



David Fall, MD • Julie Fall, MD
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PATIENT REGISTRATION OVER 18 YEARS OF AGE

Full Legal Name: _____
 Date of Birth: _____ SSN: ____ - ____ - ____ Legal Sex (circle): Male or Female
 Mailing Address: _____ City: _____ State: ____ ZIP _____
 Primary Phone #: _____ E-mail: _____
 Patient Employer/School: _____ Employer Phone: _____

Patient portals are important tools for sending messages, paying invoices, & Pre-Check-In for appointments.
 Please CIRCLE how you will access your patient portal: Phone OR Email.

Marital Status: _____ Preferred Language: _____

Please list any additional contacts that may receive information about the patient or call on their behalf to request refills, appointments, records or treatment instructions. (Information will remain on file until revoked by patient).

Name: _____ Relationship: _____ Phone: _____
 Name: _____ Relationship: _____ Phone: _____

PAST MEDICAL HISTORY

Please circle if you have any of the following.

Allergies/ Asthma/ Breathing Problems	Gynecological Problems
Arthritis	Liver Disease
Bleeding/ Clotting/ Heart Disorder	Neurological Disorder/ Chronic Headaches
Blood Pressure Disorder	Psychiatric Disorder/ Illness
Bowel/ Stomach Problems	Pulmonary Embolism/ DVT
Cancer	Stroke
Cholesterol Disorder	Seizure or Epilepsy
Diabetes	Thyroid Disorder
Eye Disorder	Urinary/ Kidney Disorder

Please list any surgeries, hospitalizations or major illnesses.

Reason: _____ Date: _____

PLEASE FILL OUT BACK OF PAGE



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PRIMARY INSURANCE INFORMATION / SELF PAY AGREEMENTS

Insurance Company Name: _____

Insurance Company Address (located on back of card): _____

ID #: _____ Group #: _____

Policy Holder Name: _____ Employer: _____

Policy Holder Date of Birth: _____ SSN: ____-____-____

Relationship to Patient: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

I agree to provide a copy of my insurance card within 30 days of my appointment. I certify that the insurance coverage indicated above is active. I acknowledge any amount not covered by insurance will become my personal responsibility. If I am unable to pay my personal balance in full within 30 days of receiving my first bill I agree to communicate with BHPFM to set up a monthly payment plan. Payments must be a minimum of \$50/month, or at least 10% of any amount over \$500. Payment amounts are subject to change if additional amounts are added to the plan.

I understand that it is my responsibility to contact BHPFM if/when my contact information or form of payment has changed. My account will be sent to collections if I become unreachable or unresponsive to the billing staff, or if my payment is declined at any time.

Insurance co-pays, or a minimum of \$50 for self-pay accounts will be due at time of service for all future appointments after a payment plan is established.

Patient Signature: _____ Date: _____

Gillette Clinic
PH: 307-687-1300 FAX: 307-682-1309
1308 West Fourth Street, Gillette, WY 82718
frontdesk@bighorn.pcc.com

Buffalo Clinic
PH: 307-620-8845 FAX: 307-285-9029
38 N. Desmet Ave. STE 1, Buffalo, WY 82834
bhpfm@bighorn.pcc.com



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I acknowledge and agree to the terms as stated below. I will be provided a copy for my records upon request.

Patient Name: _____ **DOB:** _____

Patient/Guardian Signature: _____ **Date:** _____

CLIENT BEST PRACTICES

_____ (initial) *I acknowledge and understand policies regarding CLIENT BEST PRACTICES*

CODE OF CONDUCT:

1. Appointments must be scheduled by contacting the clinic directly. No appointments will be made by contacting staff members privately through personal phones or social media.
2. Updating patient information is vital to the healthcare process. All documents required by the clinic must be filled out when requested. Please be prepared to provide your insurance card and personal ID at every visit.
3. Patients under the age of 18 **MUST BE** accompanied by an adult to all appointments.
4. Patients/Guardians must give a 72 hour notice for medication refills and document requests.
5. Our clinic is a healing environment. There is zero tolerance for all forms of aggressive or unsafe behavior. Be advised that the following incidents may result in removal from this facility and possible dismissal from the practice:
 - physical assault or verbal threats
 - verbal harassment: abusive or foul language
 - failure to respond to staff instructions
 - unruly and/or destructive behavior

WELL CHECK-UPS ARE REQUIRED:

At Big Horn Pediatrics & Family Medicine we feel strongly about children having routine well check-ups. We expect our parents and patients to follow these guidelines so that we may continue to provide quality healthcare to our patients, as well as, assess medication refills and referral requests. Preventative health care should be given at the following ages:

- Newborn Period (3-5 days of life)
- 8-10 days (two weeks of life)
- 1 month, 2 months, 4 months, 6 and 9 months of age
- 12 months, 15 months, 18 months of age
- 2 years, 2 ½ years of age
- 3 years - up (yearly) - individual insurance plans may vary.

Despite the recent health care law changes, there are some insurance plans that still require a copay for well visits, or that may not cover components of the visit in it's entirety. Some plans may not provide vaccine coverage or coverage for behavioral assessments. If the patient has symptoms for illness (example: sore throat, earache) at the time of the wellness exam, additional charges may apply. All portions of the wellness visit not covered by your insurance plan will become personal balances.

MUTUAL RESPECT OF TIME / MISSED APPOINTMENT / LATE FEE:

Although there can be emergency situations that are out of our control resulting in our running behind schedule, we pledge to provide quality care with minimal wait times to the best of our ability. In order to respect your time, we make the following requests:

1. Arrive early or on time for your appointments. **You will be assessed a late fee of \$50 if you arrive 10 minutes past your appointment time.** It may be necessary to reschedule you if there are no appointment times available when you arrive.
2. Appointments that are not canceled within 2 hours of your scheduled appointment time will be categorized as a missed appointment. **A fee of \$50 will be administered to any person who misses an appointment.** It must be paid before any future appointments will be scheduled. Patients/Guardians will be responsible for balances resulting from late fees and/or missed appointment fees. Amounts WILL NOT be submitted to insurance providers as they are not covered services.
3. If you plan on bringing an additional child to be seen during an appointment, please notify us in advance so that we can provide sufficient time for your appointment.
4. When scheduling appointments please indicate all of the symptoms or needs that the patient will be addressing at the appointment in order to schedule enough time to address all of your needs and concerns.

CONTINUED ON BACK SIDE

HIPAA NOTICE OF PRIVACY POLICIES

_____ *(initial) I acknowledge and understand the following HIPAA Notice of Privacy Practices:*

BHPFM may use and disclose health information about you (or your child) for treatment, payment, and health care operations. We may request, use or disclose your health information to a physician, pharmacy or other healthcare office(s) providing treatment to you for continuation of care, or if required to do so by law. We may share your information with the following contacts:

1. Specified by you: schools or daycares, pharmacies and designated personal contacts, via fax, phone or email. (i.e. Faxing immunization records, return to school/P.E./work excuses, medical records, prescription requests, etc.)
2. If we are required to do so by law: The use or disclosure will be made in compliance and relevant requirements of the law. These may include, but are not limited to, communicable diseases, abuse or neglect, Food and Drug Administration, legal proceedings, law enforcement, coroners or funeral directors and military.
3. Third party business associates that perform various activities for the practice: (i.e. billing, transcription, collection, and accounting services) if necessary. BHPFM will uphold confidentiality if it is necessary to disclose and personal information in any form, whether electronically, on paper or verbally.

PATIENT FINANCIAL POLICY

_____ *(Initial) I acknowledge and understand the following Patient Financial Policy items:*

INSURANCE PLAN COORDINATION: We bill participating insurance companies as a courtesy to our patients. Please bring current insurance cards with you to each visit. If your insurance changes, it is your responsibility to provide us with the new information. If we have not received payment from your insurance company within 30 days, you will be required to pay the balance due, in full. Whenever necessary, the insured agrees to assign insurance benefits to BHPFM. All patients 18 and older are responsible for charges made on their account regardless of insurance type (private, Medicaid, or Medicare) or personal payment arrangements made with other individuals. Payees are responsible for resolving insurance coordination of benefits discrepancies with their insurance.

WYOMING MEDICAID: Patients who are covered under a private health insurance, in addition to the WY Medicaid policy, must provide all additional plan details to BHPFM. WY Medicaid has the right to retract payment from previously paid claims. If this occurs then the entire balance will be the responsibility of the patient's parents and/or guardians (regardless of divorce decree).

COPAYS & DEDUCTIBLES: Copay and deductible amounts are your financial responsibility, and must be paid at each visit (by the patient or person bringing in the patient). Payment via phone can be made PRIOR to the appointment. A minimum payment of \$50 may be requested for deductible plans.

SELF-PAY ACCOUNTS/OUT OF NETWORK INSURANCE: If you do not have insurance, please come prepared to pay for your visit in full. We offer a 20% discount for all self-pay services paid in full on the day of the visit. If payment cannot be made in full at time of service, a payment plan may be established.

ACCOUNT DEFAULT: Outstanding balances must be paid within 30 days. If you are unable to pay an outstanding balance, in full, a payment plan can be established to avoid collections. If you should default on an established payment plan, it may become necessary to forward your account to a collection agency. If you should default on your account once sent to collections, you will be financially responsible for all court costs and reasonable attorney fees, in addition to the outstanding BHPFM balance and fees associated with your account incurred from the collection agency.

DIVORCE: As we are not a party to your divorce, we cannot be involved in the financial arrangements determined by your divorce decree. The parent who brings the child to the office is responsible for time of service billing. Payment for these charges will be collected at the time of service, a reasonable payment plan may be established for past-due balances. If payment arrangements are not made, it may become necessary to forward your account to a collection agency. Wyoming State Law designates that divorced and separated parents are mutually responsible for account balances should an account go to collections, regardless of court agreements, divorce settlements, or other individual financial arrangements.

NEWBORNS: Insurance companies generally allow ONLY 30 DAYS to add your newborn to your insurance plan. Please call ASAP to get this done. Once you have received the child's card, please provide us with a copy. If you fail to add the baby to a plan, you will be financially responsible for all visits prior to insurance coverage.