Family Medical Center

JCHC

497 W. Lott St. Buffalo, WY 82834
Phone: (307) 684-2228 Fax: (307) 684-2177

Patient Registration

****Please make sure Family Medical Center has an updated copy of your driver's license and insurance card****

Patient Information: (please fill out every space, put n/a if not applicable)

Last Name: _____ MI: _____ First Name: _____ Gender: Male Female Other

Mailing Address _____ City_____ State_____ Zip_____

DOB_____/_____/_____ SSN_____ **Employer** _____

Marital Status: M W S D Previous Name (if applicable): _____

PHONE: Home: _____ Cell: _____ Work: _____

COMMUNICATION PREFERENCE: (if patient is under age 18, reply with Parent/Guardian information)

Preferred Method of Contact: (circle one) **HOME CELL WORK**

*Can we leave a message regarding your medical care & test results on your preferred phone? (circle one) **Yes No**

*Can we release appointment or medical information to your spouse/family? Yes No **Names:** _____

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship to Patient: _____

*Would you like to receive **Appointment Reminders** by Text Message: (circle one) **Yes No**

*Would you like to receive health information thru our Patient Portal? (circle one) **Yes (provide email below)** **No**

Email address: _____

Preferred Language: (please select one)

_____English

_____Other:

Ethnicity: (please select one)

____ Hispanic

____Non-Hispanic

Race: (please select one)

____African/African American

____Asian/Asian American

____Caucasian

____Native American or Alaskan Native

____Native Hawaiian or other Pacific Islander

Do you smoke? (please circle) Yes No Former **Do you use smokeless tobacco?** (please circle) Yes No Former

Were you ever in the military? Yes No **Religion:** _____ **Birthplace:** _____

Responsible Party (if different than patient):

Last Name: _____ First Name: _____ MI:_____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DOB: ____/____/_____ SSN: _____ Gender_____ Relationship_____

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INSURANCE INFORMATION

Primary Insurance:

Name and Address:

_____

_____

Policy ID #_____

Group # _____

Insured's Name:_____

Insured's DOB: ___/___/_____**SSN:**_____

Patient's Relationship to Insured: (circle one)

SELF SPOUSE CHILD OTHER_____

Secondary Insurance:

Name and Address:

_____

_____

Policy ID #_____

Group # _____

Insured's Name:_____

Insured's DOB: ___/___/_____**SSN:**_____

Patient's Relationship to Insured: (circle one)

SELF SPOUSE CHILD OTHER_____

Medicare Patients Only:

Are you entitled to Medicare based on: (circle one)

AGE

DISABILITY

END-STAGE RENAL DISEASE (ESRD)

Are you eligible for: (circle one)

Black lung benefits? Yes No

Government research programs? Yes No

Veterans affairs authorization?

Yes No

Are you currently employed?

Yes No

When did you retire? _____

Is your spouse currently employed?

Yes No

When did they retire? _____

PATIENT FINANCIAL AGREEMENT: Please read and initial each line

___1. UPON CHECK-IN, we will collect your **co-pay**. We accept cash, check, Visa, Master Card, Discover, and American Express.

___2. Your insurance policy is a contract between you and the insurance company. We are not a party to that contract.

___3. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance company. If you would like to know the cost of service, please inquire **prior** to appointment. Please be aware that **not all services** are a covered benefit with different insurance companies. You are responsible for knowing what services are covered and what is not covered. **KNOW YOUR BENEFITS**

Please INITIAL below, indication that:

____1. You have had the opportunity to read our Notice of Privacy (copy available upon request).

____2. Authorizing the release of medical or other information necessary to process your insurance claim.

____3. Authorizing insurance benefits to be paid directly to FMC (you will be responsible for all non-covered services).

____4. FMC's Financial Agreement

____ 5. FMC's Appointment Policy (see additional page)

____ 6. FMC's No Show Policy (see additional page)

____7. May we take your photo for your medical chart?

Signature of Responsible Party: _____**Date:**_____

Printed Named of Responsible Party: _____**Date:**_____

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APPOINTMENT POLICY: **(Please read and initial each line)**

___1. FMC expects you to arrive 10-15 minutes prior to your scheduled appointment time. This allows you and our staff to complete any updates and paperwork before the scheduled visit. Patients who arrive late may need to reschedule their appointment.

___2. Family Medical Center is by appointment only.

___3. "Same Day" appointments consist of colds, flu and minor illnesses or injuries. A nurse is always available to answer questions if you are uncertain if the clinic is the best place for you.

___4. Please call ahead if you are late or unable to make your appointment time. We will do all that we can to be accommodating and to minimize the need to reschedule your appointment.

___5. Appointments for additional family members should be made by phone prior to coming to the office.

NO SHOW POLICY: **(Please read and initial each line)**

___ 1. Family Medical Center defines a "No Show" appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment
- Arrives 15 minutes late to scheduled appointment.

___ 2. If you miss 3 or more appointments within a year you may be dismissed from that Doctors practice at their discretion. Only Emergency medical treatment will be offered within the first 30 days of dismissal.

___3. Dismissal from a provider's practice include:

- Irresponsible behavior with medications or abuse
- Inappropriate or disrespectful behavior with providers or staff.
- Provider Incompatibility
- Your provider may ask you to establish with another provider if any of these occurrences happen.

I have read and understood the Family Medical Center Appointment/No Show Policy.

Signature of Responsible Party:

_____Date:_____

Printed Named of Responsible Party:

_____Date:_____

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