

Billing Information

Please be sure that Dr. George Knapp is the patient's designated Primary Care Provider (PCP).

Provide all health insurance identification cards at each visit.

Co-payments and deductibles are due at the time of your visit.

Advanced Beneficiary Notice of Non-coverage (ABN) are fees not covered by your insurance company and are the patient's responsibility:

No show or appointments cancelled without 24 hour's notice (business days).

Returned check fees.

Accounts not paid at day of service will be charged a billing fee and after every 30-day billing cycle

Telehealth Visits not covered by your insurance will be billed on a self-pay basis.

Any Labs, Procedures and office Visits not covered by your insurance.

Filling out forms such as FMLA, Short Term Disability, Physician statements, Handicapped parking, etc.

I, (responsible person's name), understand the financial policies. Signature of responsible person, please use full name and date.

Primary Insurance Policy Holder Name (last, first, middle):

Patient's Relationship to Insured:

Name of Primary Insurance Company:

Primary Insurance Group ID Number:

Primary Insurance Company Address (street, city, state, zip code):

Secondary Insurance Policy Holder Name (last, middle, first):

Name of Secondary Insurance Company:

Second Insurance Group ID Number:

Secondary Insurance Company Address (street, city, state, zip code):

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.

With my consent, Mcgregor Medical may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to McGregor Medical Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. McGregor Medical reserves the right to revise its Notice of Privacy Practices may be obtained by forwarding a written request.

With my consent, McGregor Medical may call my home or other designated location and leave a message on voice mail or with appropriate individuals in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, McGregor Medical may e-mail or mail to my home or other designated location any items that the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that McGregor Medical restricts how it uses or discloses my PHI to carry out TPO. However, McGregor Medical is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to McGregor Medical's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, McGregor Medical may decline to provide treatment to me.

I, (responsible person's name), understand the protected health information policies. Signature of responsible person, please use full name and date.

New Patient Health History

Patient Name (last, first, middle):

Address (street, city, state, zip code):

Phone number (home, cell, work):

Patient Social Security Number:

Marital Status:

- Married Single Divorced Widowed

Race/Ethnicity:

- American Indian or Alaska Native Asian Black or African American

- Hispanic or Latino Middle Eastern or North African White

- Native Hawaiian or Pacific Islander Other: _____

Birth Sex:

- Female Male

Sexual Orientation:

Gender Identity:

Male Female Other: _____

Preferred Language:

Communication Preference:

Home Phone Cell Phone Other: _____

Preferred Pharmacy (include pharmacy name, address, city, state, zip code):

Previous Primary Care Doctor (include Doctor's name and address):

Other Doctors and Specialty:

Occupation:

Employer Name, Address, and Phone Number:

Spouse or Guardian Employer's Name, Address, and Phone Number:

Emergency Contact Name, Relationship, and Phone Number:

Current Medications (name, dose, how many times a day):

Drug Allergies (check none if none apply):

Penicillin

Sulfa

Codeine

None

Yes

Yes

Yes

No

No

No

Penicillin reaction (if yes)

Sulfa reaction (if yes)

Codeine reaction (if yes)

Other allergy and reaction: _____

Tests and Procedures (please list the most recent year)

Tetanus shot:

Pneumonia shot:

HPV shot:

Pap smear (females):

Mammogram (females):

Prostate exam (males):

Chest X-Ray:

Bone density scan:

EKG:

Colonoscopy:

Past Medical History

High Blood Pressure

Yes

No

High Cholesterol

Yes

No

Heart Murmur

Yes

No

Palpitations

Yes

No

Heart Attack

Yes

No

Blood Clots

Yes

No

Stroke/TIA

Yes

No

Asthma

Yes

No

Chronic Bronchitis

Yes

No

Emphysema

Yes

No

Ulcer

Yes

No

Indigestion/Reflux

Yes

No

Hepatitis

Yes

No

Irritable Bowel Disease

Yes

No

Osteoarthritis

Yes

No

Rheumatoid Arthritis

Yes

No

Osteoporosis

Yes

No

Gout

Yes

No

Chronic Headaches

Yes

No

Bone Fractures

Yes

No

Location of bone fracture (if yes)

Menopause Symptoms

Yes

No

Pregnant

Yes

No

Planning Pregnancy

Yes

No

Breast Problems

Yes

No

Menstrual Problems

Yes

No

Urinary Problems

Yes

No

Kidney Problems

Yes

No

Prostate Problems/ ED

Yes

No

Chronic Rash

Yes

No

Diabetes

Yes

No

Thyroid Disorder

Yes

No

Depression

Yes

No

Nervousness / Anxiety

Yes

No

Attention Deficit

Yes

No

Sleep Disturbance

Yes

No

Migraine

Yes

No

Hearing Loss

Yes

No

Sexually Transmitted Disease

Yes

No

Other medical conditions not listed above:

Surgeries or injuries (type and approximate date):

Family Medical History

(i.e. high blood pressure, high cholesterol, cancer, etc.)

Father's:

Mother's:

Sibling's:

Other significant family medical history:

Habits

Smoking/Vaping:

If yes, how many packs a day/how often, and for how many years?

- Yes
 No

Ex-smoker:

If yes, quit date, how many packs a day, and for how many years?

- Yes
 No

Alcohol:

Drinks per week (check one)

- Yes
 No

1-7 7-14 15 or more

Cannabis:

If yes, what form do you use (smoking/vaping/edibles/oils/etc.), and how many days a week?

- Yes
 No

Illegal Drugs:

Yes

No

If yes, what drug do you/have you used, and how many days a week?

Special Diet:

Yes

No

If yes, what type of diet?

Exercise:

Yes

No

If yes, how many days a week, and for how many minutes?