Rogers Medical, LTD.

Patient Intake Form

Name:_____Today's Date: _____

First, Middle, Last

Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone( )_____ Cell Phone ( )_____
Email Address:_____ May we send information here? **Y/N**
Birth date:_____ Age:_____ SSN:_____
Employer:_____Years there:_____ Occupation:_____
Work Phone ( )_____May we contact you at work? **Y/N**

Complete this section only if someone other than the patient is financially responsible.

Responsible Party:_____ Relationship to Patient:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone( )_____ Cell Phone ( )_____
Email Address:_____ May we send information here? **Y/N**
Birth date:_____ Age:_____ SSN:_____
Employer:_____ Years there _____ Occupation:_____
Work Phone ( )_____May we contact you at work? **Y/N**

In case of emergency,contact:_____Relationship_____
Home Phone ( )_____ Work Phone ( )_____

How did you learn about our practice? (please circle)
family, friend, work, yellow pages, local church, internet, zoc doc, newspaper, other_____

[Primary Insurance]

Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____ Co-pay $_____
Group Number: _____ Policy ID Number: _____

[Secondary Insurance]

Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____C0-pay $_____
Group Number: _____ Policy ID Number: _____

- Did your injury happen on the job? **Yes/ No**
- If yes, on what date did the injury occur? _____
- Did you report the accident to your employer? **Yes/ No**

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co pay, and non-covered service amounts. See our complete financial policy for details.

I,_____have filled out all the above information to the best of my knowledge. I authorize my insurance benefit be paid directly to the physician. I understand that I am financially responsible for any balance(s). I also authorize Rogers Medical, Ltd. or insurance company to release any information required processing any claims

NO SHOW POLICY

If you are unable to come in for your appointment, please call with 24 hours of your scheduled appointment time to re-schedule or cancel. Any patient with appointments that have been and not cancelled within a timely manner with be issued a **$ 50.00 NO –SHOW- FEE**.

Signature of Patient/Legal Guardian: _____Date: _____

Current Medications: (please include over the counter medications and food supplements)

Drug Name:	**Dose**	**How often?**

Are You **ALLERGIC** to any medications? **Yes/No**
Please specify: _____

Past Medical History:

Please review the list below and check any problems you have had now or in the past

	Abnormal Pap Smear		Eczema		Osteoporosis
	Acne		Emphysema		Positive TB Skin Test
	Add/ ADHD		Frequent UTI's		Prostate Problems
	Alcohol Abuse		Sinus Infection		Psoriasis
	Anemia		Gallstones		Reflux (heartburn)
	Anxiety Disorder		Glaucoma		Rheumatoid Arthritis
	Asthma		Gout		Rosacea
	Bipolar Disorder		Heart Attack		Seasonal Allergies
	Blood Clot		Heart condition		Seizures
	Blood Transfusion		Hepatitis (specify A,B,C		Sexually Trans. Disease
	Cancer (what kind)		High blood Pressure		Stomach Ulcers
	Chronic Bronchitis		High Cholesterol		Stroke
	Crohn's Disease /IBS		Kidney Disease		Tuberculosis
	Colon Polyps		Kidney Infections		Thyroid Disease
	Colonoscopy (when)		Kidney Stones		Ulcerative Colitis
	Depression		Lupus		Warts
	Diabetes		Melanoma. Skin Cancer		Allergies(specify):
	Diverticulitis		Migraines		
	Drug Abuse		Osteoarthritis		
	Eating Disorder		Osteopenia		

Other medical problems not on list:_____

Please check or list all of the **SURGERIES** you have had:

X	Type of Surgery	Year
	Appendectomy	
	Arthroscopy	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery	
	Hemorrhoids	
	Hernia	

X	Type of Surgery	Year
	Hysterectomy	
	Knee or Hip Replacement	
	Mastectomy or Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery	
	Other(specify)	

For Women:

Last menstrual period	/ /	Age of first period		# of pregnancies	
Last pap smear n/a	/ /	# of days in cycle		# of live births	
Last mammogram n/a	/ /	Are you menopausal	Y N	# of miscarriages	
Last bone density	/ /	Age of onset menopause		# of abortions	
				# of living children	

Family History: Have any of your family members had any of the following problems?

X	Condition:	Family Member	X	Condition	Family Member
	Heart Disease/attack			Osteoporosis	
	Stroke			Migraines	
	Diabetes			Breast Cancer	
	High Blood Pressure			Colon Cancer	
	High Cholesterol			Prostate Cancer	
	Thyroid Disease			Lung Cancer	
	Depression			Ovarian Cancer	
	Alcoholism			Skin Cancer	
	Asthma			Other Cancer	

Any other illness in the family not listed?

_____

Social History:

Marital Status (circle one) *single, engaged , married , separated , divorced , widowed*

Highest Level of Education: lower, high school, college , graduate school , higher

Occupation:_____

If you have any children? Y/N

Health Habits:

1. Do you smoke currently? **Yes No** *If so, how much_____cig/d # of years smoking_____*
If no, did you smoke in the past ? **Yes No** *how may years?___ How much___pk/d quite date_____*
Are you exposed to smoke? **Yes No**
Any other tobacco use? **Yes No** *type: cigars, chewing tobacco , other_____*

2. Do you drink caffeine? **Yes No** *If so, how much?_____*

3. Do you drink Alcohol **Yes No** *what kind? beer, wine , liquor, other_____*
If so, how many times per week?_____ *month?_____year?_____*
Have you ever had a problem with alcohol in the past? *legal or social_____*

4. Have you ever used street drugs? **Yes No**
Which ones? *marijuana , IV drugs , amphetamines , cocaine, heroin , downer, inhalants other_____*
Are you still using: **Yes No** Which ones?_____

5. Are you sexually active (in the last year) **Yes No**
If yes circle all that apply: *1 partner , multiple partners*
male partner(s) , female partners(s)

Which birth control do you or your partner use? *none, condoms ,the pill, vasectomy/tubal other_____*

6. Do you exercise? **Yes No** *If so, what type and how often?_____*

7. Do you eat out at restaurants weekly? **Yes No** *Times per week_____*

8. How many servings of fruit and vegetables do you get per day*? 0 1 2 3 4 5*

9. Do you take a calcium supplement? **Yes No** *Number of dairy servings per day"____*

10. Do you wear a seatbelt? **Yes No**

11. Do you have a living will? **Yes No**

12. Is there concern for your safety? (*emotional, physical, or sexual abuse*) **Yes No**

Patients Signature/Legal Guardian:_____

Physician Signature:_____

HIPPA

I, _____, hereby request Rogers Medical, Ltd. to keep communicated regarding my protected health information confidential. To accomplish the request, please adhere to the following requests.

Phone Number(s)
Home (___) _____
Cell (___) _____
Work (___) _____

May with leave a detailed message on an answering machine or voicemail with the results? Y/N

Detailed messaged include lab results and or/diagnostic imaging (x-ray) results, and appointment reminders

May with leave a detailed message with any other person? Y/N

If so, please provide the names and relationships of authorized personnel.
_____
_____
_____

Mailing Address (Please provide billing address)
_____
_____
_____

We cannot disclosure any information to anyone, including family members without written permission of the patient unless required by law.

_____ _____
Patient Name/Date **Patient Signature/Date**

_____ _____
Guarantor Name/Date **Guarantor Signature/ Date**

Please circle the appropriate relationship between Guarantor and the Patient

Self Parent/Legal Guardian Spouse Other (Please explain_____)

Financial Responsibility Agreement

Consent to Services
Patient hereby requests registration at Rogers medical, Ltd and voluntarily consents to any facility services deemed necessary or advisable as determined by, as appropriate, the attending physician or hi/she assistant/designees, or employees or agents of Rogers Medical, Ltd with appropriate clinical privileges. Patient acknowledges that no guarantees have been made as the results of treatments or examination at Rogers Medical, Ltd.

Payment Guarantee
For and in consideration of services rendered by Rogers Medical, Ltd. patient (responsible party) hereby agrees to guarantee payments of all charges incurred for the account of the patient.

Consent to Release Information
The undersigned hereby authorize Rogers Medical, Ltd. to release to employer groups, insurance companies, government agencies or other third-party payers and their agents information concerning diagnoses and procedures performed, medical care, advice, treatment, supplies or other information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payments on the patient's behalf for the health care service rendered to the patient. Patient (responsible person) acknowledges that he or she will be financially responsible for charges incurred for the patient's treatment if revocation or refusal to authorize the disclosure of the medical records results in a payment denial of the insurance claim.

Medicare Patients
Patient certifies that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct. Patient requests that payment of authorized benefits be made on his/her behalf. Medicare patients with secondary. Patient requests that payment of authorized Medigap benefits be made to Rogers Medical, Ltd. for any services furnished by Rogers Medical, Ltd.

Assignment of Insurance Benefits
Patient (responsible person) irrevocably assigns and transfers to Rogers Medical, Ltd all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering patient, for the payment of hospital and medical care being provided. Patient (responsible party) authorizes payment directly to Rogers Medical, Ltd of said medical reimbursement benefits.

Agreement to Pay Balance
In the event that said medical insurance coverage is not sufficient to satisfy the charge in full, patient (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment of any balance due. For any non-contracted insurance carriers, Rogers Medical, Ltd will submit a courtesy claim and if no payment is received in sixty (60) days, the balance will become the patient(s) responsibility. Patient (responsible party) acknowledges responsibility for any expenses incurred by Rogers Medical, Ltd for collecting any of the charged incurred on the account of the patient.

In the event charges are not paid, due to authorization or pre-certification denials, patient acknowledges the charge is considered a not-covered service and agrees to be fully responsible for payment of any balance due.

_____ _____
Patient Name/Date **Patient Signature/Date**

_____ _____
Guarantor Name/Date **Guarantor Signature/ Date**

Please circle the appropriate relationship between Guarantor and the Patient

Self Parent/Legal Guardian Spouse Other (Please explain_____)

Use and Disclosure of Health Information

I authorize Rogers Medical, Ltd and each applicable health care provider to disclose health-related information and medical records about me (or, as applicable, the person identified above) amongst themselves for use in providing care, treatment, and other related services. If transferring to another healthcare facility, or another physician, I authorize Rogers Medical, Ltd or the applicable transferring facility or physician, to disclose, and the receiving facility or physician, or Rogers Medical, Ltd, to receive and use copies of health-related information and medical records about me for the purpose of providing care and treatment.

I authorize Rogers Medical, Ltd and each applicable health care provider to disclose health-related information and medical records about me to any person or entity (including, for example, my insurance company or employer, or a private review organization) to the extent necessary for the submission, processing, and payment of any claim for benefits related to the provision of care, treatment, or other related services to me. I understand that this may, at time, include information and records related to the diagnosis and treatment of mental illness or drug and alcohol abuse, and the results of blood test performed to determine the presence of infectious disease (including, for example, human immunodeficiency virus HIV). I consent to all such disclosures and waive any claims that may be available under federal or state law that such disclosures represent a breach of confidentiality.

I authorize and consent to the health-related information and medical records about me for the purpose relates to the health care operations of Rogers Medical, Ltd (including, for example, for quality assurance, peer review, risk-management, and accreditation purposes.) I further authorize disclosure to governmental agencies or entities of such information and records about me as they are authorized by law collect or receive.

If, in connection with my care or treatment, an employee of Rogers Medical, Ltd or any other health care provider or independent physician is exposed to my blood or bodily fluids, lauthorise and consent to a sample of my blood being drawn and test for infectious disease of any nature or description.

Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of Rogers Medical, Ltd's Notice of Privacy Practices.

I represent that I, as either the person identified above or such person's legal representative, have read and understand and am duty authorized to accept and execute, these terms and conditions. Any questions that I had have been satisfactorily answered. I hereby accept and agree to be bound by all of the above terms and conditions and I agree that a copy of this document may be used in the place of the original in enforcing any rights here under.

Acceptance and Signature

_____	_____
Patient Name/Date	**Patient Signature/Date**
_____	_____
Guarantor Name/Date	**Guarantor Signature/ Date**

Please circle the appropriate relationship between Guarantor and the Patient

Self Parent/Legal Guardian Spouse Other (Please explain_____)