Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _____ - _____

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for HARRISONVILLE FAMILY MEDICINE INC**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize HARRISONVILLE FAMILY MEDICINE INC to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for HARRISONVILLE FAMILY MEDICINE INC**

Signed_____ **Date:**_____

- **I authorize HARRISONVILLE FAMILY MEDICINE INC to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____

Harrisonville Family Medicine, Inc,
Privacy Consent Form

_____ Myself *(Only check if 18 or older)*

_____ Spouse: _____

Family members/others:

_____ All adult family members

_____ Emergency contact _____ *(only contact in emergency)*

_____ Specific people: _____

Messages:

_____ May leave a detailed message on answering machine/voicemail.

_____ NO DETAILS on answering machine or voicemail – ONLY to call office.

_____ Consent to text?

_____ Ok for portal?

_____ Consent for normal test results to be automatically posted to Patient Portal?

Email: _____

Note: It is your responsibility to notify HFM of any changes that need to be made to this form.

I acknowledge that by signing below, that I authorize Harrisonville Family Medicine, Inc. to disclose any information related to my/my child's care, with the choices I have indicated above. I also acknowledge that I have received and read a copy of HFM Notice of Privacy Practices.

_____ _____

Patient/Personal Representative **Date**

_____ _____

Relationship to Patient **Witness**

Harrisonville Family Medicine

2820 E Rock Haven Road, Ste 100
Harrisonville, MO 64701
Phone (816) 380-3582 / **Fax (816) 380-6964**

Patient Name _____ **Social Security Number** _____ **Date of Birth** _____

Releasing records ***FROM:*** _____
(Physician or Organization name)

_____
(mailing address, phone and fax number)

Releasing records ***TO***: _____
(Physician or Organization name)

_____
(mailing address, phone and fax number)

Please select only ONE of the following: I give my permission to release the following records to the above stated entity: (include dates where appropriate)

_____ Confined to records for the time period of: _____

_____ Confined to records regarding the specific information: _____

_____ All records without regard to limitations placed on dates, history of illness, or diagnostic and therapeutic information, including AIDS/HIV testing or diagnosis, information or treatment for alcohol, drug abuse, and testing and diagnosis of psychiatric illness. *We will ask for the last 2 yrs unless specific information is noted. *

For the purpose of: _____

This authorization is voluntary. This authorization will expire in _____ (e.g. 60 days) from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the office in writing, but if I do, it will not have any effect of any actions taken prior to receiving the revocation. I agree to waive all claims against the office for the release of the requested information. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the office if the recipient of the information is not a health plan, health care provider, health clearinghouse, or a business associate that has a contract with the office. I understand that I must provide the office with at least twenty-four (24) hours' notice before coming to the facility to review records. I understand that after I have reviewed the records, I must provide the office with two (2) working days advance notice of any copies of the records that I would like to pick up at the office. I understand that if I wish to have copies of records made, then the office will assess a fee for copying the records. The facility will notify me of the total amount due for copying and shipping of the requested records. I agree that the office will only send me the requested information once payment has been received in full for the charts. I understand that once the requested records leave HFM, they are the responsibility of the patient/recipient. I understand that I have the option to have these records copied to a data disc, or an electronic copy can be made. The patient/recipient will be responsible for providing a flash drive for the electronic copy.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Revised 3/07/2024

Past Medical History Form

Name:_____ DOB:_____

Gastrointestinal
- Ulcer
- Colon Polyps
- Colon Infections
- Diverticulosis
- Diverticulitis
- Acid Reflux
- Hepatitis
- Liver Disease
- Irritable Bowel
- Crohn's

Endocrine
- Elevated Thyroid Levels
- Low Thyroid Levels
- Diabetes Type I
- Diabetes Type II

Pulmonary
- Environmental Allergies
- Chronic Lung Disease
- Chronic Bronchitis
- Chronic Sinusitis
- Asthma
- Sleep Apnea

Musculoskeletal
- Low Back Pain
- Gout
- Rheumatoid Arthritis
- Osteoporosis
- Osteoarthritis
- Fibromyalgia

Cardiovascular
- Coronary Artery Disease
- Atrial Fibrillation
- Previous Heart Attack
- Elevated Blood Pressure
- Hyperlipidemia
- Blood Clot
- Congestive Heart Failure

Genitourinary
- Kidney Stones
- Chronic Kidney Disease
- Urinary Tract Infections

NeuroPsych
- Seizure Disorder
- Stroke
- Attention Deficit Disorder
- Depression
- Anxiety
- Dementia
- Alzheimer's
- Bipolar Disorder
- Migraine Headache

Miscellaneous
- Anemia
- HIV Infection
- Glaucoma

Social History

Smoking Status:
- Current
  - How Often? _____
- Former
  - Quit Date? _____
- Never
- Alcohol Use _____

Male
- Elevated PSA
- Erectile Disorder
- Prostate Enlargement

Female
- LMP
- Last Pap Smear
- History of Abnl Paps
- # of Pregnancies
- Contraception
- Sexually Active

Personal History of Cancer
- Brain Cancer
- Thyroid Cancer
- Breast Cancer
- Colon Cancer
- Lung Cancer
- Prostate Cancer
- Leukemia
- Lymphoma
- Ovarian Cancer
- Cervical Cancer
- Uterine Cancer
- Kidney Cancer

Family Medical History

	Relationship
Heart Attack	
High Blood Pressure	
Heart Disease	
Heart Failure	
Blood Clots	
Asthma	
Chronic Lung Disease	
Cancer Type: _____	
Diabetes	
Depression	
Anxiety	
Mental Illness	
Alcoholism	
Alzheimer's	
Seizure Disorder	
Migraine Headaches	
Stroke	
Kidney Disease	

Past Surgical History

Cardiovascular
- Aneurysm Repair
- Heart Bypass Surgery
- Carotid Artery Surgery
- Heart Valve Replacement
- Pacemaker
- Defibrillator
- Stent Placement

Musculoskeletal
- Hip Replacement
- Knee Surgery
- Knee Replacement
- Shoulder Surgery
- Rotator Cuff Repair
- Carpel Tunnel
- Lower Back Surgery
- Neck Surgery

Genitourinary
- Kidney Removal
- Kidney Stone Surgery
- Vasectomy
- Prostate Surgery

Gastrointestinal
- Appendectomy
- Gallbladder Removal
- Colectomy
- Colostomy
- Ileostomy
- Weight Loss Surgery
- Hemorrhoid Surgery
- Pancreas Surgery
- Spleen Removal

Hernia Repair
- Incisional
- Inguinal
- Umbilical
- Abdominal

Other
- Lung Surgery
- Thyroid Surgery
- Cateract Surgery
- Ear Tubes
- Tonsillectomy
- Adenoidectomy
- _____
- _____

OB/Gyn
- Total Abd. Hysterectomy
  - With Ovary Removal
- Vaginal Hysterectomy
- Tubal Ligation
- Cesarean Section
- Mastectomy
- Lumpectomy
- Breast Augmentation
- Breast Reduction

Revised 5-14-20

Harrisonville Family Medicine, Inc.

Financial Policy
Effective Date: 7/1/2019

Thank you for choosing Harrisonville Family Medicine as your healthcare provider. Please read the following information carefully. This is an agreement between Harrisonville Family Medicine, Inc., as creditor, and the patient / debtor / responsible party. By executing this agreement, you are agreeing to pay for all services that are received.

Contracted Insurance: You are expected to pay deductibles and co-payments at the time of service. You must also pay outstanding balances prior to being seen in the office. **If you are not able to resolve an outstanding balance or pay the copay due before your next appointment, please be aware that your appointment will need to be rescheduled until your balance is paid in full or reasonable payment arrangements are made. If your appointment is rescheduled due to non-payment at time of check in there will be a $60 no show fee applied.** The deductible will be collected until your yearly deductible has been reached. It is your responsibility to know what is and what is not covered under your plan. It is the insurance company that makes the final determination of your eligibility and coverage. **You will be responsible for any and all charges not covered by your insurance company.**

Self-Pay Patients: Payment is expected at the time of service. If you cannot pay at the time of service, your appointment will be rescheduled.

Monthly Statements: If you have a balance of $10.00 or more on your account, we will send a monthly statement. **Please remember when you receive our statement you have already received quality care from your physician, your insurance has been filed and any payment or adjustment from your insurance company has been applied. The balance on your account is due and payable when the statement is issued.**

Past Due Accounts: Balances that remain on your account past 45 days are considered overdue and full payment will be expected at future appointments unless a payment plan has been arranged and approved by our billing department. Accounts over 90 days in arrears will be sent to our collection agency. At that point, for any new charges to be added to your account our office will require a credit card on file. Once an account has been placed in collections, the physician/patient relationship could be terminated, and your records will be transferred to a physician of your choice. If your balance is paid after termination has taken effect, reinstatement will involve a fee of $25. **If a balance occurs on the account again, this will result in FINAL TERMINATION and reinstatement will not be an option.**

Forms & Fees: Your portion of any form must be filled out completely before submitting it to us. A fee will be charged and collected when your form is returned to you or submitted on your behalf.

No Show Policy: A $60 fee will be charged for any missed appointment without 24-hour notice. This is not covered by insurance and must be paid prior to your next appointment. Multiple no shows in any 12-month period could result in termination from our practice.

Print Name: _____ **Signature:** _____ **Date:** _____

Revised 10/14/2021

HARRISONVILLE FAMILY MEDICINE INC • 2820 E ROCK HAVEN RD STE 100, HARRISONVILLE MO 64701-4413

Current Medication and Supplements List

Date:_____

Patient Name: Date of Birth:

Medication or Supplement Name	Strength	Dose	Frequency
Example: Vita D3	5,000iu	1 tablet	Twice a Day