Procedure Clinic SM

www.procedureclinic.com

One Stop Medical Center

Tel: 952-922-2151

TODAY'S DATE_____

PATIENT DEMOGRAPHICS

PATIENT NAME_____BIRTHDATE_____AGE_____SEX ___M___F

ADDRESS_____CITY_____STATE_____ZIP_____

HOME#(____)_____ CELL#(____)_____ WORK #(____)_____

May OSMC leave a message on your: Home Phone: __y __n Work: __y __n Cell :__y __n

SS# __ __ __-__ __-__ __ __ __ MARITAL STATUS ___M___D___S___W

EMPLOYER_____EMPLOYERS ADDRESS_____

PRIMARY CARE PHYSICIAN & CLINIC_____

EMERGENCY CONTACT_____PHONE#_____

CONTACTS RELATIONSHIP TO YOU_____

E-MAIL _____ REFERRED BY_____

WHERE DID YOU FIND US?_____

DO YOU HAVE AN ADVANCED HEALTHCARE DIRECTIVE? IF SO, PLEASE SPECIFY _____

_____

PRIMARY INSURANCE _____ID#_____GROUP#_____

INSURED PERSON'S NAME_____ EMPLOYED BY_____

SS# __ __ __-__ __-__ __ __ __ DATE OF BIRTH___/___/_____

SECONDARY INSURANCE_____ID#_____GROUP#_____

INSURED PERSON'S NAME_____ EMPLOYED BY_____

SS# __ __ __-__ __-__ __ __ __ DATE OF BIRTH___/___/_____

*****I authorize release of my health records to any provider who is being advised or consulted with in connection to my current treatment. Initials_____**

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitle, including MEDICARE, private insurance and any other health plans to: One Stop Medical Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event that the patient fails to make payment or there is an outstanding obligation on the account, the patient hereby agrees to be responsible for all court costs and reasonable attorney fees in regards to the collection of this account.

SIGNED_____ DATE _____

PATIENT NAME_____ **DATE**_____

Procedure Clinic SM

www.procedureclinic.com

One Stop Medical Center

Tel: 952-922-2151

HISTORY OF PRESENT ILLNESS:

Purpose of this visit_____

Describe what symptoms are you having & for how long?

_____

MEDICAL HISTORY

Your answers on this form will help us to get an accurate history of any medical conditions you may have. Please mark all that apply.

__Anemia	__Arthritis	__Asthma
__Bleeding Disorder	__Blood Clots	__Cancer
__Chronic Fatigue Syndrome	__Crohn's Disease	__Diabetes
__Emphysema/COPD	__Epilepsy, seizures	__Gout
__Heart Disease	__Hepatitis	__High Blood Pressure
__High Cholesterol	__HIV/AIDS	__Irritable Bowel/IBS
__Kidney Disease	__ Liver Disease	__Skin Problems
__Sleep Apnea	__Stroke	__Thyroid Disease
__Urinary Incontinence		

Other_____

If you checked any of the above, please explain _____

Have you had a Colonoscopy in the past? No___ Yes___ When?_____

MEDICATIONS: List all medications, prescriptions, or non-prescriptions dosages and times taken per day.

Medications	Doses
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: Medications/Foods

What was your reaction?

_____	_____
_____	_____
_____	_____

Procedure Clinic℠

www.procedureclinic.com

One Stop Medical Center

Tel: 952-922-2151

SURGICAL/HOSPITALIZATION HISTORY:

Date of surgery or hospitalization

_____ _____

_____ _____

_____ _____

FAMILY MEDICAL HISTORY:

RELATIONSHIP	Living	Deceased	Age	Diseases
Father	____	____	____	_____
Mother	____	____	____	_____
Brother(s)	____	____	____	_____
Sisters(s)	____	____	____	_____
Son(s)	____	____	____	_____
Daughter(s)	____	____	____	_____

SOCIAL HISTORY: **Occupation**_____

Cigarettes or tobacco ____Yes ____No How much/how often? _____

Alcohol ____Yes ____No How much/how often? _____

Drugs ____ Yes ____No How much/how often? _____

AUTHORIZATION: To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the medical office of any changes in my medical status.

_____ Date_____

Signature of Patient or Guardian

Procedure Clinic℠
www.procedureclinic.com

One Stop Medical Center
Tel: 952-922-2151

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between One Stop Medical Center (OSMC) - the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform OSMC of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.

• Pay any additional amount owing within 30 days of receiving a statement from our office. *(When OSMC receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).*

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $30.00 Service Charge. Once notice is received of the returned check, OSMC will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee of 50% will be added to the outstanding balance – in addition to the $30.00 Check Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that OSMC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee of 50% will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) _____

Patient Signature _____ **Date** _____

Responsible Party Name (Please Print)_____

Procedure Clinic SM
www.procedureclinic.com

One Stop Medical Center
Tel: 952-922-2151

NOTICE OF PRIVACY POLICY

Patient Name (Print): _____ Date_____

I _____, have reviewed the One Stop Medical Center Privacy Policy. I agree with all the terms of this policy.

I _____, REQUEST A COPY of the One Stop Medical Center Privacy Policy. I agree with all the terms of this policy.