



JMJ Family Practice

A place of Healing and Wholeness for the entire family

Full Name: _____

Today's Date: _____

Date of Birth: _____

Gender: Male / Female

Allergies: Food, Pollens, Odors, Medicines, Pets, etc...

Current Medications, strength and dosage:

Current Herbs/Vitamins/Homeopathy/Supplements and what dosage:

Have you had any surgeries? Yes No If yes, when and for what: _____

Physical Traumas? Yes No If yes, when and what happened? _____

Any significant past medical history?

Family past medical history: check all that apply

Mom/Dad

Asthma

Bleeding Disorder

Allergies

Mental Illness

Arthritis

Liver Disease

Cancer

Seizures

Diabetes

Thyroid Disorder

Headaches

Stroke

High Blood Pressure

Heart Disease

Tuberculosis

Other: _____

Does the patient have any history of STD's? Yes No

Does the patient have a history of mental health? Yes No

Social History (Check all that apply)

Marital Status: Single Married Divorced Widowed

Occupation: Retired Homemaker Student Other:

Do you live alone, with a roommate, with family, or with a significant other? _____

Do you have children and if so, how many? _____ **Age(s)?** _____

Lifestyle/Self-care issues

Do you smoke cigarettes? Yes No If yes, how many per day: _____ #of years: _____

Did you ever smoke? Yes No if yes, when did you quit: _____

Do you drink alcohol? Yes No if yes, at what frequency: _____ How much: _____

Do you drink caffeinated beverages? Yes No if yes, which type: _____ Frequency: _____

Do you use recreational drugs? Yes No if yes, which type: _____ Frequency: _____

Do you exercise regularly? Yes No If yes, how often: _____

Preventative Screening

Last Physical exam: _____

Last Colonoscopy: _____

Last Mammogram: _____

Last Pap Smear: _____



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Patient Information Request

In order to provide you with the best service possible, we ask that you provide the information requested below.

Your Full Name: _____

Email Address: _____

Preferred Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Pharmacy information is needed in order to process prescription electronically.



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Acknowledgement of Receipt of Notice of Privacy Practice

We maintain the privacy of medical and health information of any individual for whom we provide services and endeavor to comply with all relevant state, national, and international laws and regulations including the U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996. We abide by the terms of this Notice, as amended from time to time. JMJ Family Practice reserves the right to modify the privacy practices as outlined in the notice.

Acknowledgement

I have received a copy of the Notice of Privacy Practices for JMJ Family Practice, Inc.

Patient Name (Print)

Patient Signature

Patient Representative Signature (if applicable)

Relationship to patient

Date



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Financial Policy

We are committed to providing you the best care possible and keeping you informed about the charges for your services and obligations.

1. Your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor; if you agree to have your insurance company pay the doctor directly. In the event that the insurance company does not pay JMJ Family Practice within a reasonable time, you will be billed for the services given. If a payment from the insurance company is received after you have paid for services, we will refund any overpayment to you.
2. Prior arrangements have been made with many insurance companies and health care plans to accept assignment of benefits. They will be billed directly and you will be required to pay a co-payment at the time of service.
3. If we do not have a prior arrangement with your insurance plan, we will prepare and send the claim for you on an unassigned basis. The insurance company will send the payment to you and you will be responsible for payment at the time of service.
4. Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered," you will be responsible for payment of service. Payment is due upon receipt of a statement from JMJ Family Practice.
5. Your insurance company will be billed for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the financial policy; I agree to be bound by the terms. I also understand that such terms may be amended by JMJ Family Practice.

Patient Name (Print)

Patient Signature (or responsible party)

Date



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Missed Appointment Policy

Our practice is committed to providing the best treatment to our patients, please help us better serve you by keeping you regularly scheduled appointments.

All appointments must be cancelled 24 hours prior to your scheduled appointment, failure to do so will result in a \$50.00 charge which will not be billed to the insurance company. All missed appointment fees will be billed directly to the patient.

Feel free to contact us if you have any questions or concerns.

I have read and understand the missed appointment policy and agree to abide by the guidelines.

Patient Name

Date of Birth

Patient Signature

Date