Homefield Health
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Registration Forms

Patient Information *(Please Print)*

Name (First, MI, Last): _____ Sex: ☐ Female ☐ Male ☐ Other

Birth Date: _____/_____/_____ Phone: _____ Alt Phone: _____

SS#: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about our office? _____

Responsible Party for Billing: ☐ Self ☐ Other *(If other, please fill out information below. If over 18, patient is responsible for self)*

Guarantor's Full Name: _____ Birth Date: _____/_____/_____

SS#: _____ Email: _____

Relationship: ☐ Parent ☐ Guardian ☐ Other _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance *(Please bring your card on initial date of service for our records)* ☐ Self-Pay- Please Fill Out SP Form

Primary Insurance Name: _____ Company Phone: _____

Group #:_____ ID #: _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other Copay; $_____ Effective Date: _____/_____/_____

Policy Holder's Name: _____ Birth Date: _____/_____/_____

Secondary Insurance Name: _____ Company Phone: _____

Group #:_____ ID #: _____

Relationship: ☐ Self ☐ Spouse ☐ Child ☐ Other Copay; $_____ Effective Date: _____/_____/_____

Policy Holder's Name: _____ Birth Date: _____/_____/_____

Cancellation/No Show Policy

At Homefield Health, we have a set aside time to provide you with quality care. If you need to cancel or reschedule your appointment, please contact our office as soon as you are able and no later than 24 hours. This gives us time to fill the time with other patients who are waiting for appointments. Please see our policy below:

- Any established patient who **no shows** or cancel/reschedules their appointment with **less than 24-hour notice** will be considered a no show and **charged $100 fee**.
- If a **third** no show happens, the patient **may be dismissed** from care at Homefield Health.
- Any new patient who no shows or cancel/reschedules their initial appointment three times may not be allowed to reschedule their appointment.
- All fees are **charged to the patient's account** and is due before the patient's next appointment. The provider may also choose not to refill any medications until the fee is paid or the patient is seen in office.
- If the patient is more than 10 minutes late, the patient may be asked to reschedule the appointment for a later day.

We understand there may be times of emergency when a patient might not be able to contact our clinic. Please contact our office manager if you were charged a no show fee during an emergency. You can contact our office at any time at 701-356-0097 to cancel or reschedule your appointment. If calling outside of our normal business hours, please leave a message. If the message was left 24 hours before the scheduled an appointment, a fee will not be charged.

I understand the Cancellation/No Show Policy and agree to its terms. (Initial_____)

Patient Policies (Initial_____)

- I understand it is my responsibility to know if my insurance will cover services at Homefield Health. Before my appointment, **I will call my insurance plan to see what my coverage will pay for at HFH and what my deductible/out-of-pocket will be**. If I do not check my insurance and they come back with an out-of-network status or denial based on my plan, it is **my responsibility** to cover the balance.
- I understand that all minor patients **must have** a parent or guardian present at the time of the appointment in order to be seen.
- I understand that all medications refills need to be requested to my pharmacy **a week before** my medication runs out. The pharmacy will then send a request for medication to Homefield Health on my behalf. If I need a controlled substance, I need to call the office directly to get a refill a week before my medication runs out.
- I understand that I can be charges $20.00 per 10-minute **phone call with the provider** and there can be a charge to have any outside **documentation** filled out by the provider. The cost would depend on the time to complete the document ($25 for 10-15 min; $30 for 20-30 min; $60 for 45-60 min).

Medical Consent (Initial_____)

- I consent to **all treatment** given under the general and special instructions of the attending provider. Treatment may include, but is not limited to, diagnostic procedures, administration of aesthetics, use of prescribed medication, medical services, the collection and utilization of cultures and laboratory specimens, and referral to specialty services for radiology, physician consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the attending provider or the designees.
- If a health care worker comes in direct contact with a patient's blood or bodily fluids, I understand that the patient's blood may be tested for the Hepatitis B virus, Hepatitis C virus, or HIV (human immunodeficiency virus) to determine whether or not the viruses are present, endangering the health care worker. The results of the testing will be made available to the patient.

Financial Agreement (Initial_____)

- I understand that, if my insurance plan or policy requires a co-payment from me, I am required to **pay that co-payment** at the time service is rendered. I understand that if I am self-funded**, full payment is due at the time of the service**. (See self-pay policy) I understand that I am obligated to pay the full balance on my account according the regular rates and terms of Homefield Health. If I do not pay or make payments on my account, I understand that I **can be sent to collections**. In the event that this account is placed with a collection agency or an attorney for collection, I will pay all collection fees and reasonable attorney's fees.
- I understand that Homefield Health accepts major credit cards, cash, and checks. If a check is returned, I will be responsible for an **NSF fee of $65.00**. I appoint Homefield Health as my true and lawful authority to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. In the event benefits exceed the actual charges for this account, the payment will be posted to the intended account and the refund processed accordingly.
- I understand that Homefield Health can **store a credit card** on file for my account. The card will not be charged without my knowledge and is only kept on file only to make it easier for me to make payments on my account. To make payments, I can log into my patient portal or call HFH's office. If I **do not want my card stored** on file, I will let HFH know.

Disclosure/ Use of Health Information (Initial_____)

- I authorize Homefield Health to provide **any health information related to this patient to the insurance company** or other payers for purposes of payment for the health care provided. I also authorize Homefield Health to provide health information to other physicians and healthcare facilities for continued care. I further agree that Homefield Health can use the health information for operations such as peer review and outcomes analysis. I acknowledge that I have received a copy of the Homefield Health Privacy Practices.
- I acknowledge that my agreements hereunder are with and for the benefit of each entity and provider doing business as part of Homefield Health and may be enforced under the practice name, provider name, or as Homefield Health.
- I understand I have the **rights to my medical records** and a release of information must be filled out to receive these records. Homefield Health will then release the records in 5 to 10 business days to myself of the requesting facility.

Patient Photographs (Initial_____)

- I understand that a facial photograph may be taken for identification purposes only. Initial here _____ to show I decline to have my picture taken. I understand I may be asked for photo id each visit before services are provided since I have declined my picture to be taken.

_____ _____

Signature of Patient/Guardian/Representative Date

_____

PRINT Name of Patient/Guardian/Representative

_____

(If not patient, state authority/relationship)

Patient Information *(Please Print)*

Name (First, MI, Last): _____ Sex: ☐ Female ☐ Male ☐ Other

Birth Date: _____/_____/_____ Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Divorced ☐ Widowed

Primary Physician Name: _____ Facility: _____

Preferred Pharmacy Name: _____ City: _____

Employer: _____ Position: _____

Are any of the following concerns in your health?

☐ Weight Change ☐ Energy Level ☐ Sleep Issues ☐ Anxiety ☐ Depression

☐ Hormone Issues ☐ Pain/Discomfort ☐ Headaches ☐ Skin Problems ☐ Other _____

Personal History

Have you been diagnosed with a medical condition by another physician? ☐ No ☐ Yes, please list:

Medical Condition	When

Have you had any past surgeries? ☐ No ☐ Yes, please list:

Surgery	When

Have you ever been hospitalized? ☐ No ☐ Yes, please list:

Hospitalized	When

Do you have any implantable devices? ☐ No ☐ Yes, please list:

Device	When

Please list all Medications & Supplements

Name	Strength	Frequency Taken

Do you have any allergies to medications? ☐ No ☐ Yes; If yes, to what? _____

Do you have any other allergies? ☐ No ☐ Yes; If yes, to what? _____

Family History

Please list any health problems for the following family members; Mother, Father, Siblings, Grandparents.

Who	Age	Health Problems	Alive
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

Social History

Do you smoke tobacco? ☐ Never ☐ Former ☐ Yes; If yes, how many per day? _____ Per week? _____

Do you use other forms of tobacco? ☐ Chew ☐ Pipe ☐ Cigars ☐ Vape

Do you drink alcohol? ☐ No ☐ Yes; If yes, how many drinks per day? _____ Per week? _____

Do you use recreational or street drugs? ☐ No ☐ Yes; If yes, have you ever given yourself street drugs with a needle? _____

Do you exercise? ☐ No ☐ Mild Exercise (Walking, Climb Stairs) ☐ Occasional Exercise (Less than 4x/week) ☐ Frequently

Are you on a special diet? ☐ No ☐ Yes; If yes, what type? _____

How often do you eat healthy meals? ☐ Never ☐ Occasionally ☐ Regularly; How many meals do you eat in a day? _____

Do you drink caffeine? ☐ No ☐ Coffee ☐ Soda; How many cups/cans per day? _____

Are you sexually active? ☐ No ☐ Yes; Do you practice safe sex? ☐ No ☐ Yes; If no, are you trying to conceive? ☐ No ☐ Yes

Mental Health

Is stress a major problem for you? ☐ No ☐ Yes; Do you panic when you are stressed? ☐ No ☐ Yes

Do you feel depressed? ☐ No ☐ Yes; Do you cry frequently? ☐ No ☐ Yes

Have you ever attempted or thought about hurting yourself? ☐ No ☐ Yes; About Suicide? ☐ No ☐ Yes

Do you have trouble sleeping? ☐ No ☐ Yes; If yes, how? _____

Do you have problems with eating or your appetite? ☐ No ☐ Yes; Have you ever had an eating disorder? ☐ No ☐ Yes

Have you ever been to a counselor? ☐ No ☐ Yes

Women Only

How old were you when you started your menstrual cycle? _____

When was the first day of your last cycle? _____ How long does it last? _____

Do you have heavy, irregular, or painful menstrual cycles? ☐ No ☐ Yes

Home many times have you been pregnant? _____ How many live births? _____ C-Sections? _____

Are your currently pregnant or breast feeding? ☐ No ☐ Yes

Have you had a D&C or hysterectomy? ☐ No ☐ Yes

Have you had UTI, bladder, or kidney infections in the last year? ☐ No ☐ Yes

Any blood in your urine? ☐ No ☐ Yes; Any problems with controlling your urination? ☐ No ☐ Yes

Have you had extra discharge or yeast infections in the last year? ☐ No ☐ Yes

Do you have hot flashes or sweating at night? ☐ No ☐ Yes

Have you recently experiences breast tenderness, lumps, or nipple discharge? ☐ No ☐ Yes

When was your last pap exam? _____

Men Only

Do you usually get up to urinate during the night? ☐ No ☐ Yes If yes, how many times? _____

Do you feel pain or burning with urination? ☐ No ☐ Yes; Any blood in the urine? ☐ No ☐ Yes

Do you feel burning discharge from your penis? ☐ No ☐ Yes

Do you have any problems emptying your bladder completely? ☐ No ☐ Yes;

Has the force of your urination decreased? ☐ No ☐ Yes

Do you have any problems emptying your bladder completely? ☐ No ☐ Yes

Have you had any kidney, bladder, or prostate infections within the last year? ☐ No ☐ Yes

Do you have any problems emptying your bladder completely? ☐ No ☐ Yes

Any difficulty with erection or ejaculations? ☐ No ☐ Yes; Any testicle pain or swelling? ☐ No ☐ Yes

When was your last prostate exam? _____