Heart and Soul
FAMILY MEDICINE

Patient Information

Patient Name: _____ Birthday: _____ Gender: _____

Email address: _____ Social Security No. _____

Address: _____ City/State: _____ Zip: _____

Preferred Phone: _____ Other Phone: _____

Ethnicity/Race

□ American Indian/Alaskan Native
□ Asian
□ Black/African American
□ Native Hawaiian/Pacific Islander
□ Hispanic/Latino
□ White/Caucasian
□ Other: _____
□ Decline to Specify

Marital Status: _____ Spouse's Name: _____

Emergency Contact Information

Emergency Contact: _____ Relationship: _____

Preferred Phone: _____ Other Phone: _____

Insurance

Insured Party: _____ Relationship to Patient: _____

Insured Party's Birthdate: _____ Insured Party's Social Security No. _____

Insurance Company Name: _____

If insurance card not provided to copy, please complete the following information: ☐ Card provided

Address: _____ Phone: _____

Policy No. _____ Group No. _____

Dual Coverage? _____ 2nd Insurance Company Name: _____

Insured Party: _____ Relationship to Patient: _____

Policy No. _____ Group No. _____

I authorize providers of Heart and Soul Family Medicine and/or Crison Footcare to employ X-Rays, photographs, anesthetics, medicines, surgeries and other equipment or aids as deemed necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on the patient's behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Patient Date

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Patient Name: **Date:**

Are you allergic to any medications? □ No □ Yes Please list: _____

Current Medications:

Medical History:

□ Peripheral Vascular Disease	□ Seasonal allergies	□ Blood Clots
□ Chest Pain/Angina	□ Asthma/COPD	□ Diabetes
□ High Blood Pressure	□ Stroke	□ Acid Reflux (GERD)
□ Heart Disease	□ Seizures	□ Depression
□ High Cholesterol	□ Thyroid Disease	□ Anxiety
□ Pacemaker	□ Liver Disease	□ Other (Please list)
□ Congestive Heart Failure	□ Arthritis	□ _____
□ Kidney Disease	□ Cancer	□

Surgical History (Specify approximate year):

□ Tonsils: _____	□ Gallbladder: _____
□ Appendix: _____	□ Hysterectomy: _____
□ Cataracts: _____	□ Hernia: _____
□ Back: _____	□ Heart Surgery: _____
□ Other:	

Social History

Smoking: □ Never □ Former Quit Date: _____ □ Current Packs per day: _____

Alcohol consumption: □ Never □ Occasional □ Frequent

Drug use: □ Never □ Occasional □ Current □ Type

Family History

Please list any known medical problems: □ Adopted, no known family history

Mother: _____

Father: _____

Maternal Grandmother: _____ Paternal Grandmother: _____

Maternal Grandfather: _____ Paternal Grandfather: _____

Sisters: _____ Brothers: _____

I verify that the above information factual and true to the best of my knowledge.

_____ _____

Patient Date

Patient Name_____Date_____

PAYMENT AGREEMENT

As a courtesy, Heart and Soul Family Medicine, and Crison Footcare, will file insurance claims with your insurance carrier. Your insurance company, in lieu of reimbursing you directly, will pay Heart and Soul Family Medicine, or Crison Footcare, any benefits for services rendered. Your medical insurance carrier may pay less than the actual bill for services, so you may be responsible for payment of all services rendered. Rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

Payment in full is due at the time service is provided in our office including all applicable copayments, coinsurance, and/or outstanding balance. You are responsible to provide accurate insurance information. A current insurance card will be required at every visit to ensure accurate filing of claims. When applicable, a government issued photo ID is required to be seen.

By signing below, I agree to pay all amounts owed within 30 days of when such amounts are incurred regardless of insurance coverage. I understand and agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I understand and agree that interest will accrue on all past due amounts at the rate of 33% per month until paid in full. In the event that any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, such as interest, court costs, reasonable attorney's fees, etc., I will also be responsible for a collection fee of up to 33% of the principle amount(s) owing as allowed by Utah code. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility, whether such amount(s) are incurred today or after today.

_____

Patient Signature

----------OR----------

_____ _____ _____

Patient Representative Printed Name Patient Representative Signature Relationship

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Patient Name: _____ Date: _____

LABORATORY POLICY

All lab testing ordered by the providers at Heart and Soul Family Medicine and/or Crison Footcare will be sent to an outside laboratory and will be billed separately by that laboratory to your insurance company. You will be responsible to pay for all laboratory charges, whether it is a covered benefit of your insurance. The laboratory will bill you separately for these charges. Most insurance companies have a contracted laboratory that you must use for your lab work to be covered by your insurance. You are responsible for knowing the preferred laboratory required by your insurance company. We do not know the benefits of your personal policy nor can we be familiar with all policies available. All lab testing performed is routinely sent to Lab Corp. If you require a different laboratory, please notify a staff member prior to collection of lab samples. Heart and Soul Family Medicine/Crison Footcare is not responsible for your laboratory bills.

MISSED APPOINTMENT POLICY

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time. Our missed appointment policy is as follows: a 24-hour notice is required. Arriving more than 10 minutes after your scheduled appointment is considered a missed appointment. After the first missed appointment you will receive a phone call to remind you of the missed appointment and to reschedule your appointment. After the second missed appointment you (not your insurance company) will be charged $50 for the time slot we were not able to fill when you did not keep your appointment. You will be required to hold subsequent appointments with your credit card information. On the third missed appointment, it will be our discretion as to whether a discharge letter will be sent out disengaging you from the practice and giving you 30 days to enroll with a new provider.

PRIVACY RIGHTS

As our patient you have specific privacy rights. We are required by law to attempt to obtain acknowledgement of receipt of "Patient Notice of Privacy Rights". We are required to have a notice available for our patients detailing how medical information about you may be used, disclosed and how you can get access to this information. You have a right to review our notice before signing this acknowledgement. A copy of our "Patient Notice of Privacy Rights" is available from the receptionist upon request.

CONSENT FOR TREATMENT

By signing this form, you are giving my permission for the providers and staff at Heart and Soul Family Medicine and/or Crison Footcare to provide treatment to the patient identified, including the performance of testing and/or procedures, as deemed necessary in the exercise of their professional judgment.

_____
Patient Signature

----------OR----------

_____ _____ _____
Patient Representative Printed Name Patient Representative Signature Relationship

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Your privacy is important to us. Help us understand your privacy needs by completing the information below.
*Please note, that **no** health care information will be released to anyone that is not listed below.*

May we identify ourselves over the phone? ☐ Yes ☐ No May we leave messages? ☐ Yes ☐ No

May we leave messages regarding lab results? ☐ Yes ☐ No May we text message? ☐ Yes ☐ No

I, the Patient, hereby authorize the providers at Heart and Soul Family Medicine and/or Crison Footcare to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

_____ _____ _____

Date Patient Printed Name Patient Signature (Leave blank for minor)

_____ _____ _____

Date Patient Representative Printed Name Patient Representative Signature

_____

Relationship to Patient