CREDIT POLICY

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PATIENT RESPONSIBILITY:

Patients are responsible for all charges resulting from treatment provided by their physician. As a service to you, we will bill your insurance. When you provide us with current insurance information we are able to bill primary insurance. Please notify us when you have any insurance changes. However, primary responsibility for the account is yours. Payment is due within 30 days of the first billing.

Insurance co-payments are due at the time of each visit.

DIVORCED PARENTS:

The custodial parent who brings the child (children) to the clinic will be responsible for the account of the child (children). We can bill any insurance that covers the child (children).

MOTOR VEHICLE AND THIRD PARTY BILLING CLAIMS:

When supplied with the correct billing information we will be glad to bill a third party or MVA insurance. However, our relationship is with you, our patient, and the account is your responsibility. We will not wait for litigation or settlements. We will be glad to set up a reasonable payment plan.

I have read and accept this Credit Policy for my treatment with my physician. I authorize Roberts Street Clinic, P.C. to release billing records and chart notes to the appropriate insurance companies.

____ ________________

Patient signature or guardian if patient is a minor Date

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PATIENT SOCIAL HISTORY:

Occupation: ____________________

Job Duration (yrs): ____________________

Hobbies, Interests: ____________________

____

____

Lives with: ____________________

Marital Status: ____________________

Spouse/Partner Name: ____________________

# of Children: ____________________

Primary Language: ____________________

Nickname: ____________________

Where employed: ____________________

Education level: ____________________

Pets: ____________________

____

____

Lives at: ____________________

Length of Relationship: ____________________

Spouse/Partner Health: ____________________

Religion: ____________________

Use of English Language: ____________________

Last Mammogram: ____________________

Last Colonoscopy: ____________________

Last Eye Exam: ____________________

Last Pneumovax: ____________________

Last Pap: ____________________

Last Dexa: ____________________

Last Flu Shot: ____________________

Tobacco Use

- ☐ Current every day smoker
- ☐ Never smoker
- ☐ Current some day smoker
- ☐ Smoker, current status unknown
- ☐ Former smoker
- ☐ Unknown if ever smoked
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker

Year started: __________

Pack-years: __________

Cigarettes: ☐ Yes ☐ No Amt: __________ packs/day

Cigars: ☐ Yes ☐ No Amt: __________ # per week

Counseled to quit/cut down:

____

Passive smoke exposure: ☐ Yes ☐ No

Patient Education Given ☐

Smokeless Toabacco Usage

☐ Current ☐ Former ☐ Never ☐ Unknown

Drug Use

☐ Yes ☐ No Substance: ____________________

Comments: ____________________

HIV High Risk Behavior

☐ Yes ☐ No

Comments: ____________________

Alcohol Use

☐ Yes ☐ No Type: ____________________

Has the patient: Drinks Per Day: ______

Felt need to cut down	☐ Yes	☐ No
Been annoyed by complaints	☐ Yes	☐ No
Felt guilty re: drinking	☐ Yes	☐ No
Needed eye opener in a.m.	☐ Yes	☐ No

Comments: ____________________

Counseled to quit/cut down: ☐ Yes ☐ No

Exercise

☐ Yes ☐ No Times Per Week: __________

Type of Exercise: ____________________

Other

Caffeine use (drinks/day): __________ Seatbelt Use (%): __________

Sun Exposure: ____________________

Have you fallen in the last year?	☐ Yes	☐ No
Do you feel unsteady on your feet?	☐ Yes	☐ No
History of broken bones as an adult?	☐ Yes	☐ No

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Patient Medical History Form

Date: ____________________

Patient Name: ______________________________ Date of Birth: ____________________

Allergies: ____

Current Medications: ____

FAMILY MEDICAL HISTORY Please list any significant medical conditions and age/cause of death:

Mother (biol.) ____________________
Father (biol.) ____________________
Brother (full) ____________________
Sister (full) ____________________
Maternal Grandmother ____________________
Maternal Grandfather ____________________
Paternal Grandmother ____________________
Paternal Grandfather ____________________

PATIENT MEDICAL HISTORY:

- ☐ Unremarkable
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Anemia *
- ☐ Anxiety
- ☐ Autoimmune Disorder *
- ☐ Biliary Cirrhosis
- ☐ Blood Transfusions *
- ☐ Brain Tumor
- ☐ Cerebrovascular Disease
- ☐ Cirrhosis
- ☐ CVA / Stroke
- ☐ COPD
- ☐ Colon Cancer
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ CRF
- ☐ Depression
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Diverticulitis *
- ☐ DVT *
- ☐ GI Bleed *
- ☐ GERD
- ☐ Hemochromatosis *
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Hepatitis A *
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Infertility *
- ☐ Kidney Disease *
- ☐ Kidney Stone *
- ☐ Liver Disease *
- ☐ MI
- ☐ Neurologic Disorder *
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ PUD
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Thyroid Disorder *
- ☐ Tuberculosis
- ☐ Valvular Heart Dis.
- ☐ UTI - Recurrent *
- ☐ Varicose Veins/Phlebitis *
- ☐ Abnormal Pap Smear
- ☐ Breast Disease *
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ DES Exposure *
- ☐ Diabetes-Gestational *
- ☐ RH Sensitized *
- ☐ TAH
- ☐ TAH w/BSO
- ☐ Uterine Anomaly *

Other: ____

PATIENT SURGICAL HISTORY:

- ☐ Unremarkable
- ☐ Abd Surg - Type
- ☐ Amputaton
- ☐ AV Fistule Creation
- ☐ AV Graft
- ☐ Aortic Valve Replace.
- ☐ Appendectomy
- ☐ BA-F Bypass
- ☐ Back Surgery
- ☐ Breast Surgery
- ☐ Bronchoscopy
- ☐ CABG
- ☐ Carotid Endarterectomy
- ☐ Carpal Tunnel
- ☐ Cataract Extraction
- ☐ Cholecystectomy (gallbladder)
- ☐ Colon Resection
- ☐ Craniotomy
- ☐ Gastric Bypass
- ☐ Hemorrhoidectomy
- ☐ Hip Replacement
- ☐ Interventional Pain Proced.
- ☐ Knee Arthroscopy
- ☐ Knee Replacement
- ☐ Kyphoplasty
- ☐ LA-F Bypass
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Mitral Valve Replace
- ☐ Nephrectomy - Native
- ☐ Pacemaker
- ☐ Parathyroidectomy
- ☐ Pneumonectomy
- ☐ PTCA
- ☐ RA-F Bypass
- ☐ Rotator Cuff Repair
- ☐ TAH w/BSO
- ☐ TAH
- ☐ Tonsillectomy
- ☐ Tunneled Dialysis Cath
- ☐ UPPP
- ☐ Urinary Incontinence Surg
- ☐ Vertebroplasty
- ☐ Anesthesia Prob - No
- ☐ Anesthesia Prob - Yes
- ☐ Surg Complications - No
- ☐ Surg Complications - Yes
- ☐ Post-op Delirium

Other: ____

Please fill out back of form.

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Doctor: ____________________

PATIENT INFORMATION

Name: ____________________

Address: ____________________

____

City,State, Zip: ____________________

Phone: ____________________ [ ]Home [ ]Work [X]Other

Phone: ____________________ [ ]Home [ ]Work [X]Other

Phone: ____________________ [ ]Home [ ]Work [X]Other

Ethnicity: [ ]Hispanic or Latino [ ]Non Hispanic or Latino [ ]Other

Patient ID #: ____________________ Sex: [ ]M [ ]F

Date of Birth: ____________________ Age:

Social Security #: ____________________

Preferred Language: ____________________

Marital Status: [ ]Married [ ]Single [ ]Divorced

Email Address: ____________________

Referring Physician: ____________________

Primary Physician: ____________________

Race: [ ]American Indian or Alaska Native [ ]Asian [ ]Black or African American [ ]Native Hawaiian or Other Pacific Islander [ ]White or Caucasian [ ]Other or Undetermined

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Employer's Name: ____________________

Employer's Phone: ____________________

Occupation: ____________________

EMERGENCY CONTACTS

Name	Relationship	Phone

RESPONSIBLE PARTY *(If patient is under 18 years of age)*

Name: ____________________

Address: ____________________

____

City,State, Zip: ____________________

Employer: ____________________

Home Phone: ____________________

Work Phone: ____________________

SSN: ____________________

Date of Birth: ____________________

PRIMARY INSURANCE

Insurance Company Name: ____________________

ID #: ____________________

Group/Policy #: ____________________

Subscriber's Name: ____________________

Subscriber's Phone #: ____________________

Relationship to Patient: ____________________

Subscriber's Employer: ____________________

Subscriber's SS #: ____________________

Subscriber's Date of Birth: ____________________

SECONDARY INSURANCE

Insurance Company Name: ____________________

ID #: ____________________

Group/Policy #: ____________________

Subscriber's Name: ____________________

Subscriber's Phone #: ____________________

Relationship to Patient: ____________________

Subscriber's Employer: ____________________

Subscriber's SS #: ____________________

Subscriber's Date of Birth: ____________________

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. *I understand that I am responsible for any amount not paid for by my insurance.*

____________________ PATIENT/GUARDIAN SIGNATURE ____________________ DATE

I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

____________________ PATIENT/GUARDIAN SIGNATURE ____________________ DATE

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