CROSSROADS HEALTH CLINIC
Thank you for choosing us as your Health Care Provider.

PATIENT INFORMATION

First Name: _________________ Middle Initial: ____ Last Name: ___________________
Mailing Address: ____
Street Address: ____
City: ____________________ County: ______________ State: ____ Zip: _______________
Phone #: ________________________Work: ______________________ Ext: _____
Would you like us to text you? □ Yes □ No Cell #: ___________________________
Driver's License #: ____
SSN#: ____________________________ DOB: _______________ Male □ Female □
Race: _____________________________ Ethnicity: □ Hispanic □ Non- Hispanic
Marital Status: □ Single □ Married □ Divorced □ Widowed
Spouse's Name: ____________________________ Phone: _________________________
Next of Kin: _________________________________ Relation: _______________________
Employer/ School: ____
Occupation: ____
Person to notify in the case of an emergency (**other than spouse**):
Name: ______________________________________ Phone: _________________________

Responsible party information and/or Parent information
First Name: _______________________ Middle Initial: ____ Last: ___________________
Mailing Address: ____
Street Address: ____
City: ____________________ County: ______________ State: ____ Zip: _______________
Phone #: ________________Work: _______________ Ext: _______ Cell: ______________
Would you like us to text you? □ Yes □ No Driver's License #:_________________
SSN#: ____________________________ DOB: ________________ Male □ Female □
Employer: ____

Primary Insurance
Name of Insurance: ____
Name as it appears on card: ____
Member/Policy ID: ____
Group Number: ____

Secondary Insurance
Name of Insurance: ____
Name as it appears on card: ____
Member/Policy ID: ____
Group Number: ____

INSURANCE INFORMATION:
Please present insurance card(s) and photo ID to clerk. Please expect to pay co-pay at sign-in.
Thank you. -Reception
Patient Name (please print):____

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Date of Birth ____

Consent to Examination and Treatment

As a patient of Crossroads Health Clinic, I consent to examination and treatment by the health care provider at Crossroads Health Clinic. This consent will remain in effect from the date listed below and forward unless "written" revocation of such is presented to this office by the person named below or the legally authorized representative or guardian. I understand that I have the right to question and / or refuse any proposed treatment.

Assignment of Insurance Benefits

I hereby assign to Crossroads Health Clinic all insurance benefit payments, including Medicare, Medicaid, or other third-party benefits available for health services provided to me by this provider. I understand that Crossroads Health Clinic has the right to refuse or accept assignment of such benefits. By the assignment, I authorize payment for services rendered payable directly to Crossroads Health Clinic.

Contact Authorization

I give Crossroads Health Clinic the authorization to communicate with me regarding personal health information at one or more of these contact numbers (**simply mark one or all that may apply**).

_____ home _____ work _____ cell phone

_____ May we **TEXT** you with appointment information.

_____ May we leave results on answering machine? (if applicable)

I also give Crossroads Health Clinic the authorization to communicate personal health information to the following persons in the event that I cannot be reached by the above measures (**list any family member and/or friend you want us to contact on your behalf**):

Name: ____________________________ Relation: _________ Phone: ______________

Name: ____________________________ Relation: _________ Phone: ______________

Name: ____________________________ Relation: _________ Phone: ______________

I understand I have the right to change my choice at any time and I realize it is my responsibility to notify Crossroads Health Clinic concerning any changes I desire to make.

HIPPA Privacy Notice

I have had the opportunity to read Crossroads Health Clinic's privacy notice and amendment of March 1, 2013.

Signature of Legal Responsible Party: ___________________________________Date:____________

Witness:____ Date:____________

Patient Name (please print): ____

Date of Birth: ____

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Thank you for choosing us as your Health Care Provider.

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal treatment needed to restore your health. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy.

Please read this, ask us any questions you may have, then sign in the space provided. A copy will be provided to you upon request.

Insurance: Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. We are a participating provider in many insurance plans. **If you are not insured by a plan we do business with, payment in full is expected at each visit.** It is your responsibility for knowing your policy information. We will not become involved in disputes between you and your carrier regarding deductibles or co-payments. Please contact your insurance company with any questions you may have regarding your coverage.

Overpayment: If this occurs, your account will be credited and you may request a refund as long as there are no other balances owed.

Non-covered services: Please be aware that some -and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full.

Co-payments and deductibles: **All co-payments and deductibles must be paid before being treated. This arrangement is part of your contract with your insurance company.**

- Co-payments that are a percentage of the visit will be a **minimum of $25** taken before being treated. The balance will be billed after your insurance is processed.
- When a deductible is owed, there will be a **minimum fee of $50** to be paid before being treated. The balance will be billed after your insurance is processed.
- **Balances must be paid in full prior to treatment**.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

- If your insurance company does not pay your balance in full within 45 days, we ask that you contact the carrier to help in processing your payment.
- If your insurance company does not pay within 60 days, we require you to pay the balance due.
- In the event that a charge is outstanding 60 days following date of service, a patient presented for treatment will be required to pay an estimated visit fee (**$50**) up front prior to treatment, unless the account is brought up to date at the time of the visit.
- Please be aware that if a balance remains unpaid **with in 90 days**, we may refer your account to a collection agency. If this happens, you will be responsible for all collection fees, attorney fees, interest, court cost and other collection costs and expenses.

***Coverage changes*:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

We understand that it is sometimes difficult to meet these financial obligations on the spur of the moment. If no other means of payment are available, arrangements can be made, prior to being treated, through the billing department for you to pay your account through a payment plan.

We appreciate your trust in us and we honor the opportunity to serve you.

I understand and accept financial responsibility and agree to pay Cross Roads Health Clinic for its charges for services rendered to the patient upon receipt of a statement.

Signature of Legal Responsible Party: ____**Date:**_________

Witness: ____ Date: _________________

Adult Medical History (6/1/2015)

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NAME________________________________ DOB: _____ / _____ / _____

Chief Complaint (What problem brought you to the clinic today):

____

History of Present Illness

Location: ________________________ (*Where is the pain/problem?*)

Quality: ____________________________ (*Example: normal versus abnormal color, activity, etc.*)

Severity: ________________________ (*How severe is the pain/problem on a scale of 1-10, with 10 being the most severe?*)

Duration: ___________________________ (*How long have you had this pain/problem? When did it start?*)

Timing:__________________________ (*Does the pain/problem occur at a specific time?*)

Context: ___________________________ (*Where were you at the onset of this pain/problem?*)

Associated sign/symptoms: ________________________________ (*what other associated problems have you been having?*)

Modifying factors: _________________ ___________________________________ (*What makes the pain/problem worse or better?, or, Have you had previous episodes?*)

Past Medical History **Please Indicate any PERSONAL HISTORY below:**

Ear/Nose/Throat	**Stomach/GI**	**Bones/Joints/Musc**	**Skin**
Cataracts Glaucoma Eye Injury	Acid Reflux Ulcers	Joint Pain Stiffness	Change in Hair in Skin in Nails
Hearing loss Ringing in Ears	Change in bowel habits	Muscle Weakness Cramps	Varicose Veins
Chronic sinus Chronic allergy	Hernia: What kind? __________	Back Trouble Curved Spine	Breast Pain Breast Lump
Heart	Gall Bladder Liver Problems	Arthritis OA RA JA	Rash Itching
Heart Trouble _______________	Hemorrhoids	Osteoporosis Osteopenia	**Infectious Disease**
Chest pain Palpitations	**Kidneys**	**Neuro**	Measles Mumps Chicken Pox
Shortness of breath at rest exertion	Urinary Tract Infection Cystitis	Headaches: _________________	Hepatitis HIV /AIDS
Swelling hands feet	Chronic Kidney Disease	Head Injury Memory Loss	**Health Maintenance**
High blood pressure	Kidney Stones	Seizures Confusion	Immunizations Up to Date
Cholesterol Problems	**Endocrine**	Stroke Paralysis _____________	Date of last Mammogram
Lungs	Diabetes Pancreatitis	Tremors Numbness Tingling	Date of last Pap Smear
Cough: Chronic Wheezing	Thyroid Problem : Low High	**Psych**	Date of last Dexa Scan
Asthma Bronchitis COPD	**Reproductive**	Sleeping Problems	Date of last PSA test
Hematology	Males: Testicular Pain ED	Depression Anxiety	Date of last Colonoscopy
Anemia Past Blood Transfusions	Females: Menstrual Problems	Bipolar Obsessive Compulsive	
Enlarged Glands			
History Cancer:			

Previous Hospitalizations / Surgeries / Serious Illness	**When?**	**Hospital, City, State**
____	______________	___________________________________
____	______________	___________________________________
____	______________	___________________________________

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NAME_______________________________________**DOB**______/______/______

LIST REGULAR MEDICATIONS including over the counter meds & supplements	**Allergies** *Details: (list type and severity of reaction)* ☐ NONE ☐ Latex ☐ IV Contrast **Pharmacy**

Patient Social History:

Marital Status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Lives with:	☐ Alone	☐ Spouse	☐ Family	☐ Friend	☐ Other: ________________
Home Environment:	☐ Private Home	☐ Assisted Living	☐ Nursing Home	☐ Other: ________________________________	
Alcohol History:	☐ Never	☐ Occasionally	☐ Weekly	☐ Moderate	☐ Daily
Tobacco History:	☐ Never	☐ Former User, Quit Date: _________		☐ Current User: Amount / day _______________	
Illicit Drug History:	☐ Never	☐ Former User	☐ Current User: Type/Frequency ______________________________		

Occupation: ____________________________________

Exercise History ☐ None ☐ Occasional ☐ Regular

Family Health History

☐ ***Family History Unknown***. *Do any of your family members have any chronic health problems such as the ones listed below?*

Father: ☐ High Blood Pressure ☐ Diabetes ☐ Heart ☐ Stroke ☐ Cancer ☐ Lung ☐ Arthritis ☐ Kidney ☐ Thyroid ☐ Depression ☐ Hepatitis

Mother: ☐ High Blood Pressure ☐ Diabetes ☐ Heart ☐ Stroke ☐ Cancer ☐ Lung ☐ Arthritis ☐ Kidney ☐ Thyroid ☐ Depression ☐ Hepatitis

Siblings: ☐ High Blood Pressure ☐ Diabetes ☐ Heart ☐ Stroke ☐ Cancer ☐ Lung ☐ Arthritis ☐ Kidney ☐ Thyroid ☐ Depression ☐ Hepatitis

Grandparents: ☐ High Blood Pressure ☐ Diabetes ☐ Heart ☐ Stroke ☐ Cancer ☐ Lung ☐ Arthritis ☐ Kidney ☐ Thyroid ☐ Depression ☐ Hepatitis

Notes:____

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