Bradley D Fuller, MD Melissa L Fuller, FNP-BC
4045 Avenue B, Billings, MT 59106 Phone: 406-651-9355 Fax: 406-651-8983

Welcome to Fuller Family Medicine!

Thank you for choosing our clinic for your health care needs. Our office is staffed by one physician, Dr. Brad Fuller, 1 Family Nurse Practitioner - Melissa Fuller, 1 Physician Assistant, Wendy Ruggles, 2 Registered Nurses – Ann and Kristi, 1 Licensed Practical Nurse – Heather, 1 Medical Assistant – Tryna, 1 lab director/phlebotomist - Pam, and 1 front office staff – Vanessa. Billing is processed through our office by Amanda and Amber. Dr. Fuller specializes in Internal Medicine, which is medicine for adults (heart disease, lung disease, diabetes, high blood pressure, infections, etc.). Melissa and Wendy specialize in family medicine with an emphasis on women's health care (contraception, Pap smears) and pediatrics (sports physicals, well-child exams, etc.) We will not prescribe chronic narcotics.

We pride ourselves on being punctual. We ask that you please arrive on time for your appointment and we will do our best to be on time as well. If you need to cancel an appointment, please do so no less than 24 hours before your appointment time. We know that things come up (family emergencies, weather, construction, etc.) but if there seems to be a repeated pattern of "no-shows" or late cancellations, we may have to ask you to find a new provider.

Although we perform most of our labs in our office, there are lab tests that are sent to PAML Labs to be processed and you may receive a bill from them. Also, our pathology reports (Pap smears, skin biopsies, etc.) will be processed at Unipath Labs.

Our office hours to see patients will be:
Monday – Thursday: 7am-5pm
Friday: 7am-12pm
Phone hours will be:
Monday – Thursday: 7am-5pm
Friday: 7am-12pm
After hours:
We do not have a doctor "on call" but will have voicemail to leave a message. If you would like to schedule an appointment or cancel an appointment after hours, please leave a message with your name, date of birth, and phone number. Refills need to be addressed during regular business hours and cannot be addressed after hours or on weekends. If you have a medical emergency, please go to the nearest emergency department for evaluation. We cannot be very effective providers over the phone, so we encourage you to call us during business hours to get you into the clinic for evaluation or to the emergency department after hours. We maintain that access to care is very important and we will do our best to get you into our clinic for evaluation the same day you call!

Hospital:
Dr. Fuller, Melissa, and Wendy do not have admitting privileges at either hospital. Therefore, should you need to be hospitalized,both hospitals in Billings have a Hospitalist service which will provide all care in the hospital. Unfortunately, that is a trend which is happening in most of the country and it's only a matter of time until only hospitalists will be taking care of patients in the hospital. We have agreements with both hospitals that they will contact us with questions or advice about how to treat our patients. We have access to both hospitals' electronic health records and will continue to be involved in your care.

Paperwork:
Please fill out the accompanying forms to get registered.

Encl: Consent to Treat, HIPAA Restriction of Information, Patient's Rights and Responsibilities, Prescription History consent, POLST

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Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

_____ _____

Signature Date

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Patient Information

Name: _____

○ Male ○ Female ○ Married ○ Single ○ Child ○ Other_____

Social Security #:_____-____-_____ Birthdate: _____

Phone (Home):_____ (Work): _____ (Cell):_____

Address: _____

City: _____ State: ____ Zip: _____

Responsible Party Information

Name: _____

○ Male ○ Female ○ Married ○ Single ○ Child ○ Other_____

Social Security #:_____-____-_____ Birthdate: _____

Phone (Home):_____ (Work): _____ (Cell):_____

Address: _____

City: _____ State: ____ Zip: _____

Employer Information

Employer Name: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance information

Primary:

Insurance name: _____

Name of Insured: _____

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____

City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other _____

Secondary:

Insurance name: _____

Name of Insured: _____

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____

City: _____ State: _____ Zip: _____

Insured's Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other _____

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. A service charge of 1.5 % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Provider, I agree to pay therefore the reasonable value of said services to said Provider, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cots and reasonable attorney fees if suit be instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to patient: _____

Signature of patient, parent, or guardian

_____ Date: _____ Relationship to patient: _____

Signature of guarantor of payment/responsible party

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Prescription History Consent

Please sign below for permission for Fuller Family Medicine and its staff to access your prescriptions from pharmacies. Thank you.

_____ _____
Name Date

Contact Information

Email Address: _____
(this allows you to access your chart, labs, appt. reminders, etc.)

Emergency Contact: _____
Relationship:_____
Phone number: _____

Demographics

Race:_____

Ethnicity:_____

Language spoken:_____

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USE/RESTRICTION OF PATIENT INFORMATION

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of the PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The Privacy Rule generally requires health providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose.
These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for Treatment, Payment, and Healthcare Operation (TPO) may be permitted without prior consent in an emergency.

I wish to be contacted in the following manner (check all that apply):

O Home Telephone: _____
- O OK to leave message with detail information
- O Leave message with call-back number only

O Work Telephone: _____
- O OK to leave message with detail information
- O Leave message with call-back number only

O Cell Phone_____
- O OK to leave message with detail information
- O Leave message with call-back number only

O Written Communication
- O OK to mail to my home address_____
- O OK to mail to my work/office address_____
- O OK to fax to this number _____

O Verbal Communication
- O OK to release information verbally to:

_____
_____
_____
_____
_____

It is the patient's responsibility to provide updates or changes to this information

_____ _____
Signature of patient or patient's representative Date

Montana Provider Orders For Life-Sustaining Treatment (POLST)

*THIS FORM MUST BE SIGNED BY A **PHYSICIAN, PA** or **APRN** IN SECTION D TO BE VALID*

If any section is NOT COMPLETE:
Provide the most treatment included in that section

EMS: If questions/concerns, contact Medical Control.

Patient's Last Name:

Patient's First Name:

Date of Birth:

Male Female

Section A
Select only one box

Treatment Options: If patient does not have a pulse and is not breathing:

Attempt Resuscitation (CPR) **Do Not Attempt Resuscitation (DNR)**
(Allow Natural Death)

If patient is not in cardiopulmonary arrest, follow orders found in sections **B** and **C**

Section B
Select only one box

Treatment Options: If patient has a pulse and/or is breathing:

Comfort Measures ONLY: Relieve pain and suffering through the use of medication by any route, positioning, wound care or other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer to hospital ONLY if comfort needs cannot be met in current location.***

Limited Additional Interventions: In addition to the care described above, use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions or mechanical interventions. May consider use of less invasive airway support such as CPAP or BiPAP. ***Transfer to hospital if indicated for treatment or comfort. Generally Avoid Intensive Care.***

Full Treatment: In addition to the care described above, use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. ***Transfer to hospital if indicated. Include Intensive Care.***

Other Instructions: _____

Section C
Select only one box

Artificially Administered Nutrition: (Offer food and fluid by mouth if feasible and/or desired) No Artificial Nutrition by Tube.

Defined trial period of Artificial Nutrition by Tube. Specifically: _____

Long Term Artificial Nutrition by Tube.

Section D
Select box(es)

Discussed With:
Patient **Health Care Agent or Decision-Maker** **Court Appointed Guardian**

Other _____

By signing below, the decision-maker acknowledges that these orders are consistent with the known desires of the patient.

Signature of Patient or Decision-Maker (required)	**Printed Name**	**Relationship if not Patient**

Name of Person Preparing Form	**Phone Number of Preparer**	**Date Form Prepared**

Signature of Provider: ***My signature below indicates to the best of my knowledge that these orders are consistent with the medical conditions and preferences of the patient.***

Signature of Physician, PA, or APRN (required)	**Printed Name of Physician, PA or APRN**

Date and Time	***Provider Phone Number***

FORM SHALL ACCOMPANY PATIENT WHENEVER TRANSFERRED CARE LEVELS OR TO HOME
Use of the original form is strongly encouraged. Photocopy, fax or electronic copies of signed POLST forms are legal and valid.