FAMILY MEDICINE

PATIENT REGISTRATION

NAME _____DATE OF BIRTH_____ SOCIAL SECURITY #_____

AGE _____ SEX _____RACE _____ETHNICITY _____

ADDRESS_____CITY_____STATE_____ZIP _____

PHONE#_____ALTERNATE #_____EMAIL_____

HOW DID YOU HEAR ABOUT US? ☐INTERNET/SOCIAL MEDIA ☐BUSINESS CARD/FLYER ☐FRIEND/RELATIVE/WORD OF MOUTH
☐DOCTOR_____ ☐INSURANCE_____ ☐OTHER_____

EMPLOYMENT INFORMATION

EMPLOYER_____PHONE #_____

ADDRESS_____CITY_____STATE_____ZIP _____

PARENTS OR POWER OF ATTORNEY SEEKING TREATMENT FOR PERSONS IN YOUR CUSTODY

GUARANTOR _____RELATION TO PATIENT _____

DATE OF BIRTH _____SOCIAL SECURITY # _____

ADDRESS_____CITY_____STATE_____ZIP _____

PHONE #_____ EMAIL_____

EMERGENCY CONTACT INFO.*IF MORE SPACE IS NEEDED, PLEASE ADD TO SEPARATE SHEET*

NAME _____RELATION TO PATIENT_____

PHONE #_____ALTERNATE # _____

NAME _____RELATION TO PATIENT_____

PHONE #_____ALTERNATE # _____

INSURANCE INFORMATION

PRIMARY INSURANCE_____POLICY # _____GROUP #_____

INSURED'S NAME _____ D.O.B. _____RELATION TO PATIENT _____

ADDRESS_____CITY_____STATE_____ZIP _____

SECONDARY INSURANCE_____POLICY # _____GROUP #_____

INSURED'S NAME _____ D.O.B. _____RELATION TO PATIENT _____

ADDRESS_____CITY_____STATE_____ZIP _____

<u>*YOU ARE RESPONSIBLE FOR ANY REQUIRED DEDUCTIBLE AND UNPAID BALANCE*</u>

The following authorization must be signed by the patient or Guarantor before any forms to insurance companies or medical reports can be released from this company. I am aware of my rights in regards to HIPAA. I hereby authorize payment directly to Family Medicine payable under the provisions of my policy(ies).

_____ _____

Patient/Guarantor's Signature Today's Date

H.I.P.A.A. COMMUNICATION USE & DISCLOSURE AUTHORIZATION

THIS FORM AUTHORIZES PERMISSION TO SHARE MEDICAL INFORMATION OF THE PATIENT'S

PATIENT NAME____D.O.B.____________________TODAY'S DATE: ______________

I hereby request the following regarding the use of my personal health information

You may discuss information regarding my treatment and care with the following:

NAME____RELATION TO PATIENT _________________________________

PHONE #____ALTERNATE # ____

NAME____RELATION TO PATIENT _________________________________

PHONE #____ALTERNATE # ____

NAME____RELATION TO PATIENT _________________________________

PHONE #____ALTERNATE # ____

NAME____RELATION TO PATIENT _________________________________

PHONE #____ALTERNATE # ____

NAME____RELATION TO PATIENT _________________________________

PHONE #____ALTERNATE # ____

NAME____RELATION TO PATIENT _________________________________

PHONE #____ALTERNATE # ____

NAME____RELATION TO PATIENT _________________________________

PHONE #____ALTERNATE # ____

NAME____RELATION TO PATIENT _________________________________

PHONE #____ALTERNATE # ____

You may leave the following information on voicemail and/or with the above listed individuals:

☐ REFERRAL INFORMATION

☐ PRESCRIPTION INFO.

☐ SCHEDULING FOR TEST RESULTS

☐ OTHER____

I authorize this medical facility to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached.

I understand that I may revoke/cancel this authorization by notifying the facility in writing of my intent to revoke authorization or change the names of the individual(s) to whom information is to be released.

____

SIGNATURE OF PATIENT OR GUARANTOR

____ ________________ __________________________

PRINTED NAME IF OTHER THAN PATIENT D.O.B. RELATION TO PATIENT

NEW PATIENT HISTORY INTAKE FORM

Name_____**DOB**_____**Today's Date**_____
Reason for today's visit:_____**Pharmacy:**_____

MEDICAL HISTORY (Check all that apply): ☐NONE
☐ ASTHMA ☐ANXIETY ☐THYROID DISEASE ☐DEPRESSION ☐DIABETES ☐LUNG DISEASE ☐HYPERTENSION ☐STROKE
☐ HIGH CHOLESTEROL ☐HEART DISEASE ☐KIDNEY PROBLEMS ☐FREQUENT URINARY PROBLEMS
☐ CANCER-Type_____
☐ OTHER_____

SURGICAL HISTORY ☐NONE
Please list any major surgeries/hospitalizations (including the year)

_____
_____
_____
_____

SOCIAL HISTORY:
Marital status: **S M D W Employment Status:** ☐Y ☐N **Occupation:**_____**Retired Student Disabled**
Smoking History ☐Never Smoker ☐Former Smoker ☐Current Smoker If yes, packs per day?_____ How many years?_____
Alcohol History ☐Never Drinker ☐Former Drinker ☐Current Drinker If yes, how many drinks per week? _____
Illegal Drug Use ☐Never ☐Former ☐Current If yes, how often?_____What type of drug(s)? _____
Have you ever been a victim of Abuse? ☐ YES ☐ NO

FAMILY HISTORY: ***IMMEDIATE FAMILY ONLY***

FAMILY MEMBER(S)	DISEASE(S)

ALLERGIES: (DRUG,FOOD & ENVIRONMENTAL)

_____
_____
_____

INFECTIOUS DISEASE HISTORY: ☐NONE ☐STD ☐Hepatitis ☐TB ☐ HIV/AIDS
☐OTHER_____

HEALTH MAINTENANCE HISTORY (Most Recent Date)
Colonoscopy_____BoneScan_____Vision Screening_____
(MEN ONLY) Prostate Exam_____If abnormal, please explain:_____
(WOMEN ONLY)
Last menstrual cycle_____ Age at onset:_____
Pregnancies_ _____ Live Births_____Miscarriages_____ Abortions_____
Date of last mammogram_____ If abnormal, please explain_____
Date of last Pap Smear_____If abnormal, please explain_____

REVIEW OF SYSTEMS

***Please circle each symptom as it relates to your health within the last 2-3 days**

ALLERGIC/IMMUNOLOGIC
Food Allergy
Seasonal Allergies

CARDIOVASCULAR
Chest Pressure
Heart Palpitations
Edema
Exercise Intolerance
Arrhythmia

CONSTITUTIONAL
Fever
Weight Loss
Fatigue
Night Sweats
Insomnia

DERMATOLOGIC
Rash
Skin Lesion

EYES
Vision Change
Double Vision
Blurred Vision

EAR/NOSE/THROAT
Sore Throat
Hearing Loss
Nasal Discharge
Sinus Congestion

ENDOCRINE
Goiter
Hyperglycemia
Hypoglycemia

GASTROINTESTINAL
Abdominal Pain
Nausea/Vomiting
Constipation
Diarrhea

GENITOURINARY/URINARY
Dysuria
Nocturia
Urinary Incontinence

HEMATOLOGIC/LYMPHATIC
Abnormal Ecchymoses
Petechiae
Abnormal Bleeding & Bruising
Anemia
Lymph Node Enlargement/Mass

MUSCULOSKELETAL
Swelling
Stiffness
Muscle Weakness
Myalgia

NEUROLOGICAL
Headache
Neck Pain
Dizziness
Syncope

PSYCHOLOGIC
Depression
Anxiety

RESPIRATORY
Wheezing
Cough
Dyspnea

Please explain any items circled above

MEDICATION LIST

Are you currently taking any prescription, over-the-counter or alternative supplements or medications?
Please list all current below for review with your physician. Thank you.

MEDICATION	DOSAGE	FREQUENCY	APPROXIMATE START DATE

Consent to Obtain Medication Fill History

I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. By signing this form I authorize my provider to query and review my medication fill history including drug, dose, form, strength, prescribing provider and pharmacy.

_____ _____/_____/_____

PATIENT SIGNATURE TODAY'S DATE

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

These policies are effective as of August 18, 2016

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting

  Holly Cannon, Security Officer
  Orange Ave Medical Group
  407-459-1181
  patientinfo@oacmg.com
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and in our office.

❑ I have read and the Notice of Privacy Practices and understand and consent to the use and disclosure of protected health information about myself for treatment, payment and health care operations. I may ask for a copy for my records.

_____ _____/_____/_____

SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE TODAY'S DATE

OFFICE AND FINANCIAL POLICIES

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

BASIC POLICY: Payment for service is due in full at the time service is provided by our office.

PROOF OF INSURANCE: We ask that you present your insurance card to us at each visit. If you fail to provide us with the correct insurance information at each visit, you may be responsible for payment of all services provided.

PATIENTS WITH INSURANCE: We will bill most insurance carriers for you if proper paperwork is provided to us. We will also file most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

PARTIAL PAYMENTS/PAYMENT PLANS: Partial payments will not be accepted. Our policy mandates co-payment or payment in full during your visit. We do not offer payment plans for services provided.

MEDICAL RECORDS: I authorize Family Medicine to transmit my medical records electronically. lf they are received by another party in error, I absolve Family Medicine of any and all liability relating to such submission of said records.

CONSENT TO PERFORM MEDICATION HISTORY RECONCILIATION: I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. I authorize my provider to query and review my medication fill history including drug, dose, form, strength, prescribing provider, and pharmacy.

CONTROLLED SUBSTANCES: Controlled substances MAY be prescribed at the discretion of the physician. Most times these are intended for temporary relief or to alleviate symptoms until your visit to a Specialist. Chronic refills will not be supplied.

LATE POLICY: If you are more than 15 minutes late for your appointment, you will be considered a walk-in and will be seen at the first available opportunity, if there is one. We cannot guarantee walk-ins will see the doctor on that day, based on scheduled appointments. If we cannot see a walk-in on a particular day, you will be asked to reschedule for a later date.

NO SHOW POLICY: Please allow 24 hours notice for cancellation of your appointment. In the event that you miss your appointment, you may be charged $25.00 at the discretion of the practice.

I have read and understand Family Medicine's insurance and payment policy and agree to comply with the above policies.

_____ _____ _____ _____/_____/_____

PATIENT'S PRINTED NAME D.O.B. SIGNATURE/RELATION TODAY'S DATE

MEDICAL/HEALTH PATIENT RESPONSIBILITY

Consent For Treatment/ Lifetime Authorization for Assignment of Benefits and Information Release

I hereby give release for Family Medicine to provide whatever medical services they deem necessary, I certify that the information furnished is true and correct. I am fully aware that it is a felony to falsify any information about my medical condition. I also understand that as a visiting patient of Family Medicine, I am responsible for all applicable medical charges.

I authorize Family Medicine to furnish complete information requested by my insurance carrier or its intermediates regarding services rendered. I hereby authorize Family Medicine to submit to my insurance carrier, or its intermediates for all covered services rendered by the physician(s). I also authorize my insurance carrier and its intermediates to issue payment directly to the physician(s). I confirm that in the event I do not have medical insurance coverage, I will be responsible for full payment at the time of service. I am aware that in the event my insurance does not reimburse the required amount or if my account reflects any outstanding balances, including copayments or deductibles, I will be responsible for the entire balance. I understand that my account may be placed with a National Collection Agency if I do not pay my balance in full, establish an acceptable payment arrangement, or provide the practice with a verifiable third party insurance coverage.

By signing below, I agree that I am responsible for any balance after insurance payments have been made, including any collection cost or legal fees incurred to collect these balances.

A photocopy of this agreement is considered to be as valid as an original.

_____

SIGNATURE OF PATIENT OR GUARANTOR

_____ _____ _____

PRINTED NAME IF OTHER THAN PATIENT D.O.B. RELATION TO PATIENT

ATTENTION PATIENTS

As a courtesy to our patients we have a Medical Provider on-call at all times. This service is able to provide medical advice to assist you in urgent situations that require decision-making. However, please be aware that if you have a medical emergency, you must call 911 and not our office.

To guide you as to what services can and cannot be provided to patients calling our answering service after regular hours, the following concerns cannot be accommodated:

These requests should be done during regular office hours:

1. Requests for new prescriptions or prescription refills
2. Prescribing antibiotics or controlled medications
3. Review or discussing lab or other test results

Please go to ER or urgent care facility to be evaluated have the following:

1. Chest pain/tightness
2. Shortness of breath
3. Lightheadedness/dizziness
4. Severe headache
5. Loss of consciousness/fainting
6. Prolonged or high fever
7. Abdominal pain

We wish to reiterate that the Medical Provider-On-Call can only give advice and provide you with prescriptions or diagnoses over the phone after hours. While we are pleased to be able to offer you this service, your understanding of the limitations of this service will enable us to continue providing the same.

Thank you for choosing Family Medicine for your health care needs. We look forward to serving you!