ALLDAY
Family Care
Primary Care | Behavioral Health

Welcome to Family Care Associates

d/ba All Day Family Care

We would like to welcome you to our Medical Practice. As a new patient, we want to assure you that with our staff we are fully committed to providing you with top quality healthcare service. From the moment you step foot in our practice, we want to make you feel welcome and have the freedom to consider this your "medical home". We strive to maintain your health in excellent conditions by practicing preventive medicine and following the latest published medical guidelines.

ALL DAY FAMILY CARE IS YOUR PATIENT CENTERED MEDICAL HOME!

A Medical Home is not a place, but an approach to providing care for children, youth and adults. The Medical Home enables partnerships between individual patients and their personal primary care providers and when appropriate, the patient's family. In a Medical Home, the practice is organized around the patient – communication is based on trust, respect and shared decision-making. Patients have access to personalized, coordinated and comprehensive primary care. It is essential for all new patients/families to provide a complete medical history when establishing care with us, and to share any information about care received outside of our office (hospitals, specialists, etc.)

WHAT YOU CAN EXPECT FROM YOUR CARE TEAM AT ALL DAY FAMILY CARE

- ✓ You choose the provider you want for yourself and your family
- ✓ Our office is open 7 days a week
- ✓ A safe environment to talk about your concerns
- ✓ Responses to your questions and concerns at each appointment
- ✓ Partnering with you, using shared decision making, to help you manage your health care
- ✓ Being the "Quarterback" on your health care team, coordinating care with our office and specialists you see
- ✓ After-hour medical answering service

WHAT YOUR CARE TEAM AT ADFC EXPECTS OF YOU

- ✓ Be an active participant on your health care team
- ✓ Bring your list of questions and medications to each appointment
- ✓ Bring your Photo ID, Insurance Card, and Co-Pay to every visit
- ✓ Call our office before going to the emergency room or hospital – we can usually get you into the office the same-day when appropriate
- ✓ Inform other providers you may see that All Day Family Care is your Primary Care Provider, and ask them to share with us information regarding the care they provided you

Forms to Complete: **(We will accept and we appreciate completed forms prior to your visit)**

- ☐ Form 1: Authorization to Release Health Information
- ☐ Form 2: Patient Information Form/Consent for Treatment
- ☐ Form 3: Health History Questionnaire (3 pages)
- ☐ Form 4: Financial Policy
- ☐ Form 5: Consent for Prescription History
- ☐ Form 6: Designated Contacts

Please Bring the Following to your visit:

- ☐ Insurance card and ID
- ☐ Required Co-Pay
- ☐ Completed patient forms
- ☐ All medications you are currently taking, in original containers

If you have been seen at different providers or specialists offices we would appreciate if you complete Authorization to Release Health Information (Form 1) for us to obtain your medical records.

Thank you for choosing All Day Family Care to be your healthcare provider.
We look forward to meeting you and taking care of you in the very near future. Please rest assured that your health is our priority

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OPTIONAL

FORM 1 - AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient: DOB:

I hereby authorize Family Care Associates d/ba All Day Family Care to release/obtain all medical information with respect to the treatment of the above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and /or confidential HIV related information.

Release the Medical Records From:

Method: • Mail • Pick up • Fax

Medical Group Name:_____

Address:_____

City :_____State:_____ Zip:_____

Fax: _____

Phone: _____

Send the Medical Records To:

Method: • Mail • Pick up • Fax

Send Records to:_____

Address:_____

City :_____State:_____Zip:__ Fax: _____

_____

Phone: _____

What is the Purpose of Health Information Release

_Personal
_Primary Care Physician
_Consultation
_New Physician
_Medical Ins. Claim
_Worker's Com
_Social Security Disability
_Life Insurance
_Attorney
_Other: _____

Describe the Health Information to be Released

Service Dates: from:_____to:_____Information Needed By: _____

_Complete Medical Record
_History and Physical
_Immunization Records
_Hospital Discharge Summary
_Other: _____
_EKG's
_Pathology Reports
_Operative Reports
_Laboratory Results
_Radiology Reports
_Radiology Images
_Hospital Notes
_Clinic Notes
_Billing Information

I understand that Family Care Associates d/ba All Day Family Care will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to All Day Family Care.

_____ _____

Date: **Signature of Patient or Person granting Authorization on behalf of patient**

_____

Printed Name of Person Signing (If Not the Patient) **Relationship to Patient**

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FORM 2 – PATIENT INFORMATION

Patient's First Name		Middle Name	Last Name (as it appears on insurance card or ID)
Sex	Marital Status	Date of Birth (Age)	Social Security Number

Patient's Address	City	State	Zip

Home Phone	Mobile Phone	Email Address

Pharmacy	Pharmacy Phone	Pharmacy Address

Employer/School Information

Employer/School	Occupation	Employer/School Phone

Emergency Contact Information

Emergency Contact Name	Emergency Contact Phone	Relation to Patient

Billing and Insurance

Primary Health Insurance		Secondary Health Insurance	
Insurance Company		Insurance Company	
Member ID	Group Number	Member ID	Group Number
Insured's Name (as it appears on insurance card or ID)			
Insured's Address (if different from patient)			
Insured's Social Security Number	Insured's Birthdate		

Responsible Party

Name (if other than patient)	Phone	Relation to Patient

Address	City	State	Zip

How did you hear about All Day Family Care Clinic

__ Family/Friend __ Internet Search __ Insurance __ Other

Consent for Treatment

The above information is true to the best of my knowledge. Permission is hereby given to the physicians and staff of Family Care Associates d/ba All Day Family Care to provide ordinary and necessary medical examination, diagnosis, and treatment and administer such therapeutic treatment or services that the physician may order. Ordinary and necessary medical care shall include preventive and prophylactic care, medical procedures as well as laboratory tests. I further consent to routine immunizations for future office visits.

Authorization for Release of Information for Treatment & Payment

I consent to the use and/or disclosure of my health information (including the diagnosis or treatment of mental illnesses, or drug or alcohol abuse and/or confidential HIV-related information) to any person or organization for the purpose of treatment, including coordinating my continuing care and as otherwise authorized by law, conducting certain healthcare operations. This authorization includes the release of all medical information to health care providers who are on staff at Family Care Associates d/ba All Day Family Care and who are directly involved in my care. I further consent to the use or disclosure of my health information (including mental illness, or drug or alcohol abuse and/or confidential HIV-related information) to any third parties responsible for payment of services furnished to me by or in Family Care Associates d/ba All Day Family Care. This may include reviewing and/or photocopying and/or electronic release of pertinent health information for the purposes of obtaining payment. In the event that any of the information to be released relates to diagnosis or treatment of mental illness or drug or alcohol abuse and/or confidential HIV-related information, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE.

Date | Signature of Patient or Person Granting Authorization on Behalf of Patient

If the patient has not signed this form, please print the signor's name, relationship to the patient and, if necessary, explain why the patient did not sign

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FORM 4 - FINANCIAL POLICIES

Fees and Payments
Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, personal check, money order, Visa, MasterCard, or Discover. Insurance co-payments and deductibles are due at the time of service. We will not bill your secondary insurance for co-payments. If you are unable to pay your co-payment/deductible at your visit, your appointment may need to be rescheduled

Patients are required to provide a valid credit card on file. Family Care Assoicates, d/ba All Day Family Care will charge the credit card the following charges: Copays, Deductibles, Co-Insurances, No-Show fees. Please refer to the Credit Card Authorization Form for more details. If patient declines to provide a valid credit card a $200.00 fee will be required to be paid at the time of each visit.

While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and that the services you intend to receive are covered. In order for us to file a claim, you must present a CURRENT copy of your Insurance Card at each visit and communicate any changes in your personal information.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. It is virtually impossible for us to have knowledge of what services each insurance plan covers. **Knowing your insurance benefits is your responsibility**. Insurance companies decide on different services that they will not cover; therefore we can't guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility unless required by law or our contract with your insurancecompany.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on the availability of coverage by Insurance Companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Required at Check-In

Verify Personal Contact Information	Present Current Copy of Insurance Card and Picture ID
Payment of any Outstanding Balance	Payment of Today's Visit

We will verify your coverage at each visit. If we are unable to do so, you will be considered self-pay and will be responsible for the cost of your visit.

Self-Pay
In order to address the needs of our patients without insurance and patients with coverage limitations, we offer a discount off our standard fees. This discount reflects the lower cost involved in billing and collections when a claim does not need to be submitted to a third party payer. In order to qualify, **payment needs to be made in FULL** prior to or on completion of your visit or procedure. Any remaining balance is not eligible for a discount. This discount applies to all medical services provided and is offered only at time of service.

Medicare and Medicaid
We gladly accept Medicare patients and will bill our services at the allowed rate. Medicare regulations may require that you sign an Advanced Beneficiary Notice (ABN) acknowledging that you will be financially responsible for the cost of the visit if we have reasonable doubt that Medicare will make payment for a particular service. Lab work that may not be covered will require a separate ABN signature. If you refuse to sign the ABN, we will be unable to provide the service. We gladly accept patients with Maryland Medicaid and Managed Care Organization (MCO) as well. Your current ID card must be presented at each visit. **IT IS YOUR RESPONSIBILITY TO PROVIDE THE CURRENT INFORMATION AT EACH VISIT**.

Medical Records
In order to be in compliance with Maryland State law and HIPAA regulations, we charge a per page charge, payable in advance, if you would like a copy of your records sent to you or another physician. If you request an electronic copy of your records, we will charge a reasonable fee based on the cost of producing the copy. The medical record copy fee policy is available upon request. As always, if a collaborating physician requests portions of your record to assist in your care, there is no charge.

Miscellaneous Charges
"No-Show": - If no cancellation or reschedule call was received within 24 hours prior to your scheduled appointment we will charge $50.00 for missed appointments. "No-Show" charges need to be paid in full prior to be seen.

Interest Charge - All delinquent accounts past 30 days are subject to a 6% interest rate.

Returned Check Charge - Non Sufficient Funds (NSF) checks are subject to a $25.00 fee (in addition to fees from your bank).

Collections Charge -Accounts that are not paid within 60 days from due date may be sent to our Collection unit and reported to the Credit Bureau. In addition to your outstanding balance, a $25.00 charge will be added to cover our costs. In addition, you may be terminated from the practice and refused service until your account is current. Should the account be referred to an attorney or sent to small claims court for collection, it will be patient's responsibility to pay reasonable attorney fees, court costs, collection expenses and all other costs incurred by All Day Family Care to collect balance owed.

Lab Charges -– Depending on your insurance, you may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the Lab facility.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE.

Date | Signature of Patient or Person Granting Authorization on Behalf of Patient | **Name of Primary Care Provider (PCP)**

If the patient has not signed this form, please print the signor's name, relationship to the patient and, if necessary, explain why the patient did not sign

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CREDIT CARD AUTHORIZATION FORM

PATIENT NAME:_____DATE OF BIRTH:_____

The purpose of this form is to authorize Family Care Associates d/ba All Day Family Care to retain a valid credit card number on file for you as our patient. This form will be kept confidential and only authorized staff will have access to the information. *Please ask front desk for a copy of our Office Policies or see our policy on our website at www.AllDayMedicalCare.com.* ***If patient declines to provide credit card authorization a fee of $200.00 is due at the time of each visit. A claim will be filed with the insurance. If patient responsibility is less what was paid a refund will be issued to patient. If patient owes balance statement will be sent out.*** **Your supplied credit care will be charged ONLY under the following circumstances:**

1. Family Care Associates d/ba All Day Family Care reserves the right to charge the credit card listed below for all current patient balances, including co-pays (following insurance payments) and a receipt will be kept in your patient chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current patient balances on your account.
2. If you, as the patient, miss a scheduled appointment without 24-hour notice to cancel or reschedule, Family Care Associates d/ba All Day Family Care reserves the right to charge the credit card listed below *$50.00* for our standard no-show fee and a receipt will be sent to the current address file. This notice serves as your consent to being charged for any and all no-shows. *As is customary, a representative from Family Care Associates d/ba All Day Family Care will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 24 hours prior to your scheduled appointment. It is the patient's responsibility to ensure we have a correct, current telephone number on file.*
3. If we receive notice that a payment is returned to us for any reason, Family Care Associates d/ba All Day Family Care reserves the right to charge the credit card listed below a*$25.00 returned check fee*. A receipt will be sent to the current address on file. This notice serves as your consent to being charged for any returned payments.
4. If you, as the patient, request paper records we will provide to you, upon written request, a paper copy of your medical record. Family Care Associates d/ba All Day Family Care reserves the right to charge the current medical records copying fees as set forth by the Maryland Board of Physicians. As of 2017 the current fee is $0.76 per page of the medical record and the actual cost of postage and handling. The office will provide you with a copy of your record. This notice serves as your consent to being charged for medical records request.
5. If you, as the patient receives a Fee for Service, this includes labs, procedures, supplies and other services not covered by your insurance and offered to you by Family Care Associates d/ba All Day Family Care, we reserve the right to charge the credit card listed below the cost of the services rendered. *For a list of our fee for service costs, please see the front desk.*

Other than the conditions mentioned above, under NO circumstance will Family Care Associates d/ba All Day Family Care charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted

Having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

Visa_____ MasterCard_____ Discover_____ American Express _____

Credit Card Holder's Name: _____ (Please Clearly Print)

Credit Card # _____Expiration Date: _____ CVV2/CV_____

This credit card on file is to be used for the following patient(s), please print name(s) below:

Patient Full Name: _____ DOB: ____ / ____ / _____

Patient Full Name: _____ DOB: ____ / ____ / _____

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed above. This agreement will expire for multiple users on an annual basis. If continued authorization is requested, another credit card agreement can be issued or a manager can verbally authorize and document the extension of an agreement.

X_____ Date _____
Patient Signature (or person authorized to sign)

DECLINE PARTICIPATION: I, _____ decline to provide my credit and understand that I will be charged $200.00 due at the time of each visit.

Signature _____ Date _____

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Notice of Privacy Practices Family Care Associates, d/ba All Day Family Care

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.

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 21 working 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 us using the information on page 1. 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; and 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; and 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; and 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; and 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 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, in our office, and on our web site.

Additional Notice Provisions

• Effective: December 6, 2016

• Privacy official: Juliane Schoenherr, jschoenherr@alldaymedicalcare.com, (301) 330-0006

• You may also gain access to your health information via our patient portal. Please contact our office to have a secure link provided to you for access to your electronic medical records.

• This Notice applies to not only Family Care Associates, d/ba All Day family Care but also All Day Medical Care, LLC with respect to its Organized Health Care Arrangement with Family Care Associates, d/ba All Day Family Care to provide health care services at All Day Medical Care Clinic, LLC's facilities. The parties may share PHI as necessary for treatment, to obtain payment for treatment, and health care operations.

• CRISP: We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Patient Name:_____ **DOB:** _____

_____

Signature of Patient or Person Granting Authorization on Behalf of Patient Date:

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FORM 5 – CONSENT FOR PRESCRIPTION HISTORY

At Family Care Associates, d/ba All Day Family Care, providers use an electronic medical record system that allows electronic prescribing of medications, known as ePrescribing. Medications are sent directly to your pharmacy through a secure electronic prescription connection, which improves the timely, understandable and accurate prescription transmission of your medication information.

- Formulary and benefit transactions – Gives the provider information about which drugs are covered by the drug benefit plan.
- Fill status notification – Allows the providers to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up or partially filled.
- Medication history transactions – Provides the provider with information about your current and past prescription. This allows providers to be better informed about potential medication issues and to use the information to improve safety and quality. Medication history information can assist with prescribed regimens; therapeutic intervention; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

By signing this consent form, you are agreeing that your provider may request and use your prescription medication history from other health care provider and/or third party pharmacy benefit payers for treatment purposes.
Please check only one of the following:

_____ I consent to allow my provider to access all of my medication history

_____ I DO NOT consent to allow my provider to access my medication history.

Patient Name:_____ **DOB:** _____

_____ _____
Signature of Patient or Person Granting Authorization on Behalf of Patient Date:

FORM 6 – DESIGNATED CONTACTS

Contact persons with whom we may discuss your care, give test results and account and billing information:

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

May we leave confidential information on voicemail or answering machines listed below?

Home Phone_____ ___Yes __ No

Work Phone _____ ___Yes __ No

Cell Phone _____ ___Yes __ No

Patient Signature: _____ Date:_____

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OPTIONAL

FORM 3 – HEALTH HISTORY QUESTIONNAIRE

Name:_____ DOB: _____

Current Concerns / New Problems: ❑ No concerns ❑ Establish care with a new Primary Care Provider

1. _____
2. _____
3. _____

Past Health History:

Have you had any of the following medical conditions?

- ❑ Acid reflux
- ❑ Anemia (low blood count)
- ❑ Anxiety / Panic attacks
- ❑ Arthritis
- ❑ Asthma
- ❑ Blood clotting problems
- ❑ Cancer (Type:_____)
- ❑ Chronic back pain
- ❑ Constipation
- ❑ COPD / Emphysema
- ❑ Dementia / Alzheimer's
- ❑ Depression
- ❑ Diabetes / High blood sugar
- ❑ Erectile dysfunction
- ❑ Eye disorder (Specify:_____)
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Gynecological problems (Specify:_____)
- ❑ Hearing loss
- ❑ Heart disease / Heart attack
- ❑ Heart Failure
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat / palpitations
- ❑ Joint problems (Specify:_____)
- ❑ Kidney problems (Specify:_____)
- ❑ Liver problems
- ❑ Migraines / Chronic headaches
- ❑ Mobility problems
- ❑ Osteoporosis
- ❑ Prostate problems
- ❑ Seasonal Allergies
- ❑ Seizures
- ❑ Sexually transmitted disease
- ❑ Skin condition (Specify:_____)
- ❑ Stomach / GI problems (Specify:_____)
- ❑ Stroke / TIA
- ❑ Substance or alcohol abuse
- ❑ Thyroid problems
- ❑ Urinary incontinence
- ❑ Urinary tract infections
- ❑ Other:_____
- ❑ Other:_____

Have you had any of the following surgeries?

- ❑ Appendectomy
- ❑ Back surgery
- ❑ Biopsy (Type:_____)
- ❑ Breast surgery
- ❑ Carotid artery surgery
- ❑ Cataract surgery
- ❑ Coronary artery bypass
- ❑ Colon surgery (Type:_____)
- ❑ C-Section(s)
- ❑ Dilation & Curettage (D&C)
- ❑ Gallbladder removal
- ❑ Gastric bypass / Weight loss surgery
- ❑ Heart stent(s)
- ❑ Hemorrhoidectomy
- ❑ Hernia repair (Type:_____)
- ❑ Hysterectomy
- ❑ Joint replacement (Type:_____)
- ❑ Pacemaker insertion
- ❑ Prostate surgery
- ❑ Tonsillectomy
- ❑ Skin graft
- ❑ Other:_____

Prior Hospitalizations:

Year:_____Reason:_____

Year:_____Reason:_____

Allergies: *Please include name of medication or food and type of reaction*

Name	Reaction	Name	Reaction
1)		3)	
2)		4)	

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OPTIONAL

HEALTH HISTORY QUESTIONNAIRE

Name:_____ DOB: _____

Current Medications: *Please include prescription medications, over-the-counter drugs, vitamins and supplements*

Name / Dose	# Tabs / Frequency	Name / Dose	# Tabs / Frequency
1)		4)	
2)		5)	
3)		6)	

Family History: *Please indicate if any of the following conditions are present in your family members*

Relative	**Status**	**Cancer** (Specify Type)	**Diabetes**	**Heart Disease**	**High Blood Pressure**	**Mental Illness** (Specify)	**Stroke**	**Other** (Specify)
Father	☐ Alive ☐ Deceased							
Paternal Grandfather	☐ Alive ☐ Deceased							
Paternal Grandmother	☐ Alive ☐ Deceased							
Mother	☐ Alive ☐ Deceased							
Maternal Grandfather	☐ Alive ☐ Deceased							
Maternal Grandmother	☐ Alive ☐ Deceased							

Social History:

Alcohol use: ❑ None ❑ Yes (Number of drinks/week:_____)
Smoking: ❑ Never ❑ Former Smoker (Quit Date:_____) ❑ Current Smoker (Number of cigs/day:)
Recreational drugs: ❑ None ❑ History of injection drug use ❑ Past / Current use (Specify:_____)
Do you exercise regularly? ❑ No ❑ Yes (What type and how often?_____)
Have you had a fall in the past year? ❑ No ❑ Yes
Have you traveled outside the country in the past 5 years? ❑ No ❑ Yes (Where?_____)
Do you have an Advanced Directive or Living Will? ❑ No ❑ Yes *(if yes, please make sure we receive a copy)*

Preventive Health History: *Please indicate the date the following were performed*

	Date		Date
Last preventive health visit / Complete physical		Stress test or EKG	
Breast cancer screening (Mammogram)		Hepatitis C screening (if born 1945-1965)	
Cervical cancer screening (Pap smear)		Flu Vaccine	
Colon cancer screening (Colonoscopy)		Pneumonia Vaccine	
Lung cancer screening (CT scan for high risk		Shingles Vaccine	
Osteoporosis screening (Bone density)		Tetanus / TDAP Vaccine	
Prostate cancer screening (PSA)		Other:_____	

ALLDAY
Family Care
Primary Care | Behavioral Health

What is the difference between an Annual Physical and an Office Visit?

An Annual Physical, Preventive, or Wellness Visit

Is a visit focused on preventive care and immunizations.

Physical Exams may include:
Pediatric – Development & Growth
Female – Pap smears & Breast Exams
Male – Prostate & Testicular Screenings Skin check
Healthy Lifestyles discussion
Immunizations
Lab testing as appropriate
Coordination of care/referrals for additional screenings:
– Mammograms
– Colonoscopies
– Eye Exams
– Other

Wellness visits are usually co-pay exempt. If new or chronic conditions are addressed an office visit will also be performed and billed.

An Office Visit, Sick Visit or Medication Check

Is an appointment where we discuss and evaluate new or existing medical conditions.

Office visit/Follow up appointment

- Evaluate & treat symptoms and concerns
- Address chronic problems
- Adjust medications & process refills
- Laboratory testing if necessary
- Process referrals if necessary

Co-pays, Deductibles and Co-Insurance may apply

Complete Physicals

Insurances vary on what they pay for on Complete Physicals. Most insurance plans provide full coverage for physicals, but it depends on what plan you or your employer purchased. Since we accept many insurance coverage options, it is impossible for us to track what services your insurance pays. We will help guide you when we can, but it is your responsibility to know what your insurance covers. You may ask us not to perform certain non-covered tests or services if you do not want to pay for them yourself. Please remember you are responsible for any charges that your insurance does not pay.
Our Physicians and Nurse Practitioners try to be cost effective, but they focus on providing you with the best possible care. They make recommendations based on your health, standard of care practices, and national guidelines for preventative services.
Please let them know if you cannot afford a recommended test or treatment. They will work with you to find a more economical solution.
Our providers recommend these preventative services based on national preventative guidelines:

Patients younger than age 40 should have a complete physical every 2 to 5 years, or every year if you have certain chronic medical problems such as diabetes, cancer, or hypertension. A typical physical includes:

- Preventative medical evaluation and management code: New patient 99381-99387, Established patient 99391-99397
- Venipuncture code for blood draw 36415 (typically lab test may include, CBC, CMP, Lipid panel)
- Urinalysis 81002 screens for kidney disease, kidney stones, bladder infections, and bladder/kidney cancer
- Pap smear (females) screens for cervical cancer

Patients that are age 40 or older are advised to have a complete physical every year. A typical physical includes:

- Preventative medical evaluation and management code New patient 99381-99387, Established patient 99391-99397
- Venipuncture code for blood draw 36415 (typically lab test may include, CBC, CMP, Lipid panel, PSA)
- Urinalysis 81002 screens for kidney disease, kidney stones, bladder infections, and bladder/kidney cancer
- Pap smear (females) (Medicare pays for it every 2 years) screens for cervical cancer
- EKG 93000 screens for heart disease and arrhythmias
- Mammogram (females) (Radiology Center bills it) screens for breast cancer
- Please be aware that Medicare will not pay for most labs or diagnostic tests that are not medically necessary.

Other preventative tests or vaccines that may be recommended are:

- Bone Density Test (every 2 to 3 years over age 60) (Radiology Center bills it) screens for osteoporosis
- TDAP (every 10 years from age 18 to 64) 90715 prevents Tetanus, Diptheria, and Pertussis (Whooping Cough)
- Pneumovax (age 65 or earlier with certain medical problems) 90732 prevents Pneumococcal pneumonia
- Zostavax (age 60 or older) 90736 prevents Shingles
- Influenza (every Fall for all patients unless it is contraindicated) 90658 prevents the Flu
- Gardasil 90649 prevents cervical cancer and genital warts
- Cervarix ($200) (ages 13 to 26) prevents cervical cancer
- Menactra 90734 prevents Meningococcal meningitis
- Administrative fee for giving vaccine 90471 and 90472 multiple vaccines

The extent and focus of a complete physical is for the provider to do a preventative medical evaluation and management of a patient to try to prevent diseases, or try to find a disease in an early stage that may be easier to treat. It does not include evaluating and treating an abnormality that is encountered, or treating a pre-existing problem that is above the scopes of the preventative evaluation. Examples include:

- adjustment of medications to treat diabetes, hypertension, and depression
- evaluating and treating a sinus infection, bronchitis, influenza, vaginal infection, or bladder infection
- evaluating new or worsening symptoms by ordering additional testing such as Vitamin B12/Folate levels for fatigue, Testosterone levels for erectile dysfunction, or Diagnostic Mammogram with Ultrasound to evaluate breast lumps
- referrals to Sub-Specialists for newly diagnosed problems such as hernias, prostate nodules, or suspicious moles for skin cancer