



**Dr. Karen Migliaccio**

Family Nurse Practitioner

**719-495-4554**

www.prairieviewfc.com

**Prairie View**

Family Care, LLC

7641 McLaughlin Rd., Peyton, CO 80831

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male or Female

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ SSN: \_\_\_\_\_

**Preferred Pharmacy:** Wal-Mart (Falcon) Safeway (Falcon) Walgreens (Falcon)

Other: \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Circle one:**

Race (Required by Census Bureau): American Indian, Asian, Black or African American, Black Hispanic or Latino, Native Hawaiian and other Pacific Islander, White, White Hispanic or Latino, Refused

Marital Status: Single Married Other **Spouses Name:** \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ phone number: \_\_\_\_\_

**INSURANCE INFORMATION**

**(Please give your insurance card and picture id to the receptionist)**

Primary Insurance: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Co-Payment: \$ \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient's Relationship to Subscriber: Self Spouse Child Other

Secondary Insurance (if applicable): \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Karen Migliaccio, FNP-C. I understand I am financially responsible for any balance. I also authorize Prairie View Family Care, LLC or insurance company to release any information required to process my claims.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_

**Relationship to patient:** Self Parent Guardian Other



Thank you for choosing Prairie View Family Care for your medical needs. Our primary mission is to deliver the best medical care available. An important part of the mission is making the cost of your optimal care easy and manageable. We offer several payment options to include cash, check or charge. Patients without verifiable insurance **are responsible** for payment of all services rendered at the time of service.

We participate with Medicare, Medicaid and most Insurance plans. We will file these claims for you. Patients are responsible for any deductibles, coinsurance or co-pay amounts owed at the time of service. Please be aware that we will bill you for those portions not covered by Medicare and have you sign an Advance Beneficiary Notice.

Please realize:

1. Your insurance is a contract between **you and your insurance company**. We are not a party to that contract therefore; any portion of our fees not covered may be the responsibility of the patient.
2. If you **“No Show”** for an appointment and do not cancel at least 24 hours prior to your appointment, you are subject to a **\$50.00 fee**, which is not payable by insurance.
3. **Returned checks** are subject to a **\$25.00** service charge.
4. If the account is referred to a collection agency, the patient shall pay an additional collection fee of **33.3 percent** of the principal balance plus all reasonable attorneys’ fees and all Court costs of Prairie View Family Care, LLC to any action brought to enforce this Agreement.

Regardless of insurance payment, the patient and/or guardian remains responsible for all financial obligations incurred at the time of service. In the event your account is not paid within 30 days of treatment or according to an agreed-upon plan, interest will be assessed at the rate of **18% per annum** on the unpaid balance. If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this occurs, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs. **You are ultimately responsible for payment on your account.**

By signing this financial policy, responsibility is accepted. This will remain in effect until revoked in writing by Prairie View Family Care.

\_\_\_\_\_  
**Patient or Guardian Signature**

\_\_\_\_\_  
**Date**

### **Acknowledgement of Notice of Privacy Practices**

Prairie View Family Care, endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients’ clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel and opt-out choice at any time. I have been given the opportunity to review the Notice of Privacy Practices and acknowledge the Notice describes how my protected information may be used, disclosed and how I may gain access to my information.

The preferred phone number for messages : \_\_\_\_\_ Please mark below:

\_\_\_\_\_ Leave a message to call back

\_\_\_\_\_ OK to leave detailed message

\_\_\_\_\_ OK to speak with the following person (s): \_\_\_\_\_

**By signing below, I agree to the privacy practices as stated.**

\_\_\_\_\_  
**Patient/Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

# NEW PATIENT 0-12 MONTHS

Name \_\_\_\_\_ DOB \_\_\_\_\_

Allergies \_\_\_\_\_ Current Medications \_\_\_\_\_

## Pregnancy/Delivery

Where was your baby born? \_\_\_\_\_  
Due Date? Type of birth: vaginal C-Section Breech?  
Birth Weight \_\_\_\_\_ Discharge Weight \_\_\_\_\_  
Discharge Bilirubin \_\_\_\_\_ Was Hep B Vaccine given at hospital? \_\_\_\_\_  
Complications during pregnancy? \_\_\_\_\_ during delivery? \_\_\_\_\_  
Did your baby pass the hearing screen? Yes No  
Is your baby having at least one stool a day? Yes No  
Has your baby had at least 3 wet diapers in 12 hours? Yes No  
Does your baby cry excessively? Yes No  
Does your baby have skin problems? \_\_\_\_\_

## Feeding

Are you breastfeeding? Yes No  
How often is your baby feeding? \_\_\_\_\_ Every hours? \_\_\_\_\_  
Are you having difficulties with breast feeding? Yes No  
If formula feeding, what type of formula and ounces per feeding? \_\_\_\_\_ Ounces \_\_\_\_\_  
What is the source of heat in your home? \_\_\_\_\_  
Does anyone smoke in or out of the home? Yes No  
Does your baby sleep on his/her back? Yes No  
Where does your baby sleep? \_\_\_\_\_ Type of Bed Crib or Bassinet  
Is your hot water heater turned down to less than 120 degrees? Yes No  
Does your house have smoke detectors? Yes No  
Do you have working carbon monoxide detectors? Yes No  
Do you have any concerns that you would like addresses today?

