Roberta June Guibord D.O., Inc.

Patient Information Sheet

Whom may we thank for referring you? ☐ Dr. _____,☐ Friend, ☐Insurance Plan, ☐ Yellow Pages, ☐ Hospital, ☐ Website, ☐ Buzz Book, ☐Healthy Living News, ☐ Other _____

Patient Name: _____ Race: _____
(First) (MI) (Last)

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ SS#: _____ Marital Status: _____

Employer: _____ Occupation: _____

Emergency Contact: _____

Phone: _____ Relationship to Patient: _____

(Complete If Patient Is A Minor)

Father's Name:_____ DOB:_____ SS#_____

Mother's Name: _____ DOB: _____ SS#: _____

Insurance Information

Primary Insurance: _____ Effective Date: _____

Address: _____ Phone: _____

Subscriber's Name: _____ DOB: _____

Subscriber's SS#: _____ Relationship to Patient: _____

Subscriber's Employer: _____ Employer Phone: _____

Employer Address: _____

Identification Number: _____ Group Number: _____ Co-pay: _____

Secondary Insurance: _____ Effective Date: _____

Address: _____ Phone: _____

Subscriber's Name: _____ DOB: _____

Subscriber's SS#: _____ Relationship to Patient: _____

Subscriber's Employer_____ Employer Phone: _____

Employer Address: _____

Identification Number: _____ Group Number: _____ Co-pay:_____

Consent for Treatment (self or child) /Assignment of Benefits/Financial Responsibility

I hereby consent to the medical/surgical treatment recommended for me/my child by my physician and release of my/my child's Protected Health Information for purposes of treatment, payment, and reasonable office operations. I further authorize payment of any benefit by my insurer (including Medicare), to the provider of service on my behalf, or to myself. I understand I am financially responsible for all charges not covered by my insurance, other than contractually obligated adjustments.

Signature: _____ **Date:** _____

Contact and Authorization of Release of Information

Patient Name: _____ Date/Time: _____

I wish to be contacted in the following manner (check all that apply)

Oral Communication

- ☐ Home Telephone (_____)_____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone (_____)_____
  - ☐ Okay to leave message with detailed information
  - ☐ Leave message with call-back number only

Written Communication

- ☐ Okay to mail to my home address
- ☐ Okay to mail to my work/office address

I permit the Practice to discuss my PHI with, and disclose my PHI to the following individuals:

- ☐ Spouse _____
- ☐ Adult Child(ren) _____ _____
- ☐ My Parent(s) _____ _____
- ☐ Personal Representative _____
- ☐ If checked, the following additional instructions apply:

_____

_____

_____

_____

If signed by patient's authorized representative, describe the representative's authority, please provide a copy of the documents:

- ☐ Patient is a minor, I am the patient's guardian, appointed by _____ Court.
- ☐ I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for

_____ _____

Signature Date/Time

_____ _____

Witness Date/Time

Roberta June Guibord D.O., Inc.

Patient History

Name: _____ Date_____

Medical History

Check any condition that you have or have had in the past. Please give details as to when illness occurred.

Cancer_____	Stroke_____	Stomach Ulcers_____	High Cholesterol_____
Anemia_____	Epilepsy_____	Glaucoma_____	Kidney Disease_____
Heart Problem_____	Emphysema_____	High Blood Pressure_____	Pneumonia_____
Asthma_____	Diabetes_____	Headaches_____	Thyroid Condition_____
AIDS/HIV_____	Other (explain) _____	_____	_____

Women's Medical History

Date of last period _____

Date of last pap smear _____

Have you reached menopause? Yes No

Number of pregnancies _____

Number of miscarriages _____

Allergies

Do you suffer from allergies to medication? Yes No

If yes, what medications are you allergic to?

_____

_____

_____

_____

_____

Medications

Please list all medications and dosages you currently take

_____

_____

_____

_____

_____

_____

_____

_____

Past Surgical History

Please list

1._____Year_____

2._____Year_____

3._____Year_____

4._____Year_____

5._____Year_____

6._____Year_____

Social History

Do you smoke, if so how much? _____

If yes, how long have you been a smoker? _____

If you quit, how long ago did you quit? _____

Do you drink alcohol, if so how often do you drink? _____

Number of drinks per week_____

Do you use recreational drugs, if so what? _____

_____

Have you used recreational drugs in the past, if so what? _____

_____

Do you exercise regularly, if so what kind? _____

How many hours per week? _____

Do you have a Living Will, please provide a copy if yes? Yes No

Do you have a Power of Attorney, please provide a copy if yes? Yes No

Would you like information on: POA Living Will Both

Do you drink caffeine, if so how much? _____

Do you have pets, if so what kind and how many? _____

_____

Family History

Has a blood relative had any of the following conditions?
(Please list which relative and type)

Alcoholism _____

Asthma _____

Cancer _____

Diabetes _____

Epilepsy _____

Glaucoma _____

Heart Disease/ Attack_____

High Blood Pressure _____

High Cholesterol _____

Stroke _____

Stomach Ulcers _____

Thyroid Condition _____

Other _____

Hospitals	**Physicians and Specialist**
Recent ER/Urgent Care Visits. Yes No (when & why)	Do you see any other physicians or specialists (name and reason)
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Vaccinations

When were your last vaccinations? Flu _____ Pneumonia _____ Tetanus _____ Others_____

Do you have: (check all that apply if yes)

Head and Eyes ☐ Headaches ☐ Vision Change ☐ Cataracts Ears Nose and Throat ☐ Hearing Change ☐ Ear Infection ☐ Nose Bleeds ☐ Ulcers ☐ Sores ☐ Yeast Infection ☐ Cold Sores ☐ Fever Blisters ☐ Tooth Ache ☐ Swallowing Problems GI ☐ Indigestion ☐ Reflux ☐ Nausea ☐ Vomiting ☐ Gall Bladder Problems ☐ Acid Problems ☐ Constipation ☐ Diarrhea ☐ Hemorrhoids ☐ Fissures ☐ Blood in Stool Lungs ☐ Shortness of Breath ☐ Cough ☐ Wheezing ☐ Tuberculosis	Heart ☐ Irregular Heart Beat ☐ Chest Pain ☐ Leg/Foot Swelling Breast ☐ New Lump ☐ Old Lump ☐ Soreness ☐ Increase in Size ☐ Redness ☐ Lump in Armpit ☐ Swelling in Arm Bladder ☐ Urine Burns ☐ Blood in Urine ☐ Bladder Infection ☐ Loss of Urine Control Vaginal ☐ Yeast Infection ☐ Bleeding ☐ Discharge ☐ Dryness ☐ Pain with intercourse Hair Nails and Skin ☐ Hair Loss ☐ Rash ☐ New/Change moles ☐ Itching ☐ Nail Change Blood ☐ Increased Bruising ☐ Bleeding ☐ Anemia	Pain ☐ Bone Pain ☐ Muscle Pain ☐ Joint Pain ☐ Back Pain ☐ Arthritis Neurology ☐ Numbness ☐ Tingling ☐ Muscle Weakness ☐ Fainting ☐ Confusion ☐ Speech Difficulty ☐ Forgetfulness Emotional ☐ Not Coping Well ☐ Anxious ☐ Depression ☐ Crying ☐ Guilt Feeling ☐ Can't Sleep ☐ Tired all the time ☐ Eating to much/little ☐ Stress eating ☐ Sexual Difficulty Other ☐ _____ ☐ _____ ☐ _____ ☐ _____

Roberta June Guibord D.O., Inc.

Acknowledgement of Receipt (Notice of Privacy Practice, Cancellation Policy, Medication Refill Policy, Financial Policy)

Roberta June Guibord D.O., Inc.'s Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read this entire notice.

I have received a copy of Roberta June Guibord D.O., Inc's Notice of Privacy Practice. I understand that Roberta June Guibord D.O., Inc. has the right to change its Notice of Privacy Practices and that I may contact Roberta June Guibord D.O., Inc. at any time to obtain a current copy of the Notice of Privacy Practice. If I am not a patient, I represent that I am authorized by law to act for and on the patient's behalf.

Initial _____

I have received a copy of the Financial Policy and am willing to take responsibility for any charges that my insurance does not cover. I also understand that all returned checks will be charged a $50.00 fee and that the office does not accept credit cards.

Initial _____

I have received a copy of the cancellation and "no show" policy and am willing to take responsibility of $40.00 charge if I am a "no show" more than once in a calendar year.

I have received the Prescription Refill Policy and agree to give the doctor at least 48 hours notice to refill my prescriptions.

I have received the notice that antibiotics and results will not be done by phone. If I need an antibiotic or would like the results of a test I need to schedule and appointment with the doctor.

I have received the Notice of Privacy Practice, the Financial Policy, the Cancellation Policy, and the Appointment Policy.

_____ _____

Signature of Patient / Legally Authorized Representative

Date / Time Received

Roberta June Guibord D.O., Inc.

Notice of privacy practices for protected health information

I. **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.** Roberta June Guibord D.O., Inc. is dedicated to protecting your medical information. We are required to provide you with this Notice of Privacy Practices and our legal duties with respect to our use and disclosure of your protected health information. This Notice applies to Roberta June Guibord D.O., Inc. at 900 W. So. Boundary St. 3B, Perrysburg Ohio 43551 operating as a physicians office composed of employees and clinical professionals seeing and treating patients at Roberta June Guibord D.O., Inc.

II. **USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION**

A.**USES AND DISCLOSURES THAT DO NOR REQUIRE YOUR AUTHORIZATION**

1. **USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.** We will make uses and disclosures of your personal health information as necessary for your treatment.

   We will use and disclose your personal health information for the payment purposes of those health professionals and facilities that have treated you or provided services to you.

   We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which include clinical improvement, professional peer review, business management, accreditation and licensing, and public relation activities. We may also disclose your personal health information to another health care facility, health care provider, or health plan for such things as quality assurance and case management, but only if that facility, provider, or plan also has or had a treatment relationship with you.

2. **FAMILY AND FRIENDS INVOLVED IN YOUR CARE.** Disclosures of your personal health information may be made to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care, unless you choose not to approve the disclosure. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval. We also may disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other person that may be involved in your care.

3. **APOINTMENT AND SERVICES.** We may contact you to provide APPOINTMENT REMINDERS, TO SCHEDULE TESTS OR TO PROVIDE TEST RESULTS. You have the right to request, and we will accommodate reasonable requests by you, to receive communications regarding your personal health information from us by alternative means. You may submit such a request in writing to our office, 900 W. So. Boundary St. 3B, Perrysburg Ohio 43551.

4. **BUSINESS ASSOCIATES, FUNDRAISING AND HEALTH PRODUCTS AND SERVICES.** Some of our services are performed through contracts with outside persons or organizations. In order for us to carry out our healthcare operations, it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations. We require these business associates to appropriately safeguard the privacy of your information.

   We may from time to time use your personal health information to communicate with you about health products and services related to your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

5. **OTHER USES AND DISCLOSURES.** We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization, including, but not limited to the following:

a. For any purpose required by federal, state, or local law, judicial or administrative proceedings, or law enforcement, such as when reporting gunshot or other wounds or when ordered by the court;
b. For public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
c. If we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
d. To the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
e. To your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury; in most cases you will receive notice that information is disclosed to your employer;
f. If required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;

g. If required to do so by subpoena or discovery request; in some cases you will have notice of such release;
h. To law enforcement officials as required by law to report wounds and injuries and crimes;
i. To coroners, medical examiners and/or funeral directors consistent with law;
j. In limited instances if we suspect a serious threat to health or safety of a person or to the public, we may give your information to law enforcement personnel or persons able to prevent or lessen such harm;
k. If you are a member of the military or a veteran as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities; and
l. To comply with workers' compensation laws.

A. **DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION**

1. Except as outlined herein, we will not use or disclose your personal health information unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have already taken action in reliance on the authorization.

2. Ohio law requires that we obtain a consent from you in many instances before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition; before disclosing information about drug or alcohol treatment you have receiver in a drug or alcohol treatment program; before disclosing information about mental health services you may have received; and before disclosing certain information to the State Long-Term Care Ombudsman. For full information on when such consents may be necessary, you can contact Roberta June Guibord D.O., Inc. at 900 W. So. Boundary St. 3B, Perrysburg Ohio 43551.

II. **RIGHTS THAT YOU HAVE**

A. **ACCESS TO YOUR PERSONAL HEALTH INFORMATION**. Most of the time, you have the right to copy and/or inspect much of the personal health information that we retain on your behalf. You may be charged a reasonable fee for the retrieval and duplication of your health information. All requests for access must be made in writing and signed by you or your legally authorized representative. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons why and explain how you can have the denial reviewed.

B. **THE RIGHT TO CORRECT OR UPDATE YOUR PERSONAL HEALTH INFORMATION**. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We will give each request careful consideration; but we are not obligated to make all requested amendments. In order to be considered by us, all amendment requests must be in writing, signed by you or your legally authorized representative, must state the reason for the amendment/correction request, and must be directed to Roberta June Guibord D.O., Inc. 900 W. So. Boundary St. Perrysburg Ohio 43551.

If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary.

C. **ACCOUNTING FOR DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION.** You have the right to receive an accounting of certain disclosures made by us of your personal health information. Requests must be made in writing and signed by you or your legally authorized representative. Accounting request forms are available from Roberta June Guibord D.O., Inc. You may be charged a fee for each accounting you request.

D. **RESTRICTIONS ON USE AND DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION.** There are certain uses and disclosures that we make that you have the right to request restrictions on as they relate to treatment, payment, or health care operation. A restriction must be submitted in writing and addressed to Roberta June Guibord D.O., Inc. 900 W. So. Boundary St. 3B. Perrysburg Ohio 43551. We will give each request careful consideration, but we are not obligated to agree to it. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate and we will notify you of such termination. You also have the right to terminate, in writing, any agree-to restriction by sending such termination notice to Roberta June Guibord D.O., Inc. 900 W. So. Boundary St. 3B, Perrysburg Ohio 43551.

E. **QUESTIONS/COMPLAINTS.** If you have questions, you may contact us at (419)872-5556. As a patient, you retain the right to obtain a paper copy of this Notice of Privacy Practices. If you believe your privacy rights have been violated, you can file a written complaint with Roberta June Guibord D.O., Inc., 900 W. So. Boundary St. 3B, Perrysburg Ohio 43551. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Roberta June Guibord D.O., Inc.

Office Policy
Financial Policy

We recognize the need for patients to understand what is expected of them and what they may expect, regarding financial arrangements for medical care. It is our hope that our patients will understand that many of these credit and collection policies are required by state and federal laws and to assure the financial resources necessary to provide quality medical care to the community. The existence of a formal financial policy does not circumvent our sensitivity to the needs of our patients. We encourage contact with our billing office if a problem regarding your account should arise. Our financial policy is as follows, is applicable to all patients and effective immediately.

1. It is the patient's responsibility to know what services are covered or non-covered under their health insurance policy. Many procedures, while excellent relative to a patient's overall care, are considered preventive and are not covered by some insurance plans. Examples of these services are routine PAP smears, screening PSA's (prostate cancer screening blood test), screening colonoscopies when there is a strong family history of cancer of the colon, sports physical, work physical, etc. Check with your insurer to see if these services are covered prior to scheduling any test or procedure.
2. Likewise, it is the patient's responsibility to know if a referral is required from their insurance carrier to see a specialist and to make certain the referral has been requested from their insurer. The patient will be financially responsible for any charges subsequently denied by their insurer in the absence of an appropriate referral.
3. All co-payments are due and payable at the time of service, in accordance with state and federal legal requirements for collecting patient responsibility amounts.
4. Insurance claims for our services will be submitted to your primary and secondary insurer. It is the patient's responsibility to provide our office with up-to-date and accurate insurance information. If you information is inaccurate and we are unable to file a claim, you will be billed privately for those charges. Ultimately, the patient is responsible for payment of any services provided to them or their covered dependents.
5. Once the insurer has paid the claim, any deductibles, co-payment amounts, or non-covered services will become the responsibility of the patient. Prompt payment is expected, once a statement has been received (within 30 days). If that is not possible, please contact our billing office.
6. We are participating providers with most insurance plans. Participation means we will accept what the insurer approves as payment in full, exclusive of any patient responsibility amounts, such as co-insurance, co- payment amounts, deductible amounts or non-covered services. The insurer may pay only a percentage of the approved amount, with the remainder payable by the patient or by their secondary insurance policy. We are required by state and federal laws to collect patient responsibility amounts for both federally funded programs and private insurers.
7. We are happy to provide treatment for injuries related to auto accidents for our established patients; however, the payment for these services will not be contingent upon a settlement from the accident insurer. It is the patient's responsibility to make arrangements for payment of service rendered to them as the result of an auto accident. Compensation to the patient for the payments they have made for our medical services can be directly negotiated between the accident insurer and the patient.
8. It is responsibility of those patients who receive benefits from the Ohio Department of Jobs and Family Services to provide us with a current copy of their card. Failure to provide verification of current benefits (a new card is issued every 30 days) will be financially responsible for any services provided to them as well as any non-covered services.
9. All patients may receive monthly statements from our office, even if their insurers are still processing the claims for services. These statements are informational, until such time as there is an amount listed in the "Patient Responsibility" column. Any amount so listed is due and payable upon receipt of the statement.
10. Any account delinquent for period of 120days will be referred to an outside collection agency and could result in the termination of patient care from the practice.
11. Any returned check will be charged a $50 fee.
12. We do not accept Credit/Debit Cards. We only accept cash or check

Cancellation and No Show Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement a "no show"/cancellation policy. The policy enables us to better utilize available appointment for our patients in need of medical care.

Late Cancellations (less than 24 hours notice) will be considered as a "no show". A "no show" is someone who misses an appointment without canceling with 24 hours of their appointment. "No shows" inconvenience those individuals who need access to medical care in a timely manner.

A failure to be present at the time of a scheduled appointment will be recorded in the patients' charts as a "no show" without previously mentioned notice. After the first "no show" the patient will be sent a letter reminding them of our policy. The second "no show" will result in a $40.oo charge to the patient and the patient will be sent a bill showing the charge. If the patient continues to have "no show" issues we will no longer be able to see this patient.

Prescription Refill Policy

We offer patient prescription refills at every office visit. It is best if you bring a list of your current medications to ensure timely refills. Should you require a refill outside of a visit to the office please give at least 48 hours advance notice for the request to be filled.

To obtain a prescription refill simply call us at (419)872-5556 during business hours Monday-Friday. Our receptionist will ask for this information so please have it ready.

1. Your Name
2. Date Of Birth
3. Phone Number
4. Medication Name
5. Dose
6. Pharmacy It Will Be Sent To

Office Visit Policy

We do not give results by phone all patients will need to make an office visit to go over all results with the doctor.

We do not routinely call in any antibiotics. If a patient is sick and feels that they need an antibiotic it is recommended that you call and schedule an appointment to see the doctor.