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 your have already paid, we will reimburse your 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.

PEDIATRIC MEDICAL HISTORY

Date: ______________

Child's Name: ____ Child's Date of Birth:______________

Birth weight:________________ Was baby premature?: Y / N

Was child adopted?: Y / N

Please list any significant prenatal, birth, or postnatal history:

____

____

List any major or chronic illnesses: ____

____

List any major injuries: ____

____

List hospitalizations (date & reason): ____

____

Please list any childhood problems or concerns regarding:

Growth and development: ____

Behaviors: ____

Are immunizations up-to-date? Yes / No Where are they received? ______________________

When was last well baby/child check up? ____________________ Where? ______________________

Special notes: ____

Usual health care provider: ____

Four Corners Health Care, Inc.
Pediatric Social History

Today's Date: ______________

Patient Name: ____ **Date of Birth:** _____________

Religious affiliation, (optional): ______________________________

Family Members:

Name	DOB	Relationship	Live with you? Y / N

Pets: ____

Smokers living with patient: Y /N
(including patient, if applicable)
If yes, who? _______________________________

Caffeine use: Y / N
If yes, amount: ____________________________

Alcohol use: ***(if applicable)*** Y / N
*If yes, amount:*_____________________________

Car or booster seat / safety belt: Y / N

Bicycle helmet: Y / N / Not Applicable

Grade in school: ______

Special Education Services: Y / N
If yes, why? _____________________________________

Father's occupation: __________________________ Currently employed? Y/N

Mother's occupation: __________________________ Currently employed? Y/N

Daycare arrangements: ***(if applicable)*** __________________________________

Four Corners Health Care, Inc.

Medications and Allergies List

Patient Name:________________________________ Date of Birth: ______________________

Help us care for you better by telling us what prescriptions and over-the-counter medications you take and any allergies you may have.

Prescriptions						
Name of medicine	Dose (total milligrams)	How many times per day?	When do you take it? (Morning and night? After meals?)	Who prescribed it for you?	Why do you take it?	Do you have any side-effects? Describe them.
Over-the-counter medications, herbal remedies, vitamins, aspirin, etc.						

Form of Contraception used: ____

Allergies:

Medicines: Y / N ____

Foods: Y / N ____

Animals: Y / N ____

Environmental: Y / N ____

Latex: Y / N ____

Other: Y / N ____

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	Parkinson=s 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): ____