



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 1-12 YEARS

Name _____

DOB _____

Allergies _____

Current Medications _____

Pregnancy/Delivery

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Health History

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