



**New Patient Registration and Consents**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Last 4 digits of SS #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ NM Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widow(er) \_\_\_\_\_

Living with Partner \_\_\_\_\_ Spouse or Partner's Name \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Previous/Other Providers: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ Member ID# \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Member ID# \_\_\_\_\_ Group # \_\_\_\_\_

Are you the primary insured? Yes \_\_\_ No \_\_\_

***If no, please provide the following information:***

Primary insured's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Local Pharmacy: \_\_\_\_\_ Mail Order: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

If referred by another provider or patient, whom? \_\_\_\_\_

**Consent for Medical Treatment**

I hereby authorize employees and agents of Mariposa Family Medicine (Nurse Practitioners, employees, and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency as determined by the Medical Director/FNP Tani Schare.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Share Health Information**

I authorize the names listed below to have access to my medical information. These people may call and speak with the provider and or staff about me regarding **appointments**, referrals, medications, diagnosis, and diagnostic studies. I **have the right to** revoke this agreement in part or whole at any time with notification in writing. If you do not wish anyone to have access, leave it blank.

Authorized Name

Relationship to Patient

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Billing Statement Delivery Options**

Billing statements will be sent to patients by the following options. **Mark the box for the method you are selecting. Only one form needed per household.**

Email

Text Message

For selective patients, a mailed statement can be provided. These must be approved by the owner in writing. If you want to change your billing selection you can fill out a change of billing form.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Insurance and Patient Payment Policies

**Proof of insurance-** We must verify your identification and proof of insurance at each visit. If you fail to provide us with the correct insurance information at check-in and your insurance is not active or valid, you will be responsible for the claim if insurance does not cover.

**1. Co-payments-** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company and is a portion of our payment. Copays are also due on the date of telemedicine visits. Patients will find a link to pay on the telemedicine confirmation email.

**2. Claims submission -** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim.

**3. Coverage changes-** If your insurance changes, **you must notify us at least 72 hours prior to your next visit** so we can make the appropriate changes to help you receive your maximum benefits. **We cannot verify insurance on the day of your visit so your appointment will be rescheduled.**

**4. Non-payment-** If your account is over 90 days past due from the date of the statement, you will receive a letter stating that you have 30 days to pay your account in full. **Partial payments will not be accepted unless patients are enrolled in our payment plan.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and all costs associated with recovery will be your responsibility.

**Late Cancellations-** Your appointment is confirmed when you schedule it, but we do provide multiple appointment reminders prior to your appointment as a courtesy. While late cancellations (less than 24 hours before your appointment) are not charged a fee, if at any time you have more than 2 late cancellations, you will be charged a Late Cancellation Fee of \$40.00 and may be discharged if another occurs going forward. Patients can cancel appointments on text confirmation and may call the office and leave a message more than 24 hours prior to the scheduled time.

**Missed Appointments-** Patients are given multiple ways to cancel an appointment, and there are other patients that can use that time. Missed appointments will incur a fee.

**FIRST Time -** If you do not show to an appointment for the first time, you will be charged a \$40.00 fee.

**SECOND Time -** If you do not show a second time, you will be charged a \$50.00 fee.

**THIRD Time -** If you do not show a third time, you will be charged a \$75.00 fee.

**Patients who miss 3 appointments are subject to dismissal from the practice.**

*The late cancellation and missed appointment fees are the responsibility of the patient and not the insurance company and are due at the time of rescheduling. We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office as soon as possible.*

**I have read and understand the above Practice Policy information and agree to the terms as stated above:**

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Practice Policies**

Patients need to arrive within 10 minutes of their appointment time. If it is more than 10 minutes, patients will have to reschedule and is considered a late cancellation. New patients need to arrive 15 minutes prior to their first appointment time and have all the intake forms and medical history forms completed at check-in. If you need to fill out these forms, you must arrive at least 25 minutes prior to your appointment time to fill out the forms. If not done, you may need to reschedule your appointment, or the provider will spend only the remainder of the appointment time with you and an additional appointment will be scheduled.

Follow-up appointments must be scheduled for refills on controlled substances and weight loss medications at minimum of every 12 weeks.

Providers will not prescribe any new medication without a visit. This includes ANY antibiotics, antivirals, eye drops, topicals, oral medications for any reason. Same day/next appointments are available daily but can fill up so plan accordingly.

Patients need to contact their pharmacy for any refills of a non-controlled medication. The pharmacy will send refill requests to the provider electronically or by fax. Please do not call the office unless a refill was denied and you need to schedule an appointment or if the prescription is a controlled substance (medications for pain, sleep, weight loss, ADD, testosterone replacement)

Any phone messages for the provider may take up to 3 business days to be returned by the staff. Providers do not routinely take phone calls.

Portal messages are not always answered quickly. Messages in the portal will be reviewed within 7 -10 days by staff and/or providers. If you have more urgent needs or concerns, please call the office. The portal is not to be used for new issues or concerns. Those will require an appointment to assess and address. The portal is not for scheduling an appointment. Please call the office for those. Pt messages must go through the portal. No patient messages sent to any business email will be answered as this is not HIPAA secure. No medical records will be sent in any email and can be sent in the portal, picked up in the office or mailed.

Any requests for provider letters and/or forms for the provider to fill out may take up to 7-10 business days to complete. A copy will be sent to the patient in the portal and the original may be picked up at the front desk.

All patients who have medication(s) prescribed by MFM must have an annual wellness visit in order to receive refills. All other patients must be seen every 3 years to stay in the practice.

Annual labs may be ordered prior to your annual appointment as deemed necessary by the provider. If you do not get a portal message notifying you that orders were placed, do not go to the lab. Providers may want to review any additional lab needs at your annual and will order labs during or after your visit.

**I have read and understand the above Practice Policies and agree to the terms as stated above:**

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**New Patient Medical History Form- Non Primary Care**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Medical History (Check All That Apply)**

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Allergies	<input type="checkbox"/> COPD	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes - I or II	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Measles	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis - A/B/C	<input type="checkbox"/> Migraines	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other:
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke	

**List medications you are currently taking. Including prescriptions, over-the-counter drugs, and supplements.**

Medication Name	Dose	Frequency

If more space is needed for medications, write on back of page.

Allergies/Reaction	Surgeries/Dates	Hospitalizations

**Family History ( Immediate family (parents, siblings, children)**

Diabetes    Yes ___ No ___ Who: _____	Mental Health    Yes ___ No ___ Who: _____
Hypertension    Yes ___ No ___ Who: _____	Cancer    Yes ___ No ___ Who: _____
Heart Disease    Yes ___ No ___ Who: _____	Other    Yes ___ No ___ Who: _____
Stroke    Yes ___ No ___ Who: _____	

**Do you/Have you: (Circle one, explain if yes)**

**Smoke:** Yes No Cigarettes Vape Cigars Chewing Tobacco

**Drink Caffeine:** Yes No Amount/Kind: \_\_\_\_\_

**Drink Alcohol:** Yes No Rarely Socially Occasionally Daily

**Drug Use:** Yes No Amount/Kind: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_