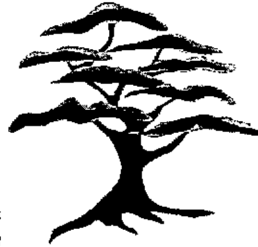
JUNIPER FAMILY MEDICINE



There is a one-time New Patient fee of $150 due at first appointment, which will be applied to your visit. This will be refunded when your insurance pays JFM. Also your first appointment with JFM will be a new patient appointment to establish care not a physical.
Your Initials:________

Circle Preferred Provider:

Laura Campbell OR Kate Pierce

Have you or a family member ever been seen here?
If yes, who?____________________________________

Were you referred by someone?

Who?________________________________

Do you need to be seen right away?

Please explain:____

Juniper Family Medicine
735 White Avenue, Grand Junction, CO 81501
Phone 970-248-5880 Fax 970-241-1112

Date: ____________

Name of Applicant for Enrollment

Name (Previous Names): ______________________ Date of Birth: ____________

Address: ______________________ City: ____________ Zip: ________

Phone Number: ______________________

Current Health Insurance: ______________________

Previous Doctor and why are you looking for a new Doctor? ______________________

____

Relationship Status: Single Married Divorced Widowed Separated

Please note that our JFM Providers will not provide Chronic pain medication such as prescription opiates. If you are seeing a specialist for your pain please list:

Medical Issues (Specialist name):

____

____

Current Pain Medications and Dose (other meds can be listed on following page:

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

Pharmacy: ______________________ Phone Number: ____________

______________________ ____________
Applicants Signature Date

Your Medical Records will be retrieved from your previous Provider once you have been accepted as a patient and before your first appointment.

For office use only

Approved by: ______________________ Date: ____________
Doctor/PA/NP

Declined by: ______________________ Date: ____________
Doctor/PA/NP

Patient Information

Patient Name: ______________________________ Date: ______________

Birth date: ____________ Age: __________ Social Security #: ______________

Sex (M/F): ____________ Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Race: ______________ Ethnicity: ______________ Language(s): ______________

Mailing Address: ______________________________

____

Email: ______________________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Where do you prefer to receive calls? □ Home □ Work □ Cell

Employer: ______________________________ Occupation: ______________

Is your condition a result of a work injury? ______________ A car accident? ______________

Other? If so, what is the date of injury? ______________________________

Emergency Contact: ______________________________ Relationship: ______________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Responsible Party: ______________________________ Birth Date: ______________

Relationship: ______________________________ Social Security #: ______________

Mailing Address (If different than above): ______________________________

____

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Employer: ______________________________

Primary Insurance: ______________________________ Phone: ______________

Primary Insured Name: ______________________________ Birthdate: ______________

Policy: ______________________________ Group: ______________

Secondary Insurance: ______________________________ Phone: ______________

Secondary Insured Name: ______________________________ Birthdate: ______________

Policy: ______________________________ Group: ______________

Your Insurance Cards, Photo I.D., and a Co-Pay will be required at each appointment for correct billing purposes.

I, the undersigned, by my presence at Juniper Family Medicine and by means of this document do hereby voluntarily consent to and authorize all medical care, diagnostics, and treatments including but not limited to history, physical examination, x-rays, injections, transfusions, anesthetics, and/or surgical by the doctor, his/her assistants, or his/her designees as in necessary and appropriate in his judgment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations in this office.

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Juniper Family Medicine, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

______________________________ ______________________________

Signature Date

Juniper Family Medicine

New patient History form

Name:____

New Patient Medical History Form We know this is very extensive – please fill out as much as you can. Thanks!
What would you like to discuss at your visit today?

____

____

____

***Past Medical History*:**

Problem:	Y/N	When?	Problem:	Y/N	When?
ADD or ADHD			GERD		
Allergies			GI problems		
Anemia			Gout		
Anesthesia problems			Headaches/Migraine		
Anxiety			Heart Problems		
Arthritis			Hepatitis		
Asthma			High Blood Pressure		
Bed Wetting			High Cholesterol		
Bladder or kidney problems			Hypothyroidism		
Blood diseases			Hyperthyroidism		
Breast Cancer			Kidney/Bladder issue		
Breast problem			Kidney stones		
Cancer			Liver disease		
Chicken Pox			Lung disease		
Chronic Pain			Muscle/joint/bone problems		
Congenital anomalies			Osteoarthritis		
Constipation			Osteoporosis		
COPD			Psychiatric illness		
Coronary Artery Disease			Pulm.emb/bloodclot		
Depression			Rheumatoid Arthritis		
Developmental/behavioral problems			Scoliosis		
Diabetes			Seizures/Epilepsy		
Diverticulitis			Serious injuries		
Ear/hearing problems			Stroke		
Eczema/Hives/Skin problem			Tuberculosis		
Endometriosis			Frequent Urine Tract		
Fibromyalgia			Varicose Veins		

Vision/eye issues					
Other					

Past Surgical History:

Procedure	Date	Surgeon/hospital

Family History: **Please specify if paternal (father's side) or maternal (mother's side) grandmother/grandfather**

Relative	Problem	Died at age?
Paternal /Grandfather Paternal/ Grandmother		
Maternal Grandfather Maternal/Grandmother		
Father		
Mother		
Siblings		
Children		
Other		

Social History: **We know you may find these questions sensitive. However, completing this section will help us take better care of you!**

Occupation:______________________

How far did you go in school?______________________

What is your current marital status?______________________

Do you have any children? If so, how many and where do they live?______________________

What is your sexual orientation?______________________

Are you currently sexually active?______________________

Are you using any type of birth control method?______________________

Do you feel safe in your current relationship?______________________

How often do you exercise? None Occasionally Moderate Heavy

Stress level: Low Medium High

Over the past 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several	More than ½ days	Nearly everyday
1.	Little interest or pleasure in doing things?	0	1	2	3
2.	Feeling down, depressed or hopeless?	0	1	2	3

How often do you drink alcohol and how many drinks at a time?______________________

Male Patients ONLY : When was the last time you had 5 or more drinks in one day?

Never More than 3 months ago 1-3 months ago 8-29 days ago In the past week

Female Patients ONLY : When was the last time you had 4 or more drinks in one day?

Never More than 3 months ago 1-3 months ago 8-29 days ago In the past week

Do you currently use tobacco products and if so, how much?______________________

Smoking:__________ Chewing tobacco:______________

If you previously used tobacco, how much did you use and when did you quit?______________

Do you use any other recreational drugs?______________________________

Caffeine intake: None 1-2/day 3-4/day 5+/day

If you have guns in your home are they locked up? (This information is not shared with anyone-it is a safety question)______________________________

Do you use your seatbelt on a routine basis?______________________________

Do you regularly use sunscreen?______________________________

Do you have carbon monoxide and smoke detectors in your home?______________________________

Do you have an Advanced Directive?______________________________

Health Maintenance (Females only)

Are you still getting pap smears?_____ When was your last one?______________________

Have you ever had an abnormal result on your pap smear?______________________

If so, what was done about it?______________________________

Are you getting mammograms?_____ Have you ever had an abnormal mammogram?______________

If so, what was done about it?______________________________

Have you had bone density screening done?_____ If so, when was it and what was the result?__________

____

Have you had a colonoscopy?_____ If so, when and what was the results?______________________

____

Health Maintenance (Males only)

Have you had bone density screening done?_______ If so, when and what was the result?______________

____

Have you had a colonoscopy?_____ If so, when and what was the result?______________________

Have you had any PSA (prostate) screening done?______________________________

***Current Medications*:**

Preferred pharmacy:______________________________

Medication	Dose	How often do you take this?

***Allergies to medications*:** Medication	Reaction

Review of systems – Please circle symptoms you are experiencing:

Constitutional: Fever Chills Night Sweats Weight gain (_____lbs) Weight loss (_____lbs)

Eyes: Dry eyes Irritation Vision changes

Ears: Difficulty hearing Ringing in your ears Ear pain

Nose: Frequent nosebleeds Congestion Frequent sinus problems

Mouth/throat: Sore throat Bleeding gums Snoring Dry mouth Tooth problems
Mouth ulcer Mouth breathing Difficulty swallowing

Cardiovascular: Chest pain on exertion Arm pain on exertion Shortness of breath with exertion
Shortness of breath when lying down Palpitations Known heart murmur
Difficulty lying flat

Respiratory: Cough Wheezing Shortness of breath Coughing up blood Sleep apnea

Gastrointestinal: Abdominal pain Vomiting Diarrhea Constipation Bloating
Black/tarry stools Blood in stool Throwing up blood Change in appetite

Urinary: Urinary loss of control Discomfort with urination Blood in urine
Difficulty starting urine stream Increased urination Feeling of incomplete emptying

Musculoskeletal: Muscle aches/pain Joint aches/pain Weakness in muscles Swelling Back pain
Neck pain

Skin: Changing mole Yellow skin Itching Growth/lesions Rash
Hair loss Increased hair growth

Neurologic: Numbness Weakness Loss of consciousness Seizures
Headaches Dizziness Restless legs

Psychiatric: Depression Anxiety Elevated mood Sleep disturbances

Endocrine: Fatigue Increased thirst Increased appetite Being colder than usual
Being warmer than usual Decreased sex drive

Hematologic: Easy bruising Swollen glands

Allergy: Runny, itching nose Itching/watery eyes Hives Sneezing

Thank you for your time in completing this form, it will really help us care for you better!

Juniper Family Medicine
735 White Avenue, Grand Junction, CO 81501
Phone 970-248-5880 Fax 970-241-1112
Laura Campbell, MD Andrea Nederveld, MD
Kate Pierce, MD
www.jfmgj.com

Juniper Family Medicine

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent ***JUNIPER FAMILY MEDICINE*** may use and disclose protected health information (PHI) about me to carry out treatment payment and healthcare operations (TPO). Please refer to ***JUNIPER FAMILY MEDICINE***'s 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. ***JUNIPER FAMILY MEDICINE*** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ***JUNIPER FAMILY MEDICINE*** Privacy Officer at 735 White Ave Grand Junction, CO 81501.

With my consent, ***JUNIPER FAMILY MEDICINE*** may call my home or other designated location and leave a message on voice mail or in person 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, ***JUNIPER FAMILY MEDICINE*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, ***JUNIPER FAMILY MEDICINE*** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that ***JUNIPER FAMILY MEDICINE*** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to requested restrictions, but if it does, it is bound by this agreement.

____

Parent or Guardian's Signature Date

____

Patient's Signature Date

Name of Patient: ______________________ **Date of Birth:** ______________

Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I understand that this organization has the right to change it Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.

______________________ ______________

Patient Signature **Date**

Authorization for Protected Communication

I, ______________________, hereby authorize JFM clinic staff to:

☐ Yes ☐ No Leave a message with ______________ (Relationship: ______________)

☐ Yes ☐ No Leave a message on my voice mail regarding my appointment

☐ Yes ☐ No Leave a message on my voice mail regarding my lab and/or x-ray results

☐ Yes ☐ No Call me at my office/work

☐ Yes ☐ No Call me on my cell phone number

☐ Yes ☐ No Do you have a Medical Power of Attorney?

Name:______________ Relationship:______________ Number:______________

☐ Yes ☐ No Do you have a Living Will, Advanced Directive or DNR/DNI on file? Please provide this Clinic with a copy to scan into your chart.

☐ Yes ☐ No Family members or friends you will allow access to your health information:

______________ ______________ ______________

______________ ______________ ______________

______________________ ______________

Patient Signature **Date**

Appointment Cancellation/No Show Policy Agreement

If you wish to cancel your appointment it must be done 24 hours in advance of scheduled time. If you fail to make your appointment and do not call to cancel it or you no show, you will be charged $50.00. This will not be paid by your Insurance, and you will be fully responsible to pay it. If you No Show 1st visit you will NOT be rescheduled. If you no-show 3 times you will dismissed from our practice.

______________________ ______________

Patient Signature **Date**

Juniper Family Medicine

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Laura Campbell, MD Andrea Nederveld, MD
Kate Pierce, MD
www.jfmgj.com

To our patients,

Please mark below which option you would like to choose regarding our privacy and security practices, as required by the Health Insurance Portability and Accountability Act (HIPAA).

______I have been given a copy of the privacy and security practices for Juniper Family Medicine (JFM). I may use this as a resource for answering my questions in addition to contacting JFM for further clarification, if needed.

_____I was offered a copy of the privacy and security practices for Juniper Family Medicine, but declined keeping a copy at this time. I am aware of what HIPAA stands for and if needed, will contact JFM with any questions or concerns regarding the privacy and security of my protected health information.

____

Patient of Guardian Signature Date

____

Printed Name

Payment Policy

It is the policy of Juniper Family Medicine, PLLC. that payment for medical services is due at the time services are provided. Where participating insurance coverage is involved we will request co-payments from you at the time of service. If we are not contracted with your insurance company we will provide you with a copy of the billing form to submit the claim yourself. Insurance settlements are strictly between you and your carrier and payment is expected at the time of service. If you are unable to make full payment arrangements must be made with our office manager. Accounts over 28 days old, from the bill date, will be charged an annual interest rate of 18% on the outstanding balance. Delinquent accounts will be turned over to our collection agency unless other arrangements are made for a payment plan.. Our collection agency charges up to 45% of the unpaid principal balance at the time it is turned to them. That fee will become your responsibility in addition to all monies owed to us. You will be responsible for any charges denied by your insurance carrier.
I have read the above policy regarding payment for services by Juniper Family Medicine, PLLC. and agree to the terms and conditions outlined therein. I further agree, in the event of nonpayment, to bear the cost of collection and/or reasonable legal fees should this be required.

____

Signature of Patient or Legal Guardian Printed Name

Juniper Family Medicine
White Ave, Grand Junction, CO 81501
Laura Campbell, MD Andrea Nederveld, MD Kate Pierce, MD
Kay McMahon, PA-C Liz Carlson, PA-C
Phone 970-248-5880 | Fax 970-241-1112 | www.jfmgj.com

Juniper Family Medicine

Clinic Policies

Payment Policies

Appointment /Check-in Policies

Effective July 9, 2012

Updated July 19, 2016

1) If you are in need of a prescription refill, please call your pharmacy so they can send us a paper request. Once we receive that request, **please allow 3 days** for your prescription to be filled so we can properly review your records.
2) We **will NOT refill any controlled substance (i.e. pain medications) on the weekends.**
3) Non-emergent labs usually take between two to three days to get the results. We will contact you once we have them. If you have not heard anything for greater then week, please call us.
4) **No-Show Policy**:. If you fail to cancel your appointment less than 24 hours before your scheduled appointment time, you will be asked to pay a $50 fee and you will not be scheduled or seen again until this bill is paid. If you **no-show 3 times, you will be dismissed from our practice.**
5) If you are going to be late for your appointment, please try to call our office to alert our staff. If you arrive greater than 15 minutes past your scheduled appointment time, you may be asked to reschedule your appointment for another time and/or date.
6) If you are interested in paying cash for your visit today, you will receive a 15% discount at the time of service.
7) **Please note that payment is due at the time of service.** Prior to any service, we will provide you with information about the estimated charges for your health services. This usually includes a copayment, an unmet deductible, or coinsurance which are to be paid at the time of service.