

****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:
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:

Other

Patient Referred by:

Primary Care Provider:

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

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:

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:

Pharmacy Information:

Name:
Crossroads:
Phone:

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, Inc.

Communications & Financial Policy

Our goal is to provide timely, consistent communication and high-quality care. The following guidelines outline typical timeframes and processes so our patients can know what to expect and plan accordingly.

1. Patient Messages:

- Phone calls and portal messages will be returned **the same business day** if received **before 3:00 PM Mon – Thurs and 2:00PM on Friday**.
- Messages received **after 3:00 PM Mon -Thurs and 2:00PM on Friday** will be returned **the next business day**, unless the matter is urgent.

2. Prescription Refills:

- Please allow **up to 72 hours** for prescription refill requests to be processed.
- Always check with your **pharmacy first**, they will contact us electronically to streamline the process.

3. Medication Policies:

- Controlled substances require regular office visits and monitoring.
- Lost, stolen, or misplaced prescriptions **cannot** be replaced unless there are extenuating circumstances.
- Certain medications may require random urine drug screening and/or a controlled substance agreement.
- **Controlled Substances will not be after clinic hours under any circumstances.**

4. Medication Prior Authorizations:

- Medication prior authorizations may take **up to 1 week** to complete.
- Timelines may vary depending on your insurance plan's requirements.

4. Lab and Test Results:

- Lab and diagnostic test results will be available **within 3 business days** after our office receives them.
- Some specialized tests may require additional time.

5. Referrals and Specialist Appointments:

- If you have not been contacted regarding a referral or specialist appointment **within 7 business days**, please check the Patient Portal or call our office so we can check on the status.

6. Provider Out of Office:

If your provider is out of the office, you have options:

- You may choose to have your question addressed by **another provider** in our practice.
- Or you may wait for your **primary provider** to return, depending on the urgency of the issue.

7. Forms and Documents: (FMLA, Letters of Medical Necessity, etc.)

- Please allow **7 business days** for completion of all forms and letters.
- All patient-required sections must be **fully completed before** submitting forms to our office.
- A **fee will be charged and collected** prior to completion or submission of any form on your behalf. Fees vary based on the type of form; please speak with a patient representative for details.

8. Appointment and Cancellation Policy:

- Please arrive **10-15 minutes early** to allow time for check-in and verification of information.
- Appointments must be canceled with **at least 24 hours' notice**.

Revised 8.25.2026

- A \$60 **no-show fee** will be charged for any missed appointments without 24-hour notice. This is not covered by insurance and must be paid prior to your next appointment. Multiple no shows could result in termination from our practice.

As always, if you have any questions, please reach out to one of our patient representatives—we're here to help! Thank you for trusting us as your partner in healthcare.

Financial Policy

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 agree 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 \$40 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.**

Patient Understanding & Acknowledgment:

I have reviewed the above and understand the general timeframes, processes and policies our office follows to provide consistent, high-quality care and that these guidelines help support smooth communication and ensure the best possible experience for all patients.

By signing below, I acknowledge that I understand these expectations and will partner with the HFM team in respectful, and open communication.

Patient Name: _____ **DOB:** _____

Signature: _____ **Date:** _____



Current Medication and Supplements List

Date: _____

Patient Name:

Date of Birth:

[illegible]

Past Medical History Form

Gastrointestinal		Social History	Past Surgical History
Ulcer		Smoking Status:	Cardiovascular
Colon Polyps		Current	Aneurysm Repair
Colon Infections		How Often?	Heart Bypass Surgery
Diverticulosis		Former	Carotid Artery Surgery
Diverticulitis		Quit Date?	Heart Valve Replacement
Acid Reflux		Never	Pacemaker
Hepatitis		Alcohol Use	Defibrillator
Liver Disease			Stent Placement
Irritable Bowel		Male	Musculoskeletal
Crohn's		Elevated PSA	Hip Replacement
Endocrine		Erectile Disorder	Knee Surgery
Elevated Thyroid Levels		Prostate Enlargement	Knee Replacement
Low Thyroid Levels			Shoulder Surgery
Diabetes Type I		Female	Rotator Cuff Repair
Diabetes Type II		LMP	Carpel Tunnel
Pulmonary		Last Pap Smear	Lower Back Surgery
Environmental Allergies		History of Abnl Paps	Neck Surgery
Chronic Lung Disease		# of Pregnancies	Genitourinary
Chronic Bronchitis		Contraception	Kidney Removal
Chronic Sinusitis		Sexually Active	Kidney Stone Surgery
Asthma			Vasectomy
Sleep Apnea		Personal History of Cancer	Prostate Surgery
Musculoskeletal		Brain Cancer	Gastrointestinal
Low Back Pain		Thyroid Cancer	Appendectomy
Gout		Breast Cancer	Gallbladder Removal
Rheumatoid Arthritis		Colon Cancer	Colectomy
Osteoporosis		Lung Cancer	Colostomy
Osteoarthritis		Prostate Cancer	Ileostomy
Fibromyalgia		Leukemia	Weight Loss Surgery
Cardiovascular		Lymphoma	Hemorrhoid Surgery
Coronary Artery Disease		Ovarian Cancer	Pancreas Surgery
Atrial Fibrillation		Cervical Cancer	Spleen Removal
Previous Heart Attack		Uterine Cancer	Hernia Repair
Elevated Blood Pressure		Kidney Cancer	Incisional
Hyperlipidemia			Inguinal
Blood Clot		Family Medical History	Umbilical
Congestive Heart Failure			Abdominal
Genitourinary		Heart Attack	Other
Kidney Stones		High Blood Pressure	Lung Surgery
Chronic Kidney Disease		Heart Disease	Thyroid Surgery
Urinary Tract Infections		Heart Failure	Cataract Surgery
NeuroPsych		Blood Clots	Ear Tubes
Seizure Disorder		Asthma	Tonsillectomy
Stroke		Chronic Lung Disease	Adenoidectomy
Attention Deficit Disorder		Cancer	
Depression		Type: _____	
Anxiety		Diabetes	OB/Gyn
Dementia		Depression	Total Abd. Hysterectomy
Alzheimer's		Anxiety	With Ovary Removal
Bipolar Disorder		Mental Illness	Vaginal Hysterectomy
Migraine Headache		Alcoholism	Tubal Ligation
Miscellaneous		Alzheimer's	Cesarean Section
Anemia		Seizure Disorder	Mastectomy
HIV Infection		Migraine Headaches	Lumpectomy
Glaucoma		Stroke	Breast Augmentation
		Kidney Disease	Breast Reduction

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