Lake City Area Medical Center

Name (Last, First, preferred name):_____

Date of Birth: _____ **Gender:** _____**Social Security Number** __ __ __-__ __-__ __ __ __

If under 18: Guardian or Parent's name(s) _____

Mother's Maiden Name: _____

Mailing address:_____
Street city, state, zip code

Physical address:_____
Street city, state, zip code

Home Phone: _____ Cell phone: _____ Work phone: _____

Would you like to get call alerts from us? ☐Yes ☐No Preferred phone # ☐Home ☐Work ☐Cell

Would you like to get text alerts from us? ☐Yes ☐No

Email address: _____☐@gmail.com ☐@yahoo.com

Would you like to enroll in our online patient portal to access your records? ☐Yes ☐No

Preferred Language: ☐English ☐Spanish ☐Other _____

Race: ☐ African American ☐ White ☐Asian ☐Native American ☐Other _____

Ethnicity: ☐Hispanic ☐Not Hispanic

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Other_____

Next of Kin: _____ Relationship: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Employer: _____ Occupation: _____ Phone: _____

Insurance Primary: ☐Medicare ☐Medicaid ☐Tricare ☐AARP ☐Anthem/BCBS

☐Aetna ☐Cigna ☐Humana ☐RMHP ☐United ☐Self-pay ☐Other:_____

Insurance ID: _____ Group #: _____

Name of Insurance Holder (if not patient): _____

Their Date of Birth: _____ Their SSN: __ __ __ - __ __ - __ __ __ __

Secondary Insurance: _____ID: _____ Group #: _____

Lake City Area Medical Center has my permission to treat me or the above named patient(s) in person or by telehealth. I authorize the release of any medical records or other information necessary to process the claim(s). I authorize the sharing of records when necessary with QHN and COHRIO. I also agree to comply with this office's payment policy.

Signature of Patient or Responsible Party: _____ Date: _____

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Would You Like To Receive Electronic Statements? ☐Yes ☐No

Any allergies to medications? **What is the reaction?**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Current Medications including herbal meds: **Dose** **How often?**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Is there anything else we should know about you?_____

_____

_____

Are any other doctors involved in your care? (Include eye doctor, mental health, specialists)

_____

_____

_____

Have you had the following vaccines? PLEASE LIST DATE RECEIVED, IF KNOWN

☐Flu _____ ☐Hep B _____ ☐Hep A _____

☐Prevnar _____ ☐Pneumovax _____ ☐ Polio _____

☐Shingrix _____ ☐ Zostavax _____ ☐Rotavirus _____

☐Tetanus _____ ☐Tdap/Dtap _____ ☐Chickenpox _____

☐Hib _____ ☐MMR _____ ☐TB test _____

☐None/avoiding vaccines (☐medical, ☐religious, ☐personal)

In the past 2 weeks how often have you felt little interest or pleasure in doing things?

☐Not at all ☐Several Days ☐More than half the days ☐Nearly everyday

In the past 2 weeks how often have you felt down, depressed, or hopeless?

☐Not at all ☐Several Days ☐More than half the days ☐Nearly everyday

Have you ever been diagnosed with any of the following?

☐ADD/ADHD	☐Chronic ear infections	☐ Hepatitis	☐ Reflux/GERD
☐Aids/HIV	☐Congestive heart failure	☐ Hypertension	☐ Seizures/epilepsy
☐Abuse/Domestic Violence	☐Constipation	☐ High Cholesterol	☐ Skin disorders
☐Allergies/Hay Fever	☐Depression	☐ Stroke	☐ Osteoporosis
☐Anemia	☐Developmental/behavioral delay		☐ Thyroid problems
☐Diabetes	☐ Kidney disease	☐ Eye problems	☐ Liver disease
☐Anxiety disorder	☐ Kidney stones	☐ TB/tuberculosis	☐ Pre-eclampsia
☐Arthritis	☐Diverticulosis/itis	☐ Heart problems	☐ Headaches
☐Asthma	☐ Lung disease	☐ Gout	☐Blood transfusion
☐Autism Spectrum	☐Ear/Hearing problems	☐ Bipolar	☐ Fibromyalgia
☐ Eczema	☐Bladder problems	☐ Cancer _____	
☐COPD/emphysema	☐ Pulmonary embolism	☐ Heart Disease	

Details: _____

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Family History:

	Diabetes	Cancer/type	Heart disease	Stroke	Heart Attack	Autoimmune
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Sister/Brother	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

Social History:

Tobacco use? ☐Yes ☐No **How many a day?** ____☐cigarettes☐packs

How many years? ____Year quit? _____

Do you drink alcohol? ☐Never ☐monthly ☐2-3 times a month ☐2-3 times a week ☐4+ a week

How many in a typical day if drinking? ☐1-2 ☐3-4 ☐5-6 ☐7-9 ☐10+

Do you ever have 6+ drinks (5+ if female)?

☐Never ☐<monthly ☐monthly ☐2-3 times a week ☐4+ days a week

Do you need help quitting alcohol, tobacco or other substances? ☐Yes ☐No

Describe your diet: ☐Low carb ☐Low fat ☐Vegan ☐DASH/Medeterrian

☐Balanced ☐Gluten Free ☐Unhealthy ☐I would like to discuss my diet

Describe your activity level: ☐sedentary ☐ light exercise ☐active

Occupation: _____☐Disabled ☐Retired, ☐exposures/hazards_____

Education: ☐ N/A ☐ high school ☐Associates/trade ☐Bachelor's/college ☐ post-grad/doctoral

Surgical History: please list surgery and approx. year including tonsils/appendix/wisdom teeth

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Hospitalizations: _____

_____

_____

Women only: Age at first period: _____ Are menstrual cycles regular? ☐yes ☐no

Approx. days between periods: _____ Date of last period: _____

# of pregnancies: _____ # live children: _____ #pregnancy losses: _____

LAKE CITY AREA MEDICAL CENTER
700 North Henson / PO Box 999
Lake City CO 81235
970- 944- 2331

-Notice Of Privacy Practices Acknowledgment-

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that *Lake City Area Medical Center* has the right to change its *Notice of Privacy Practices* from time to time and that I may contact *Lake City Area Medical Center* at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that *Lake City Area Medical Center* may restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand that *Lake City Area Medical Center* is not required to agree to my requested restrictions, but if *Lake City Area Medical Center* does agree, then *Lake City Area Medical Center* is bound to abide by such restrictions.

Patient Name (*Please Print*): _____
Patient Signature: _____
Relationship to Patient: _____
Date: _____

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date	Initials	Reason

OFFICE USE ONLY

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Lake Fork Health Service District Financial Agreement

1. All co-payments and unsatisfied deductibles must be paid at time of service. By contractual law your insurance company requires us to charge for, and you to pay for, all co-payments, co-insurance, or non- covered services. We cannot waive co-payments, deductibles, co-insurance or non-covered services defined as patient responsibility under the terms of our contracts. **Your payment options are: Check, or Credit Card.**
2. For our patients with no insurance coverage, payment is expected at the time of your visit. Partial payments or payments made after the date of service are not subject to this discount. We do offer a sliding fee scale for those who are not able to obtain/afford health insurance.
3. Insurance: Your insurance is a contract between you and the insurance company, and it is your responsibility to know your benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If your insurance card is not supplied, you will be billed for services and payment in full will be expected within 30 days of receipt of statement. If your insurance deems the visit to be out of network, you will be fully responsible all charges your insurance does not cover.
4. No/show missed appointments: Broken appointments represent not only a cost to us, but also inability to provide services to others who could have been seen in the time set aside for you. **We require 24 hour notice of cancellation to avoid $50 cancellation fee for a new patient and a $25 for an established patient appointment.**
5. Collection Accounts: All unpaid charges over 90 days will receive a letter for a final collection attempt. If you do not respond your account will be turned over to an outside collection agency. You are responsible for all legal fees, court costs, and any collection agency fee. If your mail is returned to us, we will make one attempt to correct the address. If we are unable to reach you this will be forwarded to a collection agency.
6. Returned checks: All returned checks will have a $30 NSF fee applied to your account.
7. If you have made an appointment for a wellness visit/physical only and your doctor treats you for an illness or counsels you regarding a medical condition on during this visit, there could be a separate charge and co-pay that is your responsibility.
8. Medicare patients: We participate in the Medicare program. You are responsible for your co-pay, deductible, co-insurance and NON COVERED SERVICES. We may ask you to sign an ABN (Advanced Beneficiary Notice), which lists our fee and notifies you of your financial responsibility for certain medical services.
9. Special arrangements may be made for patients having more costly procedures. We understand financial problems arise from time to time. Please let us know if you are interested in setting up a payment arrangement on your account.
10. Telephone Visits- If our provider speaks with you by phone and you are not present in the clinic, your insurance can be billed for a visit if the appropriate conditions are met.

Patient Name: _____

List Other Family Members: _____

Signature of Acknowledgment: _____

Date:_____

Lake City Area Medical Center Whole Health Screening

Patient Name: _____ DOB: _____

In the past 2 weeks how often have you felt…	Never	Several days	More than half the days	Nearly every day
…down depressed or hopeless?				
…a loss of interest in pleasure in doing things you once enjoyed?				

Would you like to talk about your mood today? ☐Yes ☐No

Have you fallen in past 12 months? ☐Never ☐Once No Injury ☐Once with Injury ☐2+ times
Would you like a referral for physical therapy for fall prevention? ☐Yes ☐No

How often do you have trouble with the following?	**Never**	**Sometimes**	**Often**
Affording housing, rent or mortgage payments			
Trouble affording enough food			
Dangers in the home from mold or lead			
Inadequate heating in the home			
Stove or oven not working in the home			
Water leaks in the home			
Carbon monoxide or smoke detectors not working			
Affording utilities like gas or electrical power			
Getting transportation to doctor offices, grocery store, etc.			
Finding childcare to allow for work or study			
Physical abuse (hitting, punching, grabbing)			
Verbal or emotional abuse (yelling, cussing, insults, threats)			
Finding enough work			

Would you like help with any of these concerns? ☐Yes ☐No

Do you use tobacco products? ☐Yes, currently ☐Formerly, but quit ☐No, Never
Would you like help cutting back or quitting? ☐Yes ☐No

Would you be interested in weekly phone calls from our nurses or providers to help you reach your health goals, or help manage your health? ☐Yes ☐No