

Chart# _____

**Four Corners Health Care, Inc.
Registration/Insurance Information**

Patient Name: _____ Date of Birth: _____
(Last) (First) (Middle)

Address: _____ Social Security #: _____

City: _____ State: _____ Zip: _____

List phone numbers in order of preference for calling: May we leave a message? Circle One:
#1-Area Code: _____ Number: _____ Yes / No Cell / Home / Other
#2-Area Code: _____ Number: _____ Yes / No Cell / Home / Other
#3-Area Code: _____ Number: _____ Yes / No Cell / Home / Other

E-mail address: _____

Male _____ Female _____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Employer: _____

Employer Phone : Area Code: _____ Number: _____

May we leave a message at your place of employment? Yes / No

If patient is a minor:

Parent/Guardian Name: _____ Parent/Guardian Employer: _____

Work Phone: Area Code: _____ Number: _____ Cell Phone: Area Code: _____ Number: _____

SSN: _____ DOB: _____

Emergency Contact: Name, home phone number, and cell number of a local person that does not live with you:

Name: _____ Relationship: _____

Home Phone: Area Code: _____ Number: _____ Cell Phone: Area Code: _____ Number: _____

Name of person who is responsible for payment: _____

Phone: Area Code: _____ Number: _____

Please note that we do not provide Workers' Compensation care at this time.

Insurance Information (you are responsible for any costs not covered by your insurance):

Allegiance _____ Blue Cross/Blue Shield _____ Health Info Net _____; Policy name: _____

Healthy MT Kids _____ Healthy MT Kids Plus _____ Medicaid _____ Medicare _____ MUST _____

Pacific Source _____ Tri-Care _____ United Healthcare _____ No Insurance _____

Other Insurance: *If you do not have a policy with one of the above insurance carriers, please see our financial policy page. Please list the name of your insurance carrier here:* _____

Policy holder: _____ Policy/ID # _____

(Please present your card(s) to the receptionist)

Note: If you have Medicare, it is usually your primary insurance

I hereby acknowledge that I have been presented with a copy of the **Four Corners Health Care, Inc. Notice of Privacy Practices.**

Signature: _____ Date: _____

Four Corners Health Care, Inc. Patient Financial Policy

The following is an explanation of our financial policy. Our fees are based upon the services provided and are competitive with other practices in the area for the same types of services. You are responsible for payment regardless of any insurance company's arbitrary determination of "reasonable, usual and customary" fees.

Patients must provide all information requested on the patient registration form. If we are filing your claim with your insurance carrier for you, please understand that the bill is your responsibility. Once your insurance carrier has processed your claim, the balance minus any insurance adjustments, will be expected within thirty (30) days. If your insurance carrier sends us a payment for charges you have already paid, we will reimburse you within thirty (30) days.

Blue Cross/Blue Shield, Allegiance, New West, Medicaid, and Tri-Care: As "providers" for these insurance companies, we will file your claim directly. You are responsible for any applicable co-payment and/or deductible at the time of service.

Medicare: Your services are always filed with Medicare. Medicare automatically transfers information to most supplemental insurances. If you are not sure about this transfer, please contact your insurance agent or call the Medicare office at 1-800-332-6146. Please keep all copies of your billing statement until you receive an explanation of payment from Medicare and your supplemental insurance.

Minor Patient: The adult accompanying a minor and the parents (or guardian) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless arrangements have been made prior to the minor's visit.

Workers' Compensation: We do not currently file Workers' Compensation claims.

Other Insurance: *If we are not providers for your insurance company, payment will be expected at the time service is rendered.* We do not file other types of insurance claims. However, we will provide you with a statement at each visit that you can submit to your insurance company for reimbursement based on your policy plan and coverage. WE suggest that you make a copy of all items you are mailing to your insurance company in the event they are lost or misplaced. We do not negotiate our service costs with insurance companies (referred to most often in terms of "reasonable and customary" discounts). We do encourage you to contact them if you have questions concerning coverage, payments, hospital stays, and preauthorization of significant procedures (i.e., CT scan, MRI).

We accept the following forms of payment:

CASH, DEBIT CARD, CHECK (\$30.00 return fee), VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER.

Any charges which are outstanding for thirty (30) days after a final payment by your insurance carrier are subject to a finance charge of 1.5% per month. In the event any action or litigation required to collect unpaid charges, Four Corners Health Care, Inc. shall be entitled to collect all costs and expenses incurred, including reasonable attorney's fees, and all costs or fees on appeal or in any bankruptcy proceeding.

Signature of Patient or responsible party Date

Print name of Patient or responsible party

FOUR CORNERS HEALTH CARE, Inc.
Assignment of Benefits/Release of Information/Disclosure

Assignment of Benefits

I hereby assign to Four Corners Health Care, Inc. any insurance or other third-party benefits available for health care services provided to me. I understand that Four Corners Health Care, Inc. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Four Corners Health Care, Inc., I agree to forward to Four Corners Health Care, Inc. all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____

Date: _____

Authorization for Release of Information

I authorize Four Corners Health Care, Inc. to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize Four Corners Health Care, Inc. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Four Corners Health Care, Inc.

I agree that these provisions will remain in effect until I provide written revocation to Four Corners Health Care, Inc.

Signature of Patient/Legal Guardian: _____

Date: _____

Disclosure

Four Corners Health Care, Inc.'s usual hours are Monday-Friday, 9AM-5PM. We are closed in the evenings, weekends, and major holidays. There may be instances when the clinic closes early or is closed for an entire day or period of time. In this event, a reasonable effort will be made to contact patients with appointments and provide a recorded phone message as to when the clinic will next open.

Health care is provided by appointment. Walk-ins are welcome, based on provider availability. For after-hours care or when the clinic is closed, go to the nearest hospital emergency room or call 911.

During the course of health care visit, it may be determined that specialty care is needed. When necessary and feasible to do so, a reasonable effort will be made to assist patients who need to be referred for specialized care. However, Four Corners Health Care, Inc. is not responsible or liable if they cannot locate a specialty care physician who will accept such referral. Urgent concerns (including anticipation of hospitalization) will be referred to the Bozeman Deaconess Hospital emergency room.

Signature of Patient/Legal Guardian: _____

Date: _____

Four Corners Health Care, Inc.
Adult Past Medical History

Date: _____

Patient Name: _____ Date of Birth: _____

Where do you receive your routine health care? _____

What other health care providers have you seen in the past 6 months? _____

Any major accidents or injuries?: No / Yes (If yes, please explain) _____

Any serious or chronic illnesses?: (Please circle as appropriate)

diabetes hypertension heart disease sickle cell anemia cancer seizure disorder Polio

Other _____

Hospitalizations/Operations?:

YEAR	REASON	YEAR	REASON

Women Only

Obstetric history:

number of pregnancies _____; number of live deliveries _____;

number of pre-term pregnancies _____; number of incomplete pregnancies _____.

Were there any problems with the postpartum course?: No / Yes _____

Adult Immunizations:

Date of last pneumococcal vaccine (65 & older) _____;

Date of last tetanus immunization _____

Child Immunizations:

Are immunizations up-to-date? No / Yes

Where do you receive immunizations? _____

Approximate date of last examination for:

dental _____; vision _____; hearing _____; EKG _____;

Stress test _____; chest x-ray _____; colonoscopy _____; PSA _____;

mammogram _____; pap smear _____;

DEXA scan _____;

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File: My Computer > Local Disk (C:) > Office Manager > Front Desk > Office Organization Items > Forms > "Adult Past Medical History Form"

Four Corners Health Care, Inc.

Adult Social History

Date: _____

Patient Name: _____ Date of Birth: _____

Marital Status: Single Married Widowed Divorced Separated

Religious affiliation, (optional): _____

Family Members and significant others:

Name	DOB	Relationship	Live with you? Y / N

Home owner/renter: House Apartment/condo Mobile home Other _____

Pets: _____

Have you ever used tobacco? N / Y
Circle as appropriate: Cigars / Cigarettes / Chewing Tobacco
How much? _____ How long? _____ When quit? _____

Do you have a marijuana card? N / Y If yes, for what? _____

Caffeine use? N / Y If yes, amount: _____

Alcohol use? N / Y If yes, amount: _____

Occupation: _____

Work exposures you are aware of: _____

Recreation activities/exercise: _____

Hobbies/interests: _____

Sources for emotional support: _____

Four Corners Health Care, Inc.

Patient & Family History

Date: _____

Patient Name: _____

Sex: M F Date of Birth: _____

Was patient adopted? Y/N

If yes, from where? _____

Please circle as appropriate: N = no and Y = yes If yes, please check who condition relates to (parents, siblings, grandparents, aunts/uncles, first cousins).

Have you or a family member had any of the following?:

	You:	Family Member (who?):
No/Yes Alcohol/Drug problems	_____	_____
No/Yes Allergies	_____	_____
No/Yes Anemia/ Low blood	_____	_____
No/Yes Anxiety	_____	_____
No/Yes AIDS/HIV	_____	_____
No/Yes Asthma/Lung problems	_____	_____
No/Yes Arthritis, Bone or joint	_____	_____
No/Yes Autism/Neurological problems	_____	_____
No/Yes Behavioral problems	_____	_____
No/Yes Blood disorders/bleeding problems	_____	_____
No/Yes Cushing's Disease	_____	_____
No/Yes Diabetes	_____	_____
No/Yes Ear/Hearing problems	_____	_____
No/Yes Heart disease/Stroke (<60 years old)	_____	_____
No/Yes High blood pressure	_____	_____
No/Yes High cholesterol	_____	_____
No/Yes Jaundice/Liver disease	_____	_____
No/Yes Kidney disease/Bladder problems	_____	_____
No/Yes Learning problems	_____	_____
No/Yes MS	_____	_____
No/Yes Obesity	_____	_____
No/Yes Parkinsons disease	_____	_____
No/Yes Psych. condition	_____	_____
No/Yes Seizure disorders	_____	_____
No/Yes Sickle cell	_____	_____
No/Yes Skin Problems/Eczema	_____	_____
No/Yes Stomach ulcers	_____	_____
No/Yes Sudden death (infancy or childhood)	_____	_____
No/Yes Thyroid problems	_____	_____
No/Yes Tuberculosis	_____	_____
No/Yes Unexpected sudden death (<60 years old)	_____	_____
No/Yes Vascular problems	_____	_____

Other (Please explain): _____