NORTHLAND FAMILY CARE, P.C.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name (Last, First, Middle Initial)		Date of Birth	Social Security #
Address		Sex	Marital Status
City, State, Zip		Home Phone	Cell Phone
Primary Employer	Work Phone		Email
Employer's Address		City, State, Zip	
Primary Physician	Referred By	Communication Preference: Please check at least one and provide information _____Home Phone _____ _____Cell Phone _____ _____Email _____	
Medical Information may be given to those checked: _____Mother _____Father _____Other/Relationship_____			
Emergency Contact (Name, Relationship)		Emergency Contact Phone #	
Primary Caregiver (for Child or Elderly) - (Last, First, MI)		Primary Caregiver Contact Number (home , cell)	

PATIENT DEMOGRAPHICS - Please Check Where Applicable

Student _____YES _____No _____Full-time Status _____Part-time Status

Retired _____Yes _____No

Veteran or Current Military Status _____Yes _____No

Race:
_____White _____Black or African American _____American Indian or Alaska Native _____Asian
_____Native Hawaiian or Other Pacific Islander _____Unknown _____Decline

Ethnicity: _____Hispanic or Latino _____Non-Hispanic or Latino _____Unknown _____Decline

Preferred Spoken Language:

Do you Smoke or use Tobacco Products _____Yes _____No

Revised July 2012 - Thank you for your assistance with government regulations

PATIENT REGISTRATION FORM

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****PLEASE NOTE THAT ALL CO-PAYS ARE DUE AT TIME OF SERVICE, THANK YOU****

PRIMARY INSURANCE INFORMATION

Name of PRIMARY Insurance Company	Policy #/ ID #	
Name of Policy Holder	Group#	
Relationship of Policy Holder to Patient	Co-Pay Amount	
Address of Insurance Company	Insured Social Security #	Insured Date of Birth
City, State, Zip	Effective Date	Expiration Date

SECONDARY INSURANCE INFORMATION

Name of SECONDARY Insurance Company	Policy #/ ID #	
Name of Policy Holder	Group#	
Relationship of Policy Holder to Patient	Co-Pay Amount	
Address of Insurance Company	Insured Social Security #	Insured Date of Birth
City, State, Zip	Effective Date	Expiration Date

PLEASE ATTACH A COPY OF INSURANCE CARD- IF NO COPY IS AVAILABLE, THE ACCOUNT WILL BE CONSIDERED "SELF-PAY"

Medical Authorization: The undersigned permits the physicians and all other personnel caring for the patient to examine, recommend treatment, and explain any associated risk involved. The undersigned also understands that this care may include diagnostic testing, examinations, or surgical treatment and no guarantees have been made regarding the outcome of this care.

Financial Agreement: I, the undersigned agree to be responsible for the balance of my account. Although an insurance claim (if applicable) will be filed with my insurance company by Northland Family Care on my behalf, negotiating payments through my insurance company is ultimately my obligation. I understand that payment will be made at the time of services rendered unless financial arrangements have been made PRIOR to the services. A statement will be mailed to me showing the balance due from me and will be considered past due after 30 days. If I am unable to make payment in full, I understand that I should contact the business office immediately to set up a payment arrangement. I understand that if no payment has been received or financial arrangements made on my balance, my account may be sent to collections. If my account is referred for collections, I understand that I will be responsible for the balance as well as any fees associated with the collection process.

SIGNATURE DATE

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Street address: _____

City, State, Zip_____

Please communicate my healthcare information in the following manner (Check all that apply):

[ ] Home telephone number: _____
- [ ] OK to leave a message with detailed information
- [ ] OK to leave a message with call-back information only

[ ] Cellular telephone number: _____
- [ ] OK to leave a message with detailed information
- [ ] OK to leave a message with call-back information only

[ ] Work telephone number: _____
- [ ] OK to leave a message with detailed information
- [ ] OK to leave a message with call-back information only

Check the appropriate box:

[ ] I was offered and made available, but I am electing not to receive a copy of the Notice of Privacy Practices

[ ] I acknowledge receiving a copy of the Notice of Privacy Practices

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name:	Telephone Number:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing or three (3) years after the date signed, whichever is first.

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Social Determinants of Health

Patient Questionnaire

Northland Family Care is truly passionate about caring for our patients. In recent months you may have seen news or magazine articles about Social Determinants of Health or Health Equity, but this is not new. Studies about the effect of one's social situation related to their health began 20 years ago. Most of the recent studies indicate that 15 – 20% of overall health outcomes are directly related to a person's social situation. Another study indicates that over 60% of US patients experience some effect on health outcomes based on their social situations.

In order to best care for our patients, we are asking 3 questions. Your answers may very well aid our providers in providing you the best possible care. We all thank you in advance for completing this short questionnaire.

Name: _____ Date of Birth: _____/____/_____

What is your housing situation today? (Please check one)[i]

[ ] I have housing.
[ ] I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car or in a park.
[ ] I choose not to answer this question.

Has lack of transportation kept you from medical appointments, meeting, work, or from getting things needed for daily living? (Check all that apply.)

[ ] Yes, it has kept me from medical appointments or from getting my medication.
[ ] Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need.
[ ] No.
[ ] I choose not to answer this question.

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (Check all that apply.)

[ ] Food
[ ] Fluids
[ ] Utilities
[ ] Medicine
[ ] Phone
[ ] Clothing
[ ] Child Care
[ ] I choose not to answer this question.
[ ] Other

Northland Family Care

Financial Policy

Effective 1/1/2018

We value our relationship with our patients. To make sure there are no misunderstandings, our office policies regarding financial responsibilities for services provided are outlined below. Please review these policies and ask us if you have any questions.

OUR RESPONSIBILITIES

- File primary insurance claims within a timely filing period following the date of service.
- File secondary insurance claims after the primary insurance payment is received.
- Provide information to your insurance company as requested.
- Contact the insurance carrier if the claim is not paid within 45 days after filing.
- Mail itemized statements to you.

YOUR RESPONSIBILITIES

- Present your insurance card and valid picture ID at the time of check-in to confirm correct insurance and billing information. If you do not have your insurance card at the time of check-in you will be considered a self-pay patient.
- Pay co-pays, deductibles and/or co-insurance at check-in by cash, check or credit card. A $20 administration fee will be charged if you do not.
- Verify that all requirements of your insurance plan are met. Two examples of this are (1) confirm with your insurance company that our providers are in network and (2) find out if approvals are needed for referrals.
- Respond immediately to insurance company correspondence concerning claims filed by Northland Family Care on your behalf.
- Contact your insurance company if your claim has not been paid, or if you have not received an explanation of benefits within 45 days.
- Pay all charges upon receipt of the initial statement.
- Call our billing department if you cannot pay your balance in full in 30 days.
- Notify us at least 24 hours in advance if you cannot keep your appointment. We will charge a $25 cancellation fee if you do not notify us at least 24 hours in advance.

ADDITIONAL POLICIES AND INFORMATION

- When treating a minor (person under the age of 18) the legal guardian must give consent for treating the minor. All other policies still apply.
- A $35 fee will be added to the amount of a check returned, regardless of the reason for the return.
- Any balances over 90 days old may, at our discretion, be turned over to a collection agency. If that occurs your account will become a self-pay account, meaning payment must be made at the time of service.
- Worker's Compensation Claims: We do not bill worker's compensation insurance. We do not treat conditions from open worker's compensation claims.
- Auto accidents: (1) All auto accidents will be self-pay appointments (2) We do not file insurance for auto accident claims and (3) we do not accept responsibility for collecting or negotiating insurance settlements. Treatment resulting from auto accident will be considered self-pay.

I have received and will abide by the above policies:

Patient Printed Name: _____ Date of Birth: _____

Patient Signature: _____ Today's Date: _____
(If the patient is a minor, responsible party please sign)

Responsible Party Printed Name (if other than the patient): _____

Welcome to Your Patient-Centered Medical Home

Northland Family Care's PCMH Philosophy: *Providing care that is respectful of and responsive to the individual patient preferences, needs and values ensuring that patient values guide our clinical decisions.*

Patient-Centered is a way of saying that you, the patient, are the most important person in the health care system. You are the center of your healthcare.

A ***Medical Home*** is an approach that yields both better healthcare care and lower costs. With your Medical Home, you are joining a team that provides centralized, comprehensive, coordinated primary evidence based care and cultivates partnerships between patients, their personal physicians, the care giving team, and the patient's family.

A Patient-Centered Medical Home is a Partnership between the patient and their physician.

Being a part of a PCMH, your doctor will:

- Work with you to improve your health
- Review your medications at every visit and discuss with you any interactions or contraindications
- Develop a personal action plan with you to address your chronic conditions
- Set goals with you and monitor your progress
- Use computer technology to monitor your progress and determine if your health is improving
- Inform you of all test results
- Help you take control of your health by providing you educational material, hosting group visits and linking you to other community programs and resources
- Provide you 24-hour access to a clinical decision-maker by phone
- Have arrangements with after-hours care to be informed of your visit or emergent treatment within 24 hours or next business day
- Reserve space in our schedule for you to accommodate a same-day appointment
- Refer you to available community resources when the need arises
- Update your medical, family, social and medication history during office visits
- Offer self-management and behavioral health support

By choosing to participate in a PCMH, YOU (the patient) agrees to:

- Provide my doctor with my entire medical history
- Tell my doctor all of the medications I am taking
- Actively participate with my doctor in planning my care
- Keep my appointments as scheduled
- Adhere to the action plan designed by my doctors
- Consult my doctor before making my own appointment with a specialist
- Request that any other doctor I see, send my doctor a report including copies of lab work, test results, and any x-rays
- Know my insurance and what it covers
- Provide the office feedback on how they can improve

NORTHLAND FAMILY CARE

Patient Centered Medical Home Patient Compact

A **Patient Centered Medical Home** is a trusting partnership between a doctor-led healthcare team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the roll of each in the total healthcare program.

We trust you, our patient to:

- Tell us what you know about your health and illnesses
- Tell us about your needs and concerns
- Take part in planning your care
- Follow the care plan that is agreed upon, or let us know why you cannot so we can try to help and change the plan
- Tell us what medications you are taking and ask for refill at your office visit when you need one
- Let us know when you see other doctors and what medications they put you on or change
- Ask others to send us a report about your care when you see them
- Learn about your insurance so you know what it covers
- Keep your appointment as scheduled, or call and let us know you cannot at least 24 hours in advance
- Pay your share of the visit fee when you are seen in the office
- Give us feedback so we can improve our service

As we build your Medical Home you will notice some changes in the way we provide care, but many things will stay the same. We will continue to:

- Provide you with your own doctor who knows you and your family whenever he/she is available
- Respect you as an individual-we will not make judgments based on race, religion, sex or disability
- Respect your privacy-your medical information will not be shared with anyone unless you give us written permission or it is required by law
- Provider care given by a team of people led by your doctor
- Give the care you need when you need it
- Give the care that meets your needs and fits with your goals and values
- Give care that is based on quality and safety
- Have a doctor on call 24 hours a day, 7 days a week
- Take care of short illness, long-term disease and give advice to help you stay healthy
- Tell you about your health and illness in a way you can understand

Over the next several months, you may notice that:

- We ask what your health care goal is, or what you want to do to improve your health
- We use current best evidence in decision making about your care and offer support for self-management of your health and healthcare
- We ask you to help us plan your care, and let us know if you think you can follow the plan
- We will give you a written copy of the care plan
- The team care members are doing more and/or different parts of the care
- We remind you when tests are due so you can receive the best quality care
- We may ask you to have blood tests done before your visits so the doctor has the results at your visit
- We may offer you a chance to join in a special type of doctors visit called a "group visit"
- We continue to increase the use of technology in the way we manager your healthcare in ways such as ePrescriptions, evisits, and online bill pay

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above, and we will acknowledge our agreement to you.

Either you or your doctor may end this partnership at any time. If you choose to end the partnership, please notify us and tell us why. If your doctor decides to stop seeing you, we will notify you with an explanation as to why. With our written permission, we will forward a copy of your information to your next doctor.

Patient Signature Date of Birth DATE Physician Signature

Northland Family Care
9151 NE 81st Terr. #100
Kansas City, MO 64158
Phone: (816) 781-4740
Fax: (816) 781-0971

Medical Record Release Authorization

Patient Name_____ Maiden Name_____ SS#_____

Date of Birth_____ Home Phone_____ Cell/Work_____

Address_____ City/State/Zip_____

Email Address: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone#_____ Fax#_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone#_____ FAX#_____

C) This request is being made for the following purpose(s):_____

Date Range_____ to_____ or ____ last 3 years or ____ last 2 years ___ or last 1 year

☐ Physicians Office Notes ☐ Cardiology/EKG Reports ☐ Lab/Path Reports
☐ Operative/Procedure Reports ☐ Radiology/XRay/MRI Reports ☐ Other _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to 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.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____**Subject to Fees
(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date: _____
(Expiration date of authorization)

***PLEASE READ** Fee Information: Northland Family Care will provide all medical records requested from our office. We reserve the right to charge the fee schedule as set by the State of Missouri. A $22.82 handling fee, $0.53 cents per page and postage may be invoiced to you from Northland Family Care with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay Northland Family Care for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.