Welcome to Gagon Family Medicine

"Expert, personalized care, and wellness for the whole family."

The providers and staff of Gagon Family Medicine welcome you to our clinic. Your health and well-being are our primary concern. Our internal goal is "to be better than good – to be GREAT" in every aspect of our service EACH time we serve you. As you get to know us, we welcome your suggestions and feedback. Any comments may be e-mailed to Gina Gagon at ggagon@gagonfamilymedicine.com or mailed to Gina's attention at PO Box 1437, Price, Utah 84501. We hope the information provided below answers your questions about our services, policies, and procedures.

Appointments

Hours of Operation:

To better serve you, our regular clinic hours of operation may change from time to time. Our phone desk typically opens 15 minutes before scheduled appointment times start and closes 15 minutes before scheduled appointment times end. We also offer walk-in urgent care hours. You can always find our most up to date business hours including holiday hours at www.gagonfamilymedicine.com or on Facebook at Gagon Family Medicine + Urgent Care Clinic.

Appointments:

We do our best to keep our appointments on schedule. However, please understand that not all patients require the same amount of time with the doctor and that emergencies do occur, so some delays are unavoidable. We will do our best to keep you informed of delays. Your patience in these situations is greatly appreciated.

Canceling Appointments/Missed Appointment Fee:

If you are unable to keep your appointment, please call us as soon as possible so that we may make your appointment time available to other patients. For your convenience, you may cancel by calling us directly during regular business hours at 435-613-2200 or you may leave a message on our cancellation line 24 hours a day, seven days a week at 435-613-2204. We do not charge a missed appointment fee, so we do appreciate as much notice as you can give us if you're not able to keep your scheduled appointment. You may also cancel by sending us a message through our patient portal.

Arriving Late to Appointments:

We understand that sometimes life just happens. Our challenge is to find a way to help you while staying on schedule for the benefit of our other patients. If you are 15 or more minutes late, we can offer you the following options:

- Wait to be worked in (this may be an extended wait depending on our schedule for the day)
- Reschedule for a different day

Contacting Your Provider

Our patient portal is the best, most direct and confidential way to contact your provider. Secure portal messages bypass the reception desk and are sent directly to your providers' nurse. You can access the patient portal by

clicking on the "Patient Portal Tab" on our website. Your provider will publish lab results, wellness reminders and patient education materials through the portal for you to view. If you choose not to sign up for our patient portal, please call the office to leave a message with a receptionist for your provider or their nurse. We do not offer the option to leave a voicemail, but you can be confident any information you provide will be kept confidential.

Financial Policy

Patient Responsibility:
When you make an appointment for our services, you are agreeing that payment for our services is ultimately your responsibility. Our practice policy requires that you pay your portion of the cost for our services at the time of service. This includes a co-pay or estimated co-insurance or deductible at the time of service plus a bank or credit card auto-bill pay authorization for any additional amounts you may owe after your insurance company has processed your claim.

Auto-Bill Pay:
Our auto-bill pay service allows us to securely store patient bank information or credit card numbers and charge them only after your insurance company has processed your claim and notified us that you have an additional balance. You will receive an email 3 days in advance letting you know the additional amount you owe and the date your auto-pay authorization will be processed. If your insurance company pays in full, the secure auto-pay authorization will automatically be cancelled, and your card or bank account will not be charged. Any additional amounts charged should also match the "Explanation of Benefits" your insurance company sent directly to you.

Patients with Medical Insurance Benefits:
Your insurance company will only pay for covered services and supplies when your insurance rules are met. This includes satisfying any Medical Necessity requirements put in place by them for your specific benefit plan. Typically, we do not know whether your insurance will pay for services and/or supplies until after we have already provided our services. Because of this, we cannot and do not guarantee that our services will be paid by your insurance company. You will be personally and fully responsible for payment of services and/or supplies in the event that your insurance company denies payment for any reason.

Our business office will submit primary and secondary insurance claims for you – subject to you having given us current insurance information at the time of your appointment. If we are unable to verify your insurance coverage at the time of your appointment, payment is due in full at the time of service or you may reschedule your appointment. If you choose to pay in full instead of rescheduling, we will still accept insurance information and bill your insurance company up to 30 days from the date of your appointment. Upon payment from your insurance company, we will refund any amounts overpaid on your account back to you.

Even if you have insurance, we require that you pay your estimated portion at the time of service. We will bill you or refund you for any balance due after the charges are processed according to the insurance contract.

Workers Compensation
As a courtesy to our patients, our business office will file workers compensation claims. However, if the claim is denied, unsettled, or is not paid within 60 days from date of service, we request that you file a personal health insurance claim or pay the charges in full. You should always notify your employer if there is any delay or problem in resolving your workers compensation claim. It is your responsibility to provide us with this information at the time of service.

Gagon Family Medicine is now offering our patients easy and private access to the record of care provided by our office. Each portal is unique to a specific patient and allows you to view your personal Gagon Family Practice health record whenever and wherever you have access to the Internet!

Gain access to your private health information and receive periodic updates and reminders from our office on your personal email address!

(No junk – we promise)

How do I Sign Up for the Patient Portal?

1. Call or come into the office.

2. Provide us with a personal (non-work) email.

3. Receive an email with your user name and temporary password.

4. Log in to the portal and change your password to something you'll remember.

Congratulations! You are now web enabled through our patient portal!

healow
Health and Online Wellness

You can now access the portal from your smartphone with the healow app!

1. Log-in at www.gagonfamilymedicine.com first using a web browser to activate your account.

2. Then go to the **App Store** and type in healow.

3. Download it to your phone

4. Type "Gagon" or code CEICBA into search field.

5. Select Shane D. Gagon MD, PC

6. Log-in with the same patient specific username and password as on the patient portal.

7. Add additional family members by clicking on "link another account" on the drop down under your name. Enter their unique user name and password to access their account.

8. Enjoy all the benefits of our portal from your smart phone!

Access Your own personal Patient Portal Online or on Your Phone!

- Visit www.gagonfamilymedicine.com
- Click on the Orange Patient Portal Tab under the picture
- Click the Green button labeled patient portal
- Enter patient specific username and password.
- Enjoy all the benefits of the patient portal!

How to Message Your Provider Using The Patient Portal

- Go to www.gagonfamilymedicine.com
- Click on Patient Portal Tab in the middle of the page
- Click the green button labeled patient portal
- Enter User Name and Password at the top of the page*
- Click on Inbox on Left hand side
- Click Compose.
- Type Subject and Message**
- Click Submit

*** Please make sure you are using the individual patient's account. Do not send messages for your children or spouse through your account.***

****Always include your name if you are not the patient and a good contact number in case we need to reach you.****

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The Patient Portal is not intended for use in emergencies. If you require urgent or immediate medical care, call 911.

GAGON FAMILY MEDICINE URGENT CARE

NEW PATIENT INFORMATION FORM

Please Print

Today's Date_____

Name: _____ Date of Birth: _____ Sex: __ M __ F

Mailing Address: _____ City/State/ Zip: _____

SS# ___-__-____ Marital Status: _____ If this patient is a newborn, who was their doctor in the hospital?

_____

Are you a student: Yes _____ No _____ Full Time: _____ Part Time: _____

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐Native Hawaiian or Other Pacific Islander ☐Hispanic or Latino ☐Other ☐Unreported/ Refused to Report

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Refused to Report

Would you like to transfer care to us? ☐**Yes** ☐**No** **Who is your Primary Care Provider?** _____
Preferred Language: ☐English ☐Indian ☐Spanish ☐Russian ☐Other _____

Please list all family members that have been seen in our office_____

Do you want this patient added to the family account ☐yes ☐No

How did you hear about us? ☐Radio ☐Newspaper ☐Website ☐Referral ☐Other _____

RESPONSIBLE PARTY INFORMATION

Name: _____Date of Birth: _____ SS# ___-__-____

Address: _____City/State/Zip: _____

Home Phone # (___) ___-____ Cell Phone# (___) ___-____

Relationship to patient: _____ HIPAA Access (access to your medical record) Y/N

Primary Insurance Name_____ Name of Policy Holder_____

Primary Policy Holder Date of Birth _____ SS# ___-__-____ Relationship to Patient _____

Employer: _____ Full Time: _____ Part Time: _____ Not Employed: _____

Secondary Insurance Name_____ Name of Policy Holder_____

Secondary Policy Holder Date of Birth _____ SS# ___-__-____ Relationship to Patient _____

Employer: _____Full Time: _____ Part Time: _____ Not Employed: _____

GAGON FAMILY MEDICINE URGENT CARE

NEW PATIENT INFORMATION CONTINUED:

As a patient of our clinic, you may be contacted by us to remind you of future appointments, to discuss your lab results, health maintenance information, and/or prescription confirmations, etc. In addition, you may have follow-up questions for us. We offer both an online patient portal and an automated calling/texting service for your convenience. In addition, you may always call our office directly.

Please provide the following information:

Patient Portal:

E-mail address: _____ (required)

Please provide an e-mail address that you can access at any time. We generally find that non-work e-mail addresses work best.

Telephone Numbers:

Preferred Phone # _____ ( ) Home ( ) Cell ( ) Other _____

Alternative Phone # _____ ( ) Home ( ) Cell ( ) Other _____

Preferred Time to Call for Appointment Reminders?

( ) Morning ( ) Afternoon ( ) Evening

Preferred Method to Receive Appointment Reminders?

( ) E-mail ( ) Voice Message ( ) Text Message

Emergency Contact and HIPAA Access:

Name: _____ Relationship: _____ Phone#: (_ _ _) _ _ _-_ _ _ _

***HIPAA Access (access your medical record) Y/N (required)**

Name: _____ Relationship: _____ Phone#: (_ _ _) _ _ _-_ _ _ _

***HIPAA Access (access your medical record) Y/N (required)**

GAGON FAMILY MEDICINE + URGENT CARE

CONSENT TO OBTAIN MEDICATION HISTORY

Patient ID: _____ **Date:** _____

As a user of an electronic medical record, Gagon Family Practice would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors may have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

An accurate medication history is very important to help us treat you and avoid potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and to give your pharmacy and your health insurance permission to give us information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your electronic medical record, should your provider feel it is important to your medical care.

This medication history is a useful guide, but it may not be complete. Some pharmacies do not make drug history available to us, and the drug history might not include drugs purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to tell us about any errors in your medication history.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Print Patient Name Patients Date of Birth

_____ _____

Signature of Patient or Guardian Relationship to Patient

GAGON FAMILY MEDICINE + URGENT CARE

Name _____ Date _____

Health History Form for NEW Patients

Welcome to our practice! Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions.

Medications: Please, list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, herbs, etc.

Medication **Dose (e.g. mg/pill)** **How many times per day?**

_____
_____
_____
_____
_____
_____
_____
_____
_____

Local Pharmacy: _____ **Mail in Pharmacy:** _____

Personal Medical History: Do you have now (current) or have you had (past) any of the following conditions?

Condition	Current	Past	Comments
Alcohol / Drug abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety/ Depression			
Arthritis			(Rheumatoid), (Osteoarthritis), (Gout)
Asthma			
Bladder / Kidney Problems / Disease			
Blood Clots			
Blood Transfusion			
Breast Lump (Benign)			
Cancer (please, specify type)			
Cataracts / Glaucoma			
Coronary Artery Disease / MI			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema / Lung			
Fracture (broken bones)			Where?
Gallbladder disease			
Gastroesophageal Reflux (heartburn/GERD) / Ulcers			
Gynecological Conditions			(Fibroids) or (Endometriosis)

Gynecological Conditions (other)			
High Blood Pressure			
Crohn's Disease / ulcerative colitis			
Congestive Heart Failure			
High Cholesterol			
Liver Disease			
Migraine Headaches			
Prostate			(Enlargement) or (Nodules)
Seizure / Epilepsy			
Skin condition			
Sleep Apnea			
Thyroid (nodule)			
Thyroid High (hyperthyroidism)			
Thyroid Low (hypothyroidism)			
Other (list)			
Other (list)			

Allergies or intolerance to medications (include type of reaction

_____ _____

_____ _____

_____ _____

_____ _____

Women's Health

Total number of pregnancies: _____ Number of births: _____

Date (month /day if known) of last menstrual period: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause): _____

Mammogram	Date_____	Abnormal?	☐No	☐Yes
Pap Smear	Date_____	Abnormal?	☐No	☐Yes
Bone Density	Date_____	Abnormal?	☐No	☐Yes

Surgical History – Please check off any procedure or surgeries. List any abnormal finding or complications. ☐**NONE**

Surgical Procedure	Yes	Year	Comments
Abdominal Surgery			
Appendectomy (appendix removal)			
Back Surgery			
Biopsy (location)			
Breast Surgery			
Colonoscopy / Sigmoidoscopy			
Coronary Bypass / Stent			
EGD (Stomach Endoscopy)			
Cataract / Eye Surgery			
Gallbladder Removal			
Heart Surgery (other than coronary bypass)			
Hip Surgery			
Hysterectomy (total) or (partial –ovaries left) / Ovary Removal			
Knee Surgery			Circle: Right Left Both
LEEP Cervix Surgery)			

Neck Surgery			
Ovary Ligation ("Tubal")			
Vasectomy			
Sinus Surgery			
Other (list)			

Family History – Indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's [illegible]	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known										
Alcoholism										
Alzheimer's										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Ovarian/ Uterine										
Cancer Prostate										
Cancer Skin										
Cancer Other										
Coronary Artery Disease, (e.g. heart attack, angina)										
Depression/Suicide/Anxiety										
Diabetes (childhood onset)										
Diabetes (adult onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Heart Disease (CHF) / Other										
Hepatitis B or C										
High Blood Pressure										
High Cholesterol										
Hypothyroidism										
Kidney Disease/ Stones										
Macular Degeneration										
Migraine Headaches										
Osteoporosis / Osteopenia										
Other (please, list)										

Other Health Issues:

Tobacco Use

Smoke cigarettes: ☐Never ☐No ☐Yes

Quit date: _____ How many years did you smoke? _____

Approximately how many packs a day did you smoke? _____

Current Smoker: Packs/day: _____ # of years: _____

Other Tobacco Use: ☐ Pipe ☐ Cigar ☐Snuff ☐Chew

Street Drugs (other drug use) ☐ Yes ☐ No

Have you had or currently have (mark answer)?

☐Hepatitis (B, or C) ☐HIV

☐AIDS ☐STD's

Immunizations

Flu Vaccination (current season) ☐No ☐Yes

Pneumonia Vaccination ☐No ☐Yes, approximate date _____

TB Test ☐No ☐Yes, approximate date_____

Family History of Cancer Questionnaire

Patient Information

Name: _____ Birthdate: _____

Street Address: _____ City: _____ State: ___ Zip Code: _____

Phone number: (___) _____ Email address: _____

Ancestry (check all that apply)

⌗ **Western/ Northern Europe**	⌗ **Central/ Eastern Europe**	⌗ **Africa**	⌗ **Near East/ Middle East**	⌗ **Other: _____ _____**
⌗ **Ashkenazi**	⌗ Latin America/ Caribbean	⌗ Asia	⌗ Native American	

Patient Personal History of cancer (Check all that apply)

- ⌗ No personal history of cancer
- ⌗ Breast Cancer, Age at diagnosis: _____
  - ⭘ Triple Negative(ER-, PR-, HER2-) ⭘ Ductal Invasive ⭘ Lobular Invasive ⭘ DCIS
  - ⭘ Bilateral ⭘ Premenopausal
- ⌗ Endometrial/ Uterine Cancer, Age at diagnosis: _____
- ⌗ Ovarian Cancer, Age at diagnosis: _____
- ⌗ Colon/ Rectal Cancer, Age at diagnosis:____
  Type if known: _____
- ⌗ Colon/ Rectal polyps, Age at diagnosis of first polyps:____
- ⌗ Bone Marrow Transplant recipient
- ⌗ Current Diagnosis of a Hematologic Cancer
- ⌗ Other cancer(s):_____ _____ Age at diagnosis:____
- ⌗ Other cancer(s):_____ _____ Age at diagnosis:____

Family History of Cancer (Please use one line per family member)

- ⌗ No known family history

Relationship	Maternal	Paternal	Cancer Site(s)	Age at diagnosis