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

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Patient Name (please print):_____
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): _____

CROSSROADS HEALTH CLINIC

Thank you for choosing us as your Health Care Provider.

Date of Birth: _____

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: _____

CROSSROADS HEALTH CLINIC

Thank you for choosing us as your Health Care Provider.

Person(s) responsible for minor: _____

Relation to minor: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____
Would you like us to text you? □ Yes □ No (applies to parent/guardian ONLY).

The person that brings the minor child is responsible for them. It is against the law for us to put the bill in someone else's name of a different address unless we have written consent or verbal permission. Thank you.

I authorize the following person(s):

1. _____
Relation to Minor: _____

2. _____
Relation to Minor: _____

3. _____
Relation to Minor: _____

4. _____
Relation to Minor: _____

5. _____
Relation to Minor: _____

To bring (minor's name) _____ in for medical treatment and examination by the staff of Cross Roads Health Clinic, P.A. This consent will remain in effect from this date forward unless "written" revocation of such is duly presented to the office of Cross Roads Health Clinic, P.A. by myself or a legally authorized representative.

Signature of Legal Responsible Party: _____Date_____
Witness: _____Date: _____

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Thank you for choosing us as your Health Care Provider.

Pediatric Health History

NAME _____DOB:_____ / _____ / _____ Age: _____

Reason for today's visit: _____

Details: _____

Past Illness: *please indicate any known medical problems:*

	Y	N		Y	N
Problems during newborn period?	□	□	Thyroid Disease	□	□
Developmental Delay	□	□	Epilepsy/seizures	□	□
Failure to thrive	□	□	Attention Deficit Disorder	□	□
Congenital Heart Disease	□	□	Gallstones	□	□
Heart Murmur	□	□	Gastro esophageal Reflux	□	□
Asthma	□	□	Broken Bones	□	□
Diabetes	□	□			

Please indicate other known medical problems:

Have there been any

bleeding problems? Yes □ No □ blood transfusion? Yes □ No □ problems with anesthesia? Yes □ N

Childhood Illnesses:

Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio □

IMMUNIZATIONS: Are child's immunizations up to date? Yes □ No □

Where were immunizations received?

Surgical History: Please list any operations:

MEDICATIONS (name/dose)	**ALLERGIES:** (drug/reaction) **NONE** □
	LATEX ALLERGY? Yes □ No □

FAMILY HISTORY: *(please indicate conditions such as heart disease, stroke, diabetes, cancer, blood di developmental delay, Arthritis)*

Mother _____ *Siblings* _____

Father _____ *Grandparents* _____

SOCIAL HISTORY: *patient lives with* Mother □ Father □ Both parents □ Grandparent □

Number of siblings? _____

For school age child: Grade _____ Any concerns about school performance? Yes □ No □

RISK FACTORS: Any environmental exposure to smoke? Yes □ No □

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