Michael H. Tarlowe MD PA

Patient Information

Date: _____
SS/HIC/ PT ID: _____
Patient Name: _____
_____
Address: _____
_____
City: _____
State: _____ Zip: _____
Email: _____
Sex: □ M □ F Age: _____ DOB: _____

□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for ____ yrs.

Occupation: _____
Patient Employer/School: _____
Employer/School Address: _____
_____
Employer/School Phone: _____
Spouse's Name: _____
DOB: _____ Phone: _____
Spouse's Employer: _____
Whom may we thank for referring you?

Phone Number

Home Phone: _____
Cell Phone: _____
Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:
Name: _____
Home Phone: _____
Cell Phone: _____
Work Phone: Ext.

Insurance

Primary Insurance_____
ID #: _____ Group #: _____
DOB: _____ SS: _____
Subscriber's Name: _____

Secondary Insurance: _____
ID #: _____ Group #: _____
DOB: _____ SS: _____
Subscriber's Name: _____

INSURANCE ASSIGNMENT AND RELEASE
I certify that I have Insurance Coverage with
_____
And assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on al insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when by current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to
_____
For any services furnished to me by that provider,
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap Insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Patient, Parent, Guardian, or Personal Representative

Please print name of Patient, Parent, Guardian, or Personal Representative

Date Relationship to PT

Family History

Date of last physical examination: _____

What is your reason for visit? _____

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES:**

□ Alzheimer's	□ Cancer	□ High Blood Pressure	□ Polio
□ Anemia	□ Diabetes	□ High Cholesterol	□ Rheumatic Fever
□ Anxiety	□ Depression	□ Joint Disorder	□ Stroke
□ Allergies	□ Epilepsy	□ Osteoporosis	□ Stomach Ulcer
□ Arthritis	□ Genetic Disorder	□ Liver Disorder	□ Substance Abuse
□ Asthma	□ Glaucoma	□ Lung Disease	□ Thyroid Disorder
□ AIDS/HIV	□ Gout	□ Measles	□ Other_____
□ Back Problems	□ Heart Disease	□ Migraines	_____
□ Bleeding Disorder	□ Heart Problems	□ Skin Disorder	_____
□ Blood Transfusion	□ Hepatitis- A, B, C	□ Pneumonia	_____

Michael H. Tarlowe MD PA

MEDICAL HISTORY Check (✓) symptoms you currently have or have had in the past year. (All information is strictly confidential)

Describe serious illnesses or operations _____

_____

GENERAL
□ Chills
□ Depression/ Anxiety
□ Fever
□ Fatigue
□ Headache
□ Loss of Sleep
□ Loss of weight
□ Weakness
□ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
□ Arms □ Hips
□ Back □ Legs
□ Feet □ Neck
□ Hands □ Shoulders

GENITO-URINARY
□ Blood in urine
□ Frequent urination
□ Lack of bladder control
□ Painful urination

GASTROINTESTINAL
□ Appetite Poor
□ Bloating / Gas
□ Bowel Changes
□ Constipation
□ Diarrhea
□ Hemorrhoids
□ Nausea
□ Rectal Bleeding
□ Abdominal pain
□ Vomiting
□ Anal Abscess/Fistula
□ Anal Fissure
□ Anal Warts
□ Anal Itching/ rash
□ Blood in Stool
□ Hernia
□ Anal Pain

EYE, EAR, NOSE, THROAT
□ Blurred/Double Vision
□ Difficulty swallowing
□ Hoarseness
□ Loss of hearing
□ Nosebleeds
□ Persistent cough
□ Sinus/Allergy Problems

SKIN
□ Bruise easily
□ Itching/Rash/Hives
□ Change in moles
□ Scars
□ Sore that won't heal

CARDIOVASCULAR
□ Chest Pain
□ High/Low blood pressure
□ Irregular/ Rapid heartbeat
□ Poor circulation
□ Swelling of ankles
□ Varicose veins

MEN only
□ Erection difficulties
□ Lump in testicles
□ Penis discharge
□ Sore on penis
□ Other

WOMEN only
□ Abnormal Pap smear
□ Breast Lump
□ Hot Flashes
□ Painful Intercourse
□ Vaginal Discharge
□ Other
Date of last
Menstrual period_____
Have you had
A mammogram? _____
Are you pregnant? _____

Check (✓) conditions you have or have had in the past.

□ AIDS
□ Appendectomy
□ Arthritis
□ Asthma
□ Bleeding Disorders
□ Cancer
□ Cataracts
□ Chemical Dependency
□ Hypertension
□ Diabetes
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Heart Disease
□ HPV
□ Herpes
□ High Cholesterol
□ HIV Positive
□ Kidney Disease
□ Liver Disease
□ IBD
□ Migraine Headaches
□ Multiple Sclerosis
□ IBS
□ Pacemaker
□ Prostate Problem
□ Peripheral Vascular Disease
□ Pulmonary Disease
□ Stroke / TIA
□ Thyroid Problems
□ Ulcers

MEDICATIONS / ALLERGIES

List medications you are currently taking:
_____
_____
_____
_____
_____
Pharmacy Name _____
Phone Number _____
List allergies to medications or substances
_____
_____

HEALTH HABITS

Check (✓) which you use and how much.
□ Caffeine _____ □ Street Drugs _____
□ Tobacco _____ □ Other _____

Check (✓) if your work exposes you to:
□ Stress □ Heavy Lifting
□ Hazardous Substances □ Other _____

Your occupation _____

Weight: Height:

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that is is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

_____ _____
Reviewed by Date

Michael H. Tarlowe MD PA

PATIENT HIPPA AWARENESS

With my permission, Dr. Michael Tarlowe may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Dr. Michael Tarlowe Notice of Privacy Practices for a more complete descriptions of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Michael Tarlowe reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Michael Tarlowe may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Michael Tarlowe may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Dr. Michael Tarlowe may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Michael Tarlowe restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Michael Tarlowe to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date

Michael H. Tarlowe MD PA

MEDICATION HISTORY CONSENT FORM

By signing below, I hereby give permission to the practice of Dr. Michael Tarlowe to access my pharmacy benefits data electronically through SureScripts. This consent will enable the practice of Dr. Michael Tarlowe to:

1. Determine pharmacy benefits and drug co-pays for patient's health plan.

2. Check whether a prescribed medication is covered (in formulary) under a patient's plan.

3. Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.

4. Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information and information about other prescriptions prescribed by other providers using SureScripts.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date

Michael H. Tarlowe MD PA

FINANCIAL POLICY
Patient Financial Agreement

The office of Michael H. Tarlowe, MD PA is committed to serving our patients with professionalism and caring and from our patients we expect the same commitment. This includes being on time for your appointment and calling to cancel an appointment if you can't make it. It also includes financial responsibility, like presenting your identification and insurance cards at every appointment and making your copay and deductible payments at the time of your office visit with cash, check or credit card.

Your responsibility is to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers. As a courtesy, our office will file your insurance claim for you. If you are a Medicare patient, we will bill Medicare and your secondary insurance for you.

For services outside of our office, like radiology, laboratory, surgery centers and anesthesia services, it is your responsibility to know which facility you are required to use. If you aren't sure, please talk to your insurance member services or one of our staff before scheduling.

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated- this document describes your financial responsibilities.

This is a legally binding contract between Michael H. Tarlowe MD PA and you. The words, *I, me, my, you and your* all refer to the patient.

_____ (initial) I agree to be financially responsible for payment of Michael H. Tarlowe MD PA's services. Cash, check, or credit cards are acceptable forms of payment for those services. I understand there will be a $25.00 fee for all returned checks.

_____ (initial) Current insurance cards must be presented at every office visit. I agree to pay any balance remaining on my account for any reason upon receipt of a statement and I understand that when requested, I must give Michael H Tarlowe MD PA my current address and other contact information. I understand that if I fail to pay the balance on my account this may result in Michael H. Tarlowe MD PA pursuing any collection means possible.

_____ (initial) I agree to give Michael H Tarlowe MD PA my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Michael H Tarlowe MD PA the balance on my account after my insurance claim has been processed.

_____ (initial) I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.

_____ (initial) I understand that my insurance may or may not agree to the usual, customary, or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed.

_____ (initial) If I have a high deductible policy or do not currently have insurance benefits, I agree to pay an estimate of charges for my office visit in advance and understand that other charges may apply.

_____ (initial) Michael H. Tarlowe MD PA has a contract with my insurance company. Michael H Tarlowe MD PA will receive payments from my insurance company for ***covered*** services provided by my insurance benefits. I agree to pay co-payments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment *may* be rescheduled.

Michael H. Tarlowe MD PA

_____ (initial) If my account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

I have read and I understand Michael H. Tarlowe MD PA's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Signature of Patient or Legal Guardian Date

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of medical benefits, including medical benefits to which I am entitled to Michael H. Tarlowe MD PA. This is a **DIRECT ASSIGNEMNET OF MY RIGHT AND BENEFITS**. This authorization will remain in effect until cancelled by me in writing. A copy of this authorization is as valid as the original document.

I authorize the release of any medical information necessary to in order to obtain payment and I understand that I am financially responsible for all charges, late fees, interest, attorney fees and collection charges considered patient responsibility by my insurance company. I understand that if I am not insured, I am responsible for the charges of all services provided to me. I authorize Michael H. Tarlowe MD PA to deposit checks received on my account when made out in my name.

I have read and I understand Michael H. Tarlowe MD PA financial policies, and I accept responsibility for the payment of any fees associated with my care.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Signature of Witness Date