Family Practice Center of Salem, Inc. - Patient Registration Form

Patient Name_____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ (Circle one) Married/Single/Divorced/Widow

Home Phone: (_____) _____-_____ Sex: M /F Cell Phone: (_____) _____-_____

Patient Address:_____
(Street) (City/State/Zip)

Employer Name:_____ Employer Phone Number: (_____)_____-_____

Employer Address:_____
(Street) (City/State/Zip)

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name:_____ Social Security Number: _____-_____-_____

Relationship to Patient: (please check): ( )Self, ( )spouse, or ( )Parent Date of Birth _____/_____/_____

Address:_____ Phone Number: ( ) _____-_____

Employer Name:_____

Employer Address: _____
(Street) (City/State/Zip)

Who to call for an emergency:

Name: _____ Address_____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ Relationship_____

FIRST INSURANCE INFORMATION

Plan Name:_____ I.D. Number:_____
Address:_____ Group Number:_____
Policy Holder_____ Effective Date:_____
Policy Holder's Social Security Number: _____-_____-_____
Policy Holder's Date of Birth: _____/_____/_____ SEX: M / F

SECOND INSURANCE INFORMATION

Plan Name:_____ I.D. Number:_____
Address:_____ Group Number:_____
Policy Holder_____ Effective Date:_____
Policy Holder's Social Security Number: _____-_____-_____
Policy Holder's Date of Birth: _____/_____/_____ SEX: M / F

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Family Practice of Salem, Inc. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature:_____ Date:_____

NEW PATIENT MEDICAL HISTORY PACKET

Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

[illegible]

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

[illegible]

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	

[illegible]

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY

❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH HABITS

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

Patient Name: _____ DOB: _____

OTHER ITEMS (cont.)

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: ❑ Male ❑ Female		
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?		***Duration:*** How long (min.): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: _____ DOB: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Family Practice Center of Salem, Inc.
2370 Southeast Blvd.
Salem, Ohio 44460
PH:(330) 332-9961 Fax: (330) 337-3282

PATIENT'S NAME: _____ DATE OF BIRTH:_____

Patient is requesting and authorizing the disclosure of confidential healthcare information.

Please print name, address and phone number from whom the records are being requested.

FROM: _____
(previous provider)
_____
_____

TO: Family Practice Center of Salem, Inc.
2370 Southeast Blvd.
Salem, Ohio 44460
Ph: (330) 332-9961 Fax: (330)337-3282
DO NOT FAX MORE THAN 20 PAGES

I would like my records released for the following reason(s)_____.

_____ Complete Records

_____ Records of care from _____ to _____only

Note: If these records contain any information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

AUTHORIZATION EXPIRES 1 YEAR FROM DATE OF SIGNATURE

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE:

_____ DATE:_____

Family Practice Center of Salem, Inc.
HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization: I _____authorize Family Practice Center of Salem, Inc., to use or disclose the protected health information described below to_____individual/entity_____ _____relationship.

2. Effective Period: This authorization for release of information covers the period of healthcare from: _____ to _____ OR: _____ all past, present and future periods.

3. Extent of Authorization:

   _____I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

   OR

   _____I authorize the release of my complete health record with the exception of the following information.
   _____Mental Health Records
   _____Communicable diseases (including HIV and AIDS)
   _____ Alcohol/drug treatment
   _____ Other (please specify)_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force indefinitely or from_____ to _____.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization of if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law.

_____

Signature of patient or personal representative

_____

Printed name of person or personal representative and his or her relationship to patient

_____

Date

Revised 07/17

FAMILY PRACTICE CENTER OF SALEM FINANCIAL POLICY

This is an agreement between FAMILY PRACTICE CENTER OF SALEM, INC. as creditor, and the patient, as debtor, named on this form. By executing this agreement, you are agreeing to pay for all services that are received.

Co-Payments & Insurance Deductibles:

Payments of insurance co-payments and deductibles are expected at the time of your office visit. The co-pay is your contract with your insurance carrier and we are required to collect that amount at the time of service. Co-pays will not be billed to your insurance carriers. Payments may be made with cash, check, Visa, MasterCard or Discover. If a non-sufficient fund check is returned to FAMILY PRACTICE CENTER OF SALEM, a $25.00 fee will be added to your account balance in addition to the amount of the check.

Self-Pay Patients:

If you do not have medical insurance, payment will be due at the time of service. The total amount of charges for services will be provided to you at the end of your visit.

Insurance Payments:

Your insurance policy is a contract between you and your insurance carrier. As a courtesy to you, we will bill your insurance carrier for services rendered in our office. It is your responsibility to advise the staff of any changes in your insurance coverage. Any unpaid charges by your insurance company will become your responsibility and will be due within 30 days of your statement.

Non-Covered Benefits:

Payment is expected at the time of service for those services that are known not to be covered by your insurance plan. In the event that we are not sure if a service is covered by your plan, we will have you sign a waiver agreeing to pay for those services that are not covered by your plan.

Other Fees:

There is a $15.00 refill request fee when a refill request is phoned into your physician. There is also a $50.00 "NO-SHOW" charge for any regular appointments and a $100.00 "NO-SHOW" charge for any physical appointments that are missed or not cancelled within 24 hours of your scheduled appointment.

Personal Balances:

If you have a personal balance you will receive a statement on a monthly basis. Payment is due upon receipt of the statement. If you are unable to make your payment in full at the time you receive your statement, it becomes your responsibility to contact our billing department to set up a monthly payment plan. **Payment plans are available through automatic monthly billing to your Visa, MasterCard or Discover. Payment plans need to be resolved within 90 days of the original balance date.** Personal balances that are not paid within 90 days from the date it becomes your personal balance will be automatically sent to an outside collection agency. In addition, your physician will send you a dismissal letter via certified mail. This means that you will be released from the practice and you will not be able to see any other physicians at FAMILY PRACTICE CENTER OF SALEM.

Auto Accidents:

The patient is responsible for payment at the time of service regardless of the outcome of the case. We cannot bill your health insurance carrier for services you receive pertaining to an automobile accident.

_____ _____

Print name of Patient Date of Birth

_____ _____

Signature of Patient/Guarantor Date Signed