

Thank you for choosing Agave Family Health, PLLC as your primary care specialist. We welcome you! We are committed to providing the finest personalized and professional care possible for our patients. We hope the following information will help you answer some of your questions and help you understand how our office operates.

Office Hours & Scheduling

Monday through Thursday 8:00 am to 5:00 pm

Fridays 8:00 am to 2:00 pm

We are closed for lunch from noon to 1 pm.

(Please arrive for your appointments 15 minutes prior or you may be required to re-schedule your appointment.)

Cancellation Policy

We realize patients may need to change their appointments, however, we require a 24-hour notification of cancellation for appointments so we may offer that time to another patient. If you fail to cancel, you may be billed for the scheduled time.

After Hours

Prescription refills, appointment scheduling, and long term illnesses should be handled during routine office hours.

If you have a life-threatening emergency, call 911 or go immediately to the nearest emergency room.

Insurance Claims/Billing

As a courtesy to our patients, we will file insurance claims for those insurances with which we participate. **The agreement of the insurance carrier to pay for medical care is a contract between you and your insurance company. Any amount not covered by your insurance company is your financial responsibility. This includes co-payment, co-insurance and deductibles.**

Payment

Payment will be requested at the time of service for all services which are non-covered or determined to be patient's responsibility, including co-payments and deductibles. (This is the policy of your insurance company) We will kindly reschedule your appointment if you do not have your co-payment. Methods of payment accepted include cash, debit, Mastercard and Visa.

Office Policies



Medication Refills

Patients may be given (with some exceptions) medication prescription refills for six months at a time. **We will not be authorizing refill requests from your pharmacy.** Please take the no refills message on the prescription bottle as a reminder to schedule your next office visit. If lab tests are required, please mention it when you schedule your appointment.

**** We do not manage chronic pain and will not fill pain medication under any circumstance.**

Please understand that this policy is for the safety and in your best interest. We care enough to be sure that you are being treated properly for your ongoing medical care.

NEW PATIENTS: Under no circumstances will our office refill medications without records being received directly from your previous doctor's office.

Referrals

When your provider suggests a specialist evaluation or diagnostic testing that requires a referral, we will make every effort to provide this for you as soon as possible. Some referrals require insurance pre-authorization and cannot be processed immediately. Insurance guidelines prohibit us from backdating referrals. We require 5-7 business days for the processing of routine referrals.

Test Results

Any normal test results will be given by a staff member.

Medical Forms

There will be a fee charged for filing out a variety of health related forms. The fee will be \$25.00. Forms cannot be filled out while you wait. We need 48 hours to fill out most forms.

Contacting Us

Dr. Finley is not available by phone during business hours. You may leave a message with a staff member and someone will get back to you.

Many routine questions can be answered by visiting our website at www.agavefamilyhealth.com.



PATIENT INFORMATION SHEET

HOW DID YOU HEAR ABOUT US?

Today's Date: _____

PATIENT'S NAME

(LAST) _____ (FIRST) _____ (M.I.) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ HOME PHONE _____

CELL _____ Work Phone _____

DATE OF BIRTH _____ AGE _____ SEX _____

SOCIAL SECURITY # _____ MARITAL STATUS _____

EMPLOYER

(NAME) (ADDRESS) (CITY/ST/ZIP) _____

OCCUPATION _____ (MAY WE CONTACT YOU AT WORK? Y N)

EMERGENCY CONTACT INFORMATION

(Name) _____ (Phone) _____ (Relationship) _____

(Address) _____ (City) _____ (State) _____ (Zip) _____

PARENT/GUARDIAN/SPOUSE

(LAST) _____ (FIRST) _____ (M.I.) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____

DATE OF BIRTH _____ AGE _____ SEX _____

SOCIAL SECURITY # _____ MARITAL STATUS _____

PRIMARY MEDICAL INSURANCE

Date of Accident (IfApplicable) _____

(Primary Insurance Company Name) _____ (ID#) _____ (Group#) _____

(Address) _____ (City/State/Zip) _____ (Phone) _____

(Policy Holder Name if different than patient) _____ (ID#) _____ (Date of Birth) _____



SECONDARY MEDICAL INSURANCE

(Primary Insurance Company Name) (ID#) (Group#)

(Address) (City/State/Zip) (Phone)

(Policy Holder Name) (ID#) (Date of Birth)

WORKERS COMPENSATION (If applicable) Date of Injury: _____

(Insurance Company Name) (Claim #) (Adjuster Name and Phone)

Has and Incident Report been filed with your employer? _____

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. **I further understand that if I do not show for an appointment or do not give 24 hours notice to Agave Family Health, PLLC when canceling an appointment I may be responsible for charges up to the potential cost of the visit.**

X _____

RESPONSIBLE PARTY

DATE

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the hereby authorize Agave Family Health, PLLC and its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to Agave Family Health, PLLC for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X _____

RESPONSIBLE PARTY

DATE

Patients with Health Insurance should plan to present their insurance card at each visit.

Patient is responsible for all labwork and must be prepared to tell the AFH staff which lab their insurance requires them to use. If presenting new insurance information on the date labs are drawn the patient should inform the person drawing the labs. AFH will not be able to make changes to the lab company once the lab leaves our office for processing.

FINANCIAL POLICIES

Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our office personnel if you have any questions.

The patient or their guarantor is responsible for payments of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. However, the agreement of the insurance company to pay for medical care is between **you and your carrier.** Please present your insurance card at each visit. **You will be responsible for all co-pay, coinsurance, balances and deductibles on the day of service.**

****IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.****

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If we do not receive payment within 30 days, the patient will be billed. **If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage.** If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen.

Delinquent accounts over 60 days will be sent to collections for processing.
At which point all collection and legal fees of 50% the total balance will be the added to the responsibility of the patient.

If your check is returned due to non-sufficient funds you will be charged an additional \$35. It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the above FINANCIAL POLICY and I agree to abide by its terms.

PRINTED NAME OF PATIENT

SIGNATURE OF PATIENT/RESPONSIBLE

DATE:



Medical History

PATIENT NAME: _____ AGE _____

WHY ARE YOU HERE TODAY?

ALLERGIES:

HAVE YOU OR ANY BLOOD RELATIVE SUFFERED ANY OF THE FOLLOWING? PLEASE CIRCLE AND INDICATE SELF OR WHAT RELATIVE.

- THYROID _____ ASTHMA _____ HYPERTENSION _____
OSTEOPOROSIS _____ HEART DISEASE _____ EPILEPSY _____
ALCOHOLISM _____ ANEMIA _____ MIGRAINE _____
HAYFEVER _____ STROKE _____ MENTAL ILL. _____
ARTHRITIS _____ DIABETES _____ GLAUCOMA _____
CANCER _____ BLEEDS EASILY _____

LIST ALL MEDICATIONS YOU ARE NOW TAKING (with Dosage)

HOSPITAL ADMISSIONS

YEAR _____ ILLNESS OR OPERATION _____

VACCINES

- TETANUS/Td
FLU
PNEUMONIA
HEPATITIS
TUBERCULOS

Please Check all that apply:

- Decreased Hearing, Ringing in Ear, Ear Infections - frequent, Dizzy Spells, Failing Vision D Eye Pain, Double or Blurred Vision, Eye Infections - frequent, Nose Bleeds - recurrent, Sinus Trouble, Sore Throats - frequent, Hayfever / Allergies, Hoarseness - prolonged, Pneumonia / Pleurisy, Bronchitis / Chronic Cough, Asthma / Wheezing, Shortness of Breath: on Exertion, Lying Flat, Chest Pain, High Blood Pressure, Heart Murmur, Irregular Pulse, Palpitations, Swollen Ankles, Fainting Spells, Leg Pain - walking, Varicose Veins / Phelbitis, Loss of Appetite-Recent, Difficulty Swallowing, Indigestion or Heartburn, Persistent Nausea / Vomiting, Peptic Ulcers, Abdominal Pain- chronic, Gall Bladder Trouble, Jaundice / Hepatitis, Change in Bowel Habits, Diarrhea D Constipation, Diverticulosis D Crohn's / Colitis, Bloody or Tarry Stools, Hemorrhoids, Hernia, Urine Infections - frequent, Blood in Urine, Urination, Overnight, >2X, Painful, Loss of Control, Decrease in Force / Flow, Kidney Stones, Venereal Disease, Urethral Discharge, Chronic Fatigue, Weight Loss - recent, Anemia, Bruise Easily, Cancer, Diabetes, Thyroid Disease, Convulsions / Seizures, Stroke, Tremor / Hands Shaking, Muscle Weakness, Numbness / Tingling Sensations, Headaches - frequent, Arthritis / Rheumatism, Back Pain - recurrent, Bone Fracture / Joint Injury, Gout, Osteoporosis, Foot Pain, Cold Numb Feet, Rashes, Hives, Psoriasis, Eczema, Sleeping - difficulty, Nervousness, Depression, Memory Loss, Moodiness - excessive, Phobias, Mental Illness, Chicken Pox, Polio ?Mumps, Measles, German Measles, Rheumatic Fever, Scarlet Fever, Tuberculosis, Herpes, Contact with Blood or Body Fluids, Alcohol oz. per week, Smoking cig. per day yrs., Coffee / Tea cups per day

FEMALES - Please complete Menstral Flow:

Reg. Irreg. Pain / Cramps
Days of Flow Length of Cycle
Date -1 st day of last period
Pain / Bleeding during or after sex
Number of:
Pregnancies Abortions
Miscarriages Live Births
Birth Control Method
B.C. Pill (name)
Flushing / Menopause
Date of last PAP Test
Normal Abnormal
Date of last Mammogram
Normal Abnormal



PATIENT COMMUNICATION LOG

Patient Name: _____

Date: _____

The following instructions pertain to the above named patient: (Please circle)

OK to call home and leave message: YES NO

OK to call work number: YES NO

OK to call cell phone: YES NO

Call this number only: _____

Permission to speak with family member listed below:

regarding labs or reports: _____

None: _____

Name:

Number:

1. _____

2. _____

3. _____

signature

date



AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

I authorize the release of my medical records by the organization or physician listed below:

****Previous Physician's Name:** _____

****Previous Physician's Address:** _____

****Previous Physician's Phone #:** _____ **Fax # of Physician:** _____

Reason for Records Release _____

These records are to be sent to Agave Family Health by fax or at the address above.

Patient's Name: _____ Phone #: _____

Social Security #: _____ DOB: _____

- ____ X-Ray films (Specify type/date) _____ Substance and Drug Abuse, if any
- ____ Immunizations _____ AIDS/HIV, if any
- ____ Most recent 3 years of Records _____ Genetic testing, from date
- ____ Entire Medical Record _____ Psychological or psychiatric conditions, if any

Other: _____

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company.

I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept full financial responsibility for any copying fees. Shipping and applicable sales tax may also be charged.

****Patient name (Print):** _____ ****Date:** _____

****Patient's (or Representative) Signature:** _____

Patient's Representative (Print): _____

Relationship to Patient: _____