Patient Registration Form

Eze Family Health Center - 11750 Business Park Drive, Ste 103 Waldorf, MD - Sepideh Dadras , MD / Chinyere Eze, PA-C

Patient Name:_____ **Social Security Number:** _____-_____-_____

Date of Birth: ____/_____/_____ **Sex:** M / F (Circle One) Married / Single / Divorced / Widow

Address:

_____

(Home Address) (City) (State) (Zip)

Cell Phone #: (____) _____-_____ **Home #:** (____) _____-_____ **Other:** (____) _____-_____

E-Mail Address: _____

Do you authorize having communications sent to you via your e-mail address? YES / NO
Do you authorize communications via text message to your cell phone? YES / NO

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

How did you hear about our practice? _____

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

Who to call for an emergency:

Name: _____Address:
_____

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

Primary Insurance Information ____HMO _____PPO ***Please have insurance card with you***

Plan Name: _____ I.D. Number_____ Group #_____

Policy Holder: _____ Effective Date: _____Copay Amount $_____

Do you have Secondary Insurance ___Yes ___ No *(if Yes, please provide the receptionist this card)*

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Eze Family Health Center. I acknowledge that I am financially responsible for

payment whether or not covered by insurance. Additionally, I understand that there is a $25 No Show / Cancellation fee for non-emergent appointment cancellations not notified at least 24 hours in advance.

Signature:_____ Date: _____

Eze Family Health Center

Patient Name: _____ Date of Birth _____

Integrative / Holistic Health Questionnaire

What are your <u>TOP 3</u> primary goals with your health?

___ Reduce and/or eliminate prescription medication use
___ Avoid development of chronic medical conditions
___ Improve my overall wellness in mind, body and spirit
___ Reduce stress
___ Reduce impact of aging on my life
___ Lose weight
___ Get my health "back on track"
___ Increase my energy level
___ Improve my sex life
___ Improve health habits in diet & exercise
___ Other: _____

Prioritize your most important health concerns?

Concern	**Onset**	**Frequency**	**Severity**
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

What prior experiences have you had with alternative or complementary medicine?

_____
_____
_____
_____
_____

With whom do you live? (Include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship	Name	Age	Relationship
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

What are the major stressors in your life?

_____
_____

What do you do to relax/relieve stress? What interest/hobbies do you have? _____

_____
_____

OCCUPATION

(Current- within past year) _____

(Past – more than 1 year ago) _____

Spiritual beliefs/religious affiliations, past, and present _____

_____
_____

LIFESTYLE

What physical activity do you participate in, and how often?

_____
_____

_____
_____

During the day, how would you describe your energy level? ___ Low ____ Moderate _____ High

Approximately, how many hours do you sleep at night? ____ Less than 4 ___ 5-6 ____7-8 _____More than 8

How would you describe your quality of sleep? ____ Poor ____ Good

How would you describe your Stress Level: ____ Low _____ Moderate _____High

NUTRITION

How many meals do you generally eat per day? _____ Do you skip meals? _____

How many servings of fruit per day? (Svg: 1 small fruit, ½ C canned/chopped fruit, ¼ C dried fruit)____

How many servings of vegetables do you consume each day? (Svg: ½ C raw/cooked, 1 C leafy veg.)_____

Are you currently on a special diet? Foods you avoid? Vegetarian, Gluten-free?

_____

What are your sources of protein? _____

What type of oil or spreads do you add to your food? _____

_____

What and how much do you drink on a typical day? (i.e: water, caffeine drinks, soda, etc.)

_____

How would you describe your relationship with food? _____

_____

How often do you eat out? _____ Who prepares the meals at home? _____

RECREATIONAL SUBSTANCE USE

Type	Amount Per Day	Amount Per Week
Cigarrettes		
Cigar / Pipe		
Chewing Tobacco		
Marijuana		
Other:_____ _		

Have you ever had to cut down on your drinking? _____ Yes _____ No
Do you get annoyed when someone asks about your drinking? _____ Yes _____ No
Do you ever feel guilty about your drinking? _____ Yes _____ No
Do you ever make excuses for drinking or for your behavior while drinking? _____ Yes _____ No

PERSONAL MEDICAL HISTORY

Please check the following conditions that apply to you and circle the appropriate choice when given.

____ Alcoholism or Substances Abuse

____ Anemia (Sickle Cell or Other)

____ Arthritis/Joint Disease

____ Blood Clots/Phlebitis

____ Cancer (Specific Type: _____

_____)

____ Diabetes

____ Digestive (Ulcerative Colitis, Crohns, etc.)

____ Easy Bleeding

____ Frequent Sinusitis

____ Gall Bladder Trouble

____ Hay Fever, Allergy, Eczema

____ Hearing Loss

____ Heart Attack, Heart Disease, Heart Failure

____ Heart Murmer

____ Headaches (Migraines, etc.)

____ High Blood Pressure

____ High Cholesterol

____ History of Infertility

____ Kidney Infection/ Stones

____ Liver Disease, Hepatitis, etc.

____ Lung Disease (Asthma, COPD, etc.)

____ Mental Trouble/ Depression/ Anxiety, etc.

____ Pneumonia

____ Radiation Treatments

____ Rheumatic Fever

____ Seizures, Epilepsy

____ Serious Injury or Accident

(Type _____)

____ Sexually Transmitted Disease

(Chlamydia, Warts, Herpes)

(Specify Other _____)

____ Skin Disease

____ Stroke

____ Thyroid Disease

____ Tuberculosis (TB)

____ Urinary Difficulties

(Incontinence, Infections, etc.)

____ Vision Problems

____ Other (Specify) _____

____ Other (Specify) _____

____ Other (Specify) _____

Please list any operations/surgical procedures/blood transfusions/major injuries (with dates):

_____
_____

Adult Immunizations/Vaccinations:

_____
_____
_____

MEDICATIONS

What medications are you taking now? (Include prescription and over-the-counter drugs.)

Medication	**Reason**	**When Started**	**Dosage Per Day**	**Cost**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to or have had a “bad reaction” to any medications or other substances?

_____ No _____ Yes

If yes, please specify drug(s) and type of reaction below:

Medication	**Type of Reaction**

Do you have any food Allergies? _____ No _____ Yes
If Yes, please list:
_____

What vitamins/mineral/herbal supplements are you taking now?

Vitamin	Reason for Taking	When Started	Dosage Per Day

WOMEN ONLY

What date was your last: _____ PAP Smear _____Mammogram _____Colonoscopy _____ Eye Exam
Did you have any abnormal findings in your last tests or anytime in the past? Please give details:
_____
_____

Reproductive History

Age at 1st menstrual period _____ First day of most menstrual period _____

Usual flow: _____ Heavy _____ Moderate _____ Light Length of period in days _____

Number of days between periods _____

Do you have (please circle): Painful Periods, Spotting between Periods, Vaginal Bleeding, Unusual Discharge/ Infection, Recurring Vaginal bleeding? _____

Date of last Pap _____ History of abnormal Paps? _____

Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriage _____

Have you experienced complications during pregnancy/delivery/ other problems?
_____

Contraceptive History

Please circle the method of contraceptive you are currently using

Birth Control Pills Type _____ Total years of Use _____

Diaphragm/Cap Type _____ Size _____

IUD Type _____ Date of Last change _____

Norplant, Condom and or Foam, Suppository Tubal Ligation

Hysterectomy Partner with Vasectomy None

Other _____

Problems with current method _____

Sexual Preference:

_____ Heterosexual _____ Homosexual _____ Bisexual

MEN ONLY

What date was your last: _____ Prostate Exam _____PSA test _____Colonoscopy _____ Eye Exam
Did you have any abnormal findings in your last tests or anytime in the past? Please give details:
_____
_____

Do you have: ____ Prostate Problems _____ Testicular Cancer?

____ Vasectomy _____ Sexual Dysfunction

FAMILY MEDICAL HISTORY

Who in you immediate family has any of the following? Place appropriate letter in blank.

(**F**=father, **M**=mother, **S**=sibling {brother / sister} , G=grandparent)

_____ Alcoholism or Substance Abuse

_____ Anemia (Sickle Cell or Other)

_____ Arthritis

_____ Cancer (Specify Type _____)

_____

_____ Diabetes

_____ Digestive (Ulcerative Colitis, Crohns, etc.

_____ Easy Bleeding

_____ Glaucoma

_____ High Blood Pressure

_____ Hay Fever, Allergy, Eczema

_____ Headaches (Migraine, etc.)

_____ Heart attack, Heart Disease, Heart Failure

_____ High Cholesterol

_____ Kidney Disease

_____ Liver Disease (Hepatitis, etc.)

_____ Lung Disease (Asthma, COPD, etc.)

_____ Mental Trouble/ Depression/ Anxiety

_____ Seizure

_____ Stroke

_____ Suicide

_____ Thyroid Disease

_____ Tuberculosis (TB)

_____ Ulcers

_____ Other:_____

_____ Other :_____

OFFICE POLICIES

(UPDATED 6/16)

TO ENSURE THAT WE PROVIDE THE BEST HEALTHCARE SERVICES FOR YOU AS A VALUED PATIENT, WE ASK THAT YOU READ AND INITIAL BELOW TO ENSURE YOU UNDERSTAND OUR OFFICE POLICIES.

APPOINTMENTS & NO SHOW FEES

WE REQUIRE A **24 HOUR NOTICE** IF YOU ARE NOT ABLE TO MAKE YOUR SCHEDULED APPOINTMENT. IF WE DO NOT RECEIVE A PHONE CALL WITHIN 24 HOURS THERE WILL BE A NO SHOW FEE OF **$25.00**.

Initials _____

APPOINTMENTS AND OFFICE VISITS

YOU WILL BE SEEN BASED ON YOUR COMPLAINT AT THE TIME THE APPOINTMENT IS SCHEDULED. PRIMARY CARE AND WEIGHT LOSS VISITS ARE TWO SEPARATE TYPES OF VISITS. IF YOU CHOOSE TO COMBINE VISITS WE CHARGE YOU FOR PRIMARY CARE (CO-PAY) AND WEIGHT LOSS VISIT.

Initials _____

MEDICAL PAPERWORK / FORMS & LETTERS

IF YOU REQUIRE ANY MEDICAL PAPERWORK OR FORMS TO BE COMPLETED BY THE PRATICITIONER, YOU MAY BE REQUIRED TO COME IN FOR AN OFFICE VISIT (DEPENDING ON THE TYPE OF FORM). IF YOU ARE DROPPING OFF A FORM TO BE COMPLETED (WITHOUT AN APPOINTMENT), YOU ARE REQUIRED TO PAY A **$10.00** ADMINISTRATION FEE. ONCE YOUR REQUEST IS RECEIVED PLEASE ALLOW UP TO **5 BUSINESS** DAYS FOR THE PAPERWORK OR LETTER TO BE COMPLETED. THIS INCULDES REQUESTS PAPER STATEMENTS AND RECIEPTS FOR PRIOR VISITS.

Initials _____

MEDICATION REFILL

PLEASE ALLOW AT LEAST **3 BUSINESS DAYS** FOR MEDICATION REFILLS TO BE PROCESSED AND REFILLED. PLEASE CALL THE PHARMACY FIRST TO ENSURE THAT THE PRESCRIPTION WAS RECEIVED.

Initials _____

By signing below, I understand and will abide by the office polices of Eze Family Health Center.

Signature _____ Date: _____

Eze Family Health Center

Financial & Health Services Policy

Welcome to *Eze Family Health Center*. We are pleased you have chosen our practice for your medical care. We ask that you **carefully read** and sign the following statement. We must emphasize that, as your medical care provider, our relationship is with you and **not** your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, **you are the sole responsible party for all charges incurred and guarantee payment** thereof. If we are contracted with your insurance company, including Medicare, we will accept assignment**. You will be responsible for your payment portion at the time of service**. F**ailure to provide current, accurate billing information will result in all charges for service becoming the sole responsibility of the patient/responsible party.** You are expected to understand your benefits coverage and responsibilities**. All copays, co-insurance and deductibles are due and payable at the time services are rendered.** If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at the time services are rendered.

In consideration of the services performed by EZE Family Health Center you agree to abide by the terms of this Financial Statement.

_____

Patient Initials

PATIENT AUTHORIZATION

I certify that I, and /or my dependent(s), have insurance coverage with **(insurance company)** _____

and assign directly to Eze Family Health Center all insurance benefits, if any, otherwise payable to me for services rendered. I request payment form all insurance's including Medicare be made directly to EZE Family Medical Center. I authorize the use of my signature on all insurance submissions. EZE Family Health Center may use my health care information and may disclose such information to the above name insurance carrier for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

PRESCRIPTION MEDICATION POLICY

Eze Family Health Center is committed to providing quality health care services for our valued patients. In keeping with this commitment, we discourage any potential issues of fraudulent use or abuse of controlled medications. It is our policy here at Eze Family Health Center, that **no Schedule I or Schedule II pain medications will be prescribed** from our facility. If an intense course of pain management is warranted, we will assist patients with transitioning their healthcare to a Pain Management specialist.

Eze Family Health Center reserves the right to refer patients to other medical specialists if patient's needs are beyond the scope of practice of our medical facility.

I certify that the above information I have provided on this form is correct. By signing, I understand and will follow the policy.

_____ _____ _____

PRINT NAME **SIGNATURE** **DATE**

Protected Health Information (PHI) / HIPAA

Patient Keep Copy

Patient Name (Print) _____ Date_____

Due to recent implemented Federal Regulations the following public notice by EZE Family Health Center is effective as of November 1, 2011.

By Law EZE Family Health Center is required to:

Maintain the privacy of your health information.

- Provide you with this notice as to our legal duties and privacy practices with respect to your information we collect and maintain about you.
- Abide by the terms of this practice.

- Notify you if we are unable to agree to a requested restriction, and accommodate any reasonable request you may have to communicate health alternative means or alternative locations.
- We will not use or disclose your health information without your authorization, except as described in this notice.
- We will use and disclose your PHI in order to bill and collect payment for the services and items you may have received from us. For example, we will contact your insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment.

WE ARE PERMITTED TO USE, AND MAY BE REQUIRED, TO DISCLOSE YOUR PHI UNDER SPECIAL CIRCUSTANCES:

1. **Disclose Required By La**w: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law, including health oversight activities, court or administrative orders or similar legal proceedings.
2. **Public Health Risk:** Our practice may disclose your PHI to public health authorities who are authorized to collect information for such purposes as maintaining vital records, preventing or controlling disease, injury, or disability; or notifying a person regarding potential exposure to a communicable disease.
3. **Serious Threats to Health of Safety**: Our practice may disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
4. **Deceased Patients:** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
5. **Organ Donor:** Our practice may release PHI to a medical facility for tissue procurement of transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
6. **Worker's Compensation:** Our practice may release your PHI for workers' compensation and similar programs.

Our practice may contact you or your authorized representatives (see authorization form attached) to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice will routinely contact patients via telephone at home and /or work, via mail at home, and unless otherwise requested, may leave messages on the appropriate voic3e mail or answering service regarding appointments and billing questions.

There will be no information given over the phone or fax in reference to lab results. Each patient is given this information during their examination, and they are to schedule a follow-up visit to obtain lab results.

Patient with a normal pap will be notified by contacting the lab line directly. If your result is abnormal, you will be asked to contact your physician office directly.

All requests for medical records should be written and contain:

- **Social Security Number**
- **Date of Birth**
- **Insurance Carrier**
- **Mailing Address**
- **Written Signature**

In addition an advanced fee will be accessed for copy and mailing of all medical records information.

At no time will any person, including your spouse, be able to obtain information from your medical record without prior written authorization. Only parents or legal guardian of a child under the age of 18 will be allowed to access medical record information, with proof of child's social security number and date of birth.

There will be a fee of $15 dollars to complete medical forms containing 1-2 pages, and $25 for forms that contain 3 or more. Medical forms such as: school physicals, work physicals, and any other form(s) which may require the use of your medical record to complete your request.

Patient Rights

1. **Confidential Communications:** You have the right to request that our practice communicate with you about health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable request.
2. **Requesting Restrictions**: You have the right to request restriction on our use of disclosure of you PHI for treatment, payment, or health care operations. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. **Inspection and Copies:** You have the right to suspect and obtain a copy of your PHI. Our practice will charge a fee for the cost of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy limited circumstances; however, you may request a review of our denial.
4. **Amendment:** You may ask us to amend health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for this practice. You request must provide us with the reason that supports your request for amendment. Your request may be denied if you ask us to amend information that is in our opinion: a) accurate and complete; b) not part of the PHI kept by or for the practice; c) not part of the PHI that you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Rights to a paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
6. **Rights to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any question regarding this notice or would like to exercise any of your rights under this notice, you may contact:

Privacy Officer
EZE Family Health Center
11750 Business Park Drive
Suite 103
Waldorf, MD 20601
Phone (240-419-3865

Eze Family Health Center

Complete then return to Receptionist*

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Eze Family Health Center, and understand that if I have questions regarding this Notice I may contact the Privacy Officer at 11750 Business Park Lane Suite 103 Waldorf, MD 20601 (240) 419-3865.

Indicated below are names of any Person(s) to who I would like Eze Family Health Center to allow disclosure of Individually Identifiable Health Information (IIHI). (Please, specify the type of information that may be disclosed, such as lab test, appointment information, prescription information, etc. You may indicate “All” if appropriate).

Name	Relation (Spouse, Child, Friend, etc.	Allowed Disclosure
1.		
2.		
3.		

_____ _____

Patient Signature Date

_____ _____

Signature Legal Guardian Date

Relationship to Patient_____

FOR OFFICE USE ONLY
Date Received: _____
Received By: _____