____

Allergies: _____

Date Last Menstrual Period: _____ Normal: Y N Flow: Norm Heavy Light

Are your periods regular? _____ Medications Taken? _____

Birth Control: _____ How long? _____

Date of last Pap: _____ Normal or Abnormal: _____

Explain treatment & list dates: _____

PREGNANCY HISTORY: Total including live, abortions, & miscarriages: _____

Live: _____ Dates: _____ Premature _____ Dates: _____

Stillbirths: _____ Dates: _____ C-Section: _____ Dates: _____

Miscarriage(s): _____ Dates: _____ Abortion(s): _____ Dates: _____

PAST MEDICAL HISTORY – Check Yes/No (If yes, give date of occurrence)

ISSUE	Y	N	COMMENT	ISSUE	Y	N	COMMENT	ISSUE	Y	N	COMMENT
Breast Lumps				HIV				Asthma			
Kidney/Bladder Infections				Migraines							
Blood Clots				Bleeding Disorders							
Diabetes				Heart Problems							
Ovarian Cysts				Pelvic Inflammatory Disease							
Seizures				Uterine Fibroids							
Genital Herpes				High Cholesterol							
High Blood Pressure				Sexually Transmitted Disease							

PERSONAL HISTORY:

Do you perform monthly self-breast exams? _____ Have you had a Mammogram? _____ Date: _____

If Mammogram was not routine, please list reason: _____

Do you exercise, how, what type, how often: _____

Do you wear seat belts? _____ Date of last dental exam: _____ Date of last cholesterol test: _____

Do you experience loss of urine when you cough or sneeze? Y N Constipation? Y N Diarrhea? Y N

Any concerns about intercourse? _____

Do you Smoke? Y N How much per day? _____ Alcohol Y N How much per day? _____

Caffeinated Beverages or Energy Drinks? Y N How much per day? _____

PATIENT NAME:

DOB:

Would you describe yourself as happy? _____ Depressed? _____ Anxious? _____

Have you experienced physical, sexual or emotional abuse? Y N _____

Have you ever had an eating disorder? _____ Have you had the Gardasil vaccine? _____

MEDICATIONS: Please list all medications including vitamins, herbs, and pain pills; please include dose

Please list any serious illnesses, hospitalizations or surgeries:

Family History - Please check the following:

	Mother	Father	Brother	Sister	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Other
Currently alive?									
Deceased?									
Asthma									
Arthritis									
Bleeding Disorder									
Breast Cancer									
Colitis									
Diabetes									
High Blood Pressure									
Depression									
High Cholesterol									
Heart Attack									
Kidney Disease									
Migraines									
Stroke									
Suicide									
Thyroid Disease									

Reason for Today's Visit: _____

Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

PATIENT NAME:

DOB: