Dr. Karen Migliaccio
Family Nurse Practitioner
7641 McLaughlin Rd., Peyton, CO 80831

719-495-4554
www.prairieviewfc.com
Prairie View
Family Care, LLC

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**

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Name:________________________________DOB:________________Age:________

Reason for today's visit
1.____________________________
2.____________________________

Previous Medical Problems
1.____________________________
2.____________________________
3.____________________________

Surgeries/Hospitalizations & Year
1.____________________________
2.____________________________
3.____________________________
4.____________________________

Medications Prescribed/Milligrams/Frequency
1.________________/_________/_________
2.________________/_________ /__________
3.________________/_________/__________
4.________________/_________/__________
5.________________/_________/__________

Vitamins and Supplements taken regularly
1.______________________
2.______________________
3.______________________

Allergies to Medications: 1.___________2.__________3.___________ □No Known Drug Allergy

Occupation:________________________________

Do you use Tobacco? □Yes □No _____pks/day _______years Smokeless tobacco: □Yes □No

Do you drink alcohol? □Yes _______drinks a day □No

Do you use recreational or street drugs? □Yes □No

Household members that reside with patient: ________________________________

Month and Year of Last:

Tetanus Booster:_________________ Shingles Vaccine:_________________
Influenza Vaccine:_______________ Pneumonia Vaccine:______________
Colonoscopy:____________________ Mammogram:_________ Where:______________________
Pap Smear:______________________ Bone Density Scan:_____Where:______________________
Cholesterol Testing:______________ Hearing Testing:__________________
Eye Exam:_______________________ Dental Exam:______________________

Family Medical History:

1. Cancer □Mother □Father □Sibling
   Type of Cancer____
2. Heart Disease □Mother □Father □Sibling
3. Diabetes □Mother □Father □Sibling
4. Arthritis □Mother □Father □Sibling
5. Alzheimer's □Mother □Father □Sibling
6. Lupus □Mother □Father □Sibling
7. Multiple Sclerosis □Mother □Father □Sibling
8. No Known Illness □Mother □Father □Sibling
9. Other:____
   ____

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Patient Name: ___________________ **Date of Birth:** ____________

Emotional Health

Part of routine screening for your health includes reviewing mood and emotional concerns. Have you been bothered by any of the follow problems?

1. Feeling down, depressed, irritable or hopeless? □Yes □No
2. Little interest or pleasure in doing things? □Yes □No

If you answered **"YES"** to either question above, please answer all the questions below.

During the past two weeks, how often have you been bothered by the following problems?	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable or hopeless?				
Little interest or pleasure in doing things?				
Trouble falling or staying asleep or sleeping too much?				
Poor appetite, weight loss, or overeating?				
Feeling tired or having little energy?				
Feeling bad about yourself – or feeling that you are a failure, or have let yourself or your family down?				
Trouble concentrating on things, like reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you were moving around a lot more than usual?				
Thoughts that you would be better off dead or of hurting yourself in some way?				
If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? □ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult				

X ____ **/ /201___**

Patient, Guardian or Caregiver Signature **Date**

For office use only: Total Score [ ]