Coho Family Medicine LLC. Dr. Steve Parker, MD
General Adult Medical

Name:______________________ Date of Birth:______________________

Chief complaint:______________________

DRUG ALLERGIES

____
____
____
____
____

CURRENT MEDICATIONS

____
____
____
____
____
____
____
____
____
____

FAMILY HISTORY

	father	mother	father's parents	mother's parents	siblings	children
Heart disease						
High blood pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/convulsions						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Mental illness						

HOSPITALIZATIONS OR SURGERIES

Reason	Date	Reason	Date

PAST MEDICAL HISTORY

- Headaches______________
- Shortness of breath______________
- Heart palpitations______________
- Heart murmur______________
- Chest pain______________
- Dizziness/fainting______________
- Peripheral vascular disease______________
- Allergies/hay fever______________
- Asthma______________
- Bronchitis______________
- Pneumonia______________
- Ulcer______________
- GI disorder______________
- Gall bladder disease______________
- Prostate disease______________
- Bowel irregularity______________
- Sexual/menstrual dysfunction______________
- Venereal disease______________
- Frequent infections______________
- Hepatitis______________
- Anemia______________
- Arthritis______________
- Nervousness______________
- Depression______________
- Gout______________
- Chronic rashes______________
- Rheumatic fever______________
- Mumps______________
- Rubella______________
- Polio______________
- Diphtheria______________
- Tetanus______________
- Other______________
- ______________
- ______________
- ______________
- ______________
- ______________

IABITS

- Smoke Packs Daily______________ How long?______________ When stopped?______________
- Exercise routine ______________
- Alcohol Type/amount______________

Coho Family Medicine LLC

5050 E. Dunbar Drive Suite D
Wasilla, AK 99654
P(907)357-0820 F(888)424-5578

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Patient's Name:____________________ **Phone:**___________________________

Date of Birth:_____________________ **Social Security #:**___________________

I request and authorize:

Name:____

Address:____

City: _______________________ State: _____________ Zip Code:______________

to release healthcare information of the patient named above to:

Dr. Steve E. Parker, Coho Family Medicine LLC
5050 E. Dunbar Dr. Suite D
Wasilla, AK 99654
P(907)357-0820 F(888)424-5578

This request and authorization applies to:

_____ Healthcare information relating to the following treatment, condition, or dates:

____

____

_____ All Healthcare information

_____ other (specify) ____________________________

____ Social Security #:_______________

Signature of Patient Date OR

Date of Birth:_________________

This Authorization Expires Ninety Days After It Is Signed.

Coho Family Medicine LLC, Dr. Steve Parker, MD

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and reviewed a copy of Coho Family Medicine's HIPAA Notice of Privacy Practices.

Patient Name (Please Print) ____

PatientSignature___________________________Date_________________________

OR Signature of Personal Representative ______________________________________

Authority of Personal Representative to Sign for Patient (check one)

__ Parent __ Guardian __ Power of Attorney __Other ______________________________

I would also like Coho Family Medicine to share my private medical information with the below listed individuals. This may be spouse, family member or friend. This means that Coho Family Medicine may communicate with your representative and pass on medical information related to all medical care unless limited by yourself.

Name: ____

Relationship: ________________________Phone:____________________________

Name: ____

Relationship: ________________________Phone:____________________________

Name: ____

Relationship: ________________________Phone:____________________________

** In accordance with Alaska State law and the Privacy rule of the Health Insurance Portablility and Accountability Act of 1996(HIPP), I understand that 1. This Authorization may incluse disclosure of information relating to drugs, alcohol, HIV or other health informaiton.I specifically authorize release of such information to the person(s) indicated. 2. I have the right to revoke this authorization any time by writing to the clinic.I understand I can revoke this authotrization except to the extent that action has already been taken based on this authorization. 3. I understand signing this is voluntary.My treatment , paymemt , enrollment in a health plan or eligibility for beneifits will not be conditioned upon my authorization of this disclosure. 4. Information disclosed under this authorization might be re -disclosed by the recipient and this re- disclosure may no longer be protected b y federal or state law. I release and hold harmless Coho Family Medicine LLC,and members andemployees therof, from any and all consequences of this release.

Coho Family Medicine Payment Policy

Coho Family Medicine does in house billing. Charges from the days visit will be sent in the mail. Co-pay is expected at the door before time of service. For patients without health insurance, we require $100 at the time of service. This might not cover the whole amount of the visit, but it will be credited to the amount of the visit. Overcharges will be refunded in a timely manner. If you need to make a payment plan, please inform us so we can set it up.

Coho provides as a service to you of filling insurance claims to your insurance. To be able to do this you must provide us with the proper information. Please bring your insurance cards to every visit. Payment policy is between you and Coho Family Medicine LLC. You are responsible for full payment of your account regardless of the status of your insurance plan.

Many insurances do not cover certain physicals. Because of this, at the time of visit, we will collect $50.00 for sport physicals and $150.00 for DOT/CDL physicals. If your insurance policy covers them you may be entitled to a refund if you have met the requirements of your insurance company.

Fees for medical services are based on the cost of procedures performed, the amount of professional skills involved, the amount of administration, record review required, and the amount of time spent. Coho Family Medicine fees for professional service follow the guide lines from Blue Cross Blue Shield.

Not showing up to an appointment or failing to cancel significantly affects our ability to provide flexible times. We have a no show policy, that allows us to charge a fee of $25.00 for each missed appointment. If you cannot make an appointment, please call 24 hours in advance. We do make acceptations depending on the circumstances.

For payment we do accept; cash, personal checks, visa, debit, and credit. Payments can be made; over the phone, through mail, or in person. Coho Family Medicine will be happy to assist you in any questions you may have. We are willing to set up payment plans, however, if a patient does not fulfill their obligations after 90 days, these accounts will be referred to a collections agency. A fee of $25.00 will be assessed with the referral to collections.

"I understand that I am financially responsible for all charges whether or not paid by an insurance company. I know that it is my responsibility to notify Coho Family Medicine LLC of any changes to my account. These changes include; Insurance, address, phone numbers, emergency contact, ect..."

Print Name.________________________________

Signature.__________________________________

Date.___________

Coho Family Medicine LLC.
Patient Registration Form

Social Security #____________________ Today's Date: ____________

Name: __________________________ Date of Birth: ____________

Address: ____________________________________
Street

____
City, State, Zip Code

Home Phone: __________________ Work Phone: __________________

Cell Phone: ______________ Email: ________________________

Circle One **Sex:** Male Female **Marital Status:** Single Married Divorced Other

Patient's Employer: ____________________________________

Employer's Address: ____________________________________
Street, City, State, Zip

Employer's Phone #:____________________

How did you hear about us? (Circle one) friend, newspaper, yellow pages, dentist/doctor

BILLING AND INSURANCE INFORMATION

Name of Insurance Company: ________________________________

Membership #:__________________ Group #:____________________

Name of Policy Holder: __________________ Date of Birth (policy holder):__________

SS# (policy holder):____________________

Employer of Policy Holder: ________________________________

Secondary Insurance: ____________________________________

Membership #:__________________ Group #:____________________

Name of Policy Holder: ____________________ Date of Birth (policy holder):________

IN CASE OF EMERGENCY

Name of local Friend or Relative (not living with you):________________________

Relationship: ______________ Number: ______________________

Signature of Person Completing This Form: ____________________ Date:________