Associates In Family Medicine LLC

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Board Certified Care for You and Your Family
Adult Medicine/Geriatrics
Adolescent, Pediatric, & Newborn Medicine
Minor Surgical Procedures

Welcome to Associates In Family Medicine! The following pages include:

1. Medical History Form for Adult Patients.
2. Communication Form
3. Records Request Form
4. Financial Policy Form

Fill out as much as you can before your first visit. Don't forget to sign at the bottom of each form.

Thank you for choosing Associates In Family Medicine. We hope to serve you in all your health needs.

-- ADULT INTAKE FORM --

Name _____ Age _____ Birth date _____ Sex ☐M ☐F
Address _____ Home Phone _____
_____ Cell Phone _____
_____ Email _____
_____ Race/Ethnicity (government required categories):
SS# _____ ☐ Asian ☐Black ☐ Non-white Hispanic
☐ White Hispanic ☐White ☐Other _____

Emergency Contact name and phone: _____
Marital Status and if married, spouse's name: _____
Children's names and ages: _____

ALLERGIES to Medications, X-ray dyes, or other substances: ☐ No ☐ Yes
If yes, list to what and what kind of reaction: _____

MEDICAL HISTORY - Please check if you have had problems with any of the following:

☐ High blood pressure	☐ Cancer	☐ Acid Reflux/Ulcers	☐ Migraines
☐ Heart attack or blockages	☐ Asthma	☐ Tuberculosis (T.B.)	☐ Stroke
☐ Diabetes	☐ Urinary problems	☐ Hay Fever/Allergies	☐ HIV
☐ High Cholesterol	☐ Hepatitis	☐ Thyroid problems	☐ Alcohol/Drug problems
☐ Kidney stones	☐ Arthritis	☐ Back problems	☐ Anemia
☐ Anxiety/Depression	☐ Heart Murmur	☐ Other: _____	

OPERATIONS ï ☐ Tonsils, ☐ Gallbladder, ☐ Appendix, ☐ Uterus (hysterectomy), ☐ Ovaries, ☐ Heart Bypass, ☐ Sterilization, ☐ Other surgery/operations: _____

OB/GYN HISTORY – Age at onset of periods: _____, Pregnancies: _____, Births: _____, Miscarriages: _____
☐ History of abnormal Pap test (When and what treatment): _____

MEDICATIONS – Please list all medications, inhalers, birth control, vitamins, natural products.

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY ï Has a family member had? ☐ Cancer (Type _____), ☐ Migraines, ☐ Heart Attack, ☐ Diabetes, ☐ Stroke or blood clots, ☐ Anxiety/Depression/Mental Illness, ☐ Thyroid problems, ☐ Asthma/allergies, ☐ Other: _____
If yes, please give relationship to you and age when diagnosed: _____

HEALTH MAINTANANCE & PREVENTION

- Have you ever smoked? _____
- If you smoke now, how many packs a day? _____ and how many years have you smoked? _____
- If you smoked in the past, when did you quit? _____ and how many packs a day did you smoke? _____ and how many years did you smoke? _____
- How much alcohol do you drink (drinks per week)? _____
- How many cups of caffeinated beverage do you drink a day? _____ Circle: coffee, tea, caffeinated soda
- If any history of drug use, what kind and when quit? _____
- Any history or current concern of physical abuse? _____
- What exercise routine do you have? _____
- Do you have a living will? ☐ Yes ☐ No

I certify the above information is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical information.

_____ ____/____/_____
Signature of patient or parent/guardian ***Date***

COMMUNICATION

Please sign this form to tell us how to contact you with protected health information.

We may contact you and leave information on your:

Home Telephone	☐ Yes	☐ No	Number: ( ) _____
Answering Machine	☐ Yes	☐ No	
Work Telephone	☐ Yes	☐ No	Number: ( ) _____
Voice Mail	☐ Yes	☐ No	
Cellular Phone	☐ Yes	☐ No	Number: ( ) _____
Email	☐ Yes	☐ No	_____ _____

Please list authorized personal representative names:

Spouse/Fiancé:	_____	☐ Yes	☐ No
Parent/Guardian:	_____	☐ Yes	☐ No
Brother/Sister:	_____	☐ Yes	☐ No
Son/Daughter:	_____	☐ Yes	☐ No
Friend:	_____	☐ Yes	☐ No
Other:	_____	☐ Yes	☐ No

I authorize Associates In Family Medicine to leave protected health information pertaining to my care by the above methods and will assume responsibility to notify them whenever this information changes. I acknowledge that this consent can only be amended or rescinded by me in writing.

Please initial below:

_____ **I have been provided a copy of Associates in Family Medicine's *Notice of Privacy Practices*.**

_____ **I authorize Associates in Family Medicine to obtain the past 12 months of my prescription history.**

_____
Patient Name

_____ _____
Patient/Guardian Signature Date

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RECORDS REQUEST

Please sign this form to let us request in or send out your records.

PATIENT'S FULL NAME: ***(Please Print)***_____

BIRTHDATE: _____/_____/_____

I hereby authorize Associates in Family Medicine to:

☐ RECEIVE RECORDS FROM: _____

☐ SEND RECORDS TO: _____

_____

Check (✓) what is to be received or sent: Dates of Service _____ to _____

☐ Complete Medical Record ☐ Other _____

Check (✓) Purpose of Disclosure:

☐ Change of Insurance ☐ Disability Application ☐ Legal Request ☐ Moving Out of Area ☐ Referral Appointment

☐ Transfer of Care - To continually improve our services, please provide reason for transfer of care:

_____

You must read the following statement:

I understand the information to be disclosed to the above person, organization or agency may be protected by the Drug and Alcohol Abuse Control Act (Pennsylvania Law, Act 63) and/or the Mental health Procedures Act (Pennsylvania P.L. 817) and /or Confidentiality of HIV Related Information Act (Pennsylvania Law, Act 148). My signature below authorizes release of all such information by routine/express mail service or facsimile transaction unless I check here to not disclose such records. Checking or not checking the box is not an indication that such information exists.

Records **NOT** to disclose: ☐ HIV/Sexually transmitted disease information ☐ Mental health services

☐ Drug and/or alcohol use, abuse, treatment, or referrals for treatment.

EXPIRATION DATE: *I understand that this authorization shall expire 6 months from the date requested unless specified with an alternate expiration date. I choose to assign an alternate expiration date of _____/_____/_____.*

RIGHT TO REVOKE: *I understand that I may revoke this authorization at any time by notifying Associates In Family Medicine in writing. A revocation will not impact any actions taken prior to our receipt of the revocation in reliance on this authorization.*

RIGHT TO NOT SIGN: *I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Associates In Family Medicine, not will it affect my eligibility for benefits.*

RE-DISCLOSURE NOTICE: *This information has been disclosed to you from records protected by Federal and State confidentiality laws. It prohibits you from making any further disclosures unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise authorized.*

I have read and fully understand this authorization, and authorize use and disclosure of protected health information about the named patient as described in this authorization. My signature authorizes the release of such information to be sent by mail or fax. **This authorization will not be accepted unless completed in its entirety.** A copy of this document may be used in lieu of an original. I understand that Associates In Family Medicine does charge to copy and send medical records, which may be my financial responsibility.

_____ _____

Signature of Patient/Guardian or Personal Representative — Date

_____ _____

Print Personal Representative's Name — Relationship to Patient

_____ _____

Signature of Staff Person Obtaining Authorization — Date

ASSOCIATES IN FAMILY MEDICINE, LLC

FINANCIAL POLICY

- Please present your insurance card at every visit.
- The copay is collected when you register with our check-in secretary. Copays that are not paid at that time will be assessed a $5.00 billing fee.
- There is a $20.00 charge for all missed appointments unless 24 hours notice has been given.
- There is a $25.00 fee for a returned check.
- Outstanding balance is due within 30 days of the statement date. All balances must be satisfied prior to any future services. Payment remains your responsibility whether or not your insurance pays. All balances that reach 90 days past due will be sent to external collections. Should your account be sent to an outside collection service, you will be financially responsible for all collection and legal fees incurred to collect the delinquent balance and will be considered discharged from the practice. If you need special payment arrangements, please advise our Patient Accounts Coordinator or Practice Manager.
- If you are unsure of your coverage, we suggest you contact member services at the telephone number on your insurance card. If the correct information is not given to Associates In Family Medicine, the patient is responsible for the bill.
- If your insurance company deducts multiple copays for a physical and a medical condition, you are responsible for both copays.
- If you have an HMO and Associates in Family Medicine is not listed as the primary care physician (PCP) on your insurance card at the time of your visit, the patient will be responsible for the bill. If the HMO requires a referral for services outside of our office, the patient is required to request and obtain the referral 48 hours prior to the date of service.
- If we do participate with your insurance company, all services performed in our office will be submitted to your carrier as a courtesy to you, unless we have prior notification of non-covered services.
- If you do not have insurance or office visit coverage, full payment is required at time of visit. A discount will be applied to all services paid at time of visit. If payment is not received at time of service, full charges will be billed to the patient.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary. Any balance not covered by the insurance company becomes the responsibility of the patient.
- We require a Medical Consent Authorization before services are rendered to a child less than 18 years of age. The parent, guardian, or adult accompanying a minor is responsible for any payment due. We will not be involved in negotiating between parents in custody disputes.

I have read and fully understand the financial policy set forth by Associates in Family Medicine and agree to te terms. I also understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification.

_____ _____

Signature of Patient or Patient's Representative **Date**

_____ _____

Patient Name **Date of Birth**