Mariposa Family Medicine

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? _____

Mariposa Family Medicine

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: _____

Mariposa Family Medicine

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 a 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: _____

Mariposa Family Medicine

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: _____

Mariposa Family Medicine

Pediatric <13 Medical History

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Current/Past Provider(s) _____

Pharmacy-Local: _____ Mail Order: _____

Grade: _____ School: _____

PRESENT HEALTH CONCERNS

1. _____
2. _____
3. _____
4. _____

PAST MEDICAL HISTORY

MEDICATIONS: Please list all medications including over the counter medications, dose and how often

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

SUPPLEMENTS: Please list vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGIES: Please include mild to severe or life-threatening allergies and reaction (symptoms)

1. Medications: _____
2. Environment: _____
3. Food: _____

Last Name:_____First Name:_____Date of Birth:_____

IMMUNIZATIONS

Has your child ever had a reaction to an immunization? Yes No

If so, which vaccine and what was the reaction:_____

_____

PAST MEDICAL HISTORY

CHILDHOOD ILLNESSES: (Circle and indicate age of illness OR mark C for current as it applies to your child)

Acne:	No	Yes/Age	Ear Infections:	No	Yes/Age
ADD:	No	Yes/Age	Eating Disorders:	No	Yes/Age
ADHD:	No	Yes/Age	Eczema:	No	Yes/Age
Alcohol use:	No	Yes/Age:	Headaches:	No	Yes/Age
Allergies:	No	Yes/Age	Head lice:	No	Yes/Age
Asthma:	No	Yes/Age	Mononucleosis:	No	Yes/Age
Bedwetting:	No	Yes/Age	Obesity/Overweight:	No	Yes/Age
Behavior problems:	No	Yes/Age	Pink eye:	No	Yes/Age
Bronchitis	No	Yes/Age	Pneumonia:	No	Yes/Age
Colic:	No	Yes/Age	Colds:	No	Yes/Age
Constipation:	No	Yes/Age:	Sinus Infection:	No	Yes/Age
Cough:	No	Yes/Age:	Thrush:	No	Yes/Age
Croup:	No	Yes/Age	Vomiting:	No	Yes/Age
Depression/ Anxiety	No	Yes/Age	Whooping cough:	No	Yes/Age
Diaper Rash:	No	Yes/Age:	Other Illness:		Age
Diarrhea	No	Yes/Age:	Other Illness:		Age
Drug Abuse	No	Yes/Age:			

Please comment on any illnesses indicated above: _____

_____

_____

_____

Last Name:_____First Name:_____Date of Birth:_____

PAST MEDICAL HISTORY

SERIOUS INJURIES AND/OR ACCIDENTS: (Indicate type, date and treatment used)

Type	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

HOSPITALIZATIONS:

Reason for Hospitalization	Date
_____	_____
_____	_____
_____ _____	_____

SURGERIES:

Type of Surgery	Date
_____	_____
_____	_____
_____ _____	_____

LABS AND EXAM HISTORY:

Date of last well child check:_____ Date of last blood work: _____

Date of last urine test:_____ Date of last EKG:_____

Female Adolescents:

Date of last PAP and pelvic exam: _____

SOCIAL HISTORY

Parent's Marital Status:

□ Single □ Married □ Divorced □ Separated/Not Divorced □ Widowed □ Domestic Partnership

Living With:

□ Both Parents □ Mother □ Father □ Grandparents □ Foster Family □Other_____

Siblings (Indicate names and ages)

1. _____ 2. _____

3. _____ 4._____

5. _____ 6._____

Mother's Occupation: _____ Father's Occupation: _____

Guardian's Occupation:_____

Last Name:_____First Name:_____Date of Birth:_____

SOCIAL HISTORY – School agers/Adolescents Only

SUBSTANE USE:
Identify any substances you have used and circle whether in the past (P) or are currently using (C)

Soda:	P	C	Freq:_____	Tobacco:	P	C	Type/Freq_____
Coffee:	P	C	Freq: _____	Recreational Drugs:	P	C	Type/Freq_____
Alcohol:	P	C	Freq:_____	Other:	P	C	Type/Freq _____

FAMILY HISTORY

Please place a "C" for current or "P" for past in the box next to each condition as it applies to your family members.

	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism							
Allergies							
Anemia							
Arthritis							
Asthma							
Cancer							
Depression							
Diabetes							
Drug Addiction							
Eczema							
Epilepsy							
Headaches							
Heart Disease							
Hepatitis							
High Blood							
Kidney Disease							
Stroke							
Tuberculosis							