Welcome To Our Practice

We would like to take this opportunity to welcome you to our practice, and look forward to the privilege of meeting your health care needs. Please don't hesitate to let us know at any time if we are not meeting your needs or if you have questions. We have a satisfaction survey that we would like for you to complete after your visit. This will allow us to know how we can better improve our service.

As a member of Oconee Physician Practices and an affiliated health partner with Oconee Medical Center; we are dedicated to providing high quality health care. We are a local non-profit medical group sponsored by the hospital. As a result, any bill you receive from us will have the name of **Oconee Physician Practices** as well as your physician name versus the name of this individual practice location. Completely

For your convenience, you may pay any open balances from other practices affiliated with Oconee Physician Practices at any of our locations.

PLEASE FIND BELOW A LIST OF ALL OUR PRACTICES:

Between the Lakes Primary Care
Blue Ridge Women's Center
Clemson-Seneca Pediatrics
Keowee Family Urology
Mountain Lakes Community Care
Mountain Lakes ENT and Allergy Center
Mountain Lakes Family Medicine
Mountain Lakes Internal Medicine
Oconee Geriatric & Palliative Medicine
Oconee Heart Center
Oconee Kidney Center
Rheumatology Consultants
Seneca Medical Associates
South Carolina Cardiology Consultants
Timothy Sanders Family Medicine
Upstate Family Medicine
Upstate Surgical Associates

OCONEE
Physician Practices

HOW TO PREPARE FOR YOUR NEW PATIENT VISIT

The New Patient Pack that you received at our office will need to be filled out completely and returned to our office *at least three days* before your scheduled appointment.

Please be sure to bring all your medication bottles to each of your appointments. This should include all prescription drugs, over the counter medications and/or any herbal remedies you have been taking. Also, we ask that you not wear any oil or lotions and ladies please remove all finger nail polish prior to your appointment.

WHAT TO EXPECT AT YOUR NEW PATIENT VISIT

At check in you will be asked to provide your current insurance card and photo identification. Also be prepared to pay any copayment that is printed on your insurance card at that time.

At every appointment your height, weight, temperature, pulse and blood pressure will be checked. We will go over your medical, family, and social history. The provider will do a limited exam and order any necessary diagnostic tests. A follow up visit will be scheduled for you at check out if necessary.

OFFICE COURTESIES

A 48 business hours notice is required for all call in prescriptions. Please do not wait until you are out of a medication to call for a refill.

If you need to cancel an appointment please call our office 24-48 hours a head of time. This will allow an opening for the physician to see other patients that may be in need of an appointment.

You can reach office staff Monday through Friday between the hours of 8:30 a.m. to 12:00 p.m. and 1:30 p.m. to 5:00 p.m.

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Physician Practices

- Between the Lakes
- Blue Ridge Women's Center
- Clemson-Seneca Pediatrics
- Dr. Timothy Sanders Family Medicine
- Keowee Family Urology
- Mountain Lakes Community Care
- Mountain Lakes ENT & Allergy Center
- Mountain Lakes Family Medicine
- Mountain Lakes Internal Medicine
- Oconee Geriatric & Palliative Medicine
- Oconee Heart Center
- Oconee Kidney Center
- Rheumatology Consultants
- Seneca Medical Associates
- South Carolina Cardiology Consultants
- Upstate Family Medicine
- Upstate Surgical Associates

Release of Information Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policy

This signed form acknowledges that you have received a copy of our practice's Notice of Privacy Practices as required by Federal Law and our Financial Policy. By signing below you are acknowledging that you understand and have read the notices. The notices are yours to keep.

With whom may we discuss patient's financial information?

Patient Only: [ ]

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

May we leave messages regarding appointments and lab results?

YES ☐ _____
What Phone Number
NO ☐

(Messages regarding any other information will be left as call back request only)

Would you like to designate an individual with whom the practice may discuss the patient's medical information? Patient Only: [ ]

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

I acknowledge that I have read and received a copy of the No-Show Policy, which outlines a $15.00 charge if I do not notify the office at least 24-hours prior to the scheduled appointment time. _____ (initial)

_____ _____
Print Patient Name **Patient Date of Birth**

_____ _____
Signature of Guarantor/ Patient/ Legal Guardian Date

This authorization is in effect until revoked in writing.

Revision date: 01.21.2014

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Physician Practices

Patient Information

Last Name						Social Sec #	
First Name						Birth Date	
Middle Name						Sex (M or F)	
Street Address						Race	
Suite / Apt #						Primary Language	
City		State		Zip		Marital Status	
Mailing Address						Legal Guardian	
City		State		Zip		Legal Guardian's Primary Phone	
Home Phone		Work Phone				Cell Phone	
Email Address							

Guarantor Information (Person Responsible For Bill)

Last Name						Social Sec #	
First Name						Birth Date	
Middle Name						Sex (Male or Fem)	
Street Address						Relationship	
City		State		Zip		Home Phone:	
Mailing Address						Work Phone:	
City		State		Zip		Cell Phone:	

Employment Information

Patient's Employer		Employer Phone	
Spouse's Employer			

Emergency Contact Information

Name		Relationship		Phone	

Physician Information

Name of Family Physician		City/State	
Name of Referring Physician		City/State	

Insurance Information For Patient– Provide complete and provide copy of insurance card(s)

Primary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Secondary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Additional Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:

I give permission to the provider's to treat the patient. _____

Signature of Responsible Party/Self

Assignment of Benefits: I hereby authorize payment of medical benefits directly to Oconee Physician Practices for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Signature Of Patient Or Guardian >> **Date:**

Revision date: 01.21.2014

OCONEE
Heart Center

Patient Medical/Surgical History

Name_____ DATE OF BIRTH _____

Please List All Allergies to Medications and Environment:

_____

_____

Childhood Diseases (√)

___Chickenpox ___German Measles/Rubella ___Scarlet Fever
___Measles ___Mumps ___Polio ___Rheumatic Fever

Please mark <u>Medical Conditions</u> you have or have had with a <u>"C"</u> for Current conditions and <u>"P"</u> for Past conditions.

Heart/Circulation

___HTN**, high blood pressure**
___MI, old/**heart attack** ___Angina Pectoris/**Chest Pain**
___Arrhythmia/**irregular heartbeat** ___Atrial fib___PSVT
___Anticoagulant therapy/**blood thinners**
___Rheumatic heart disease
___Disease of Heart Valve (aortic, tricuspid, pulmonary)
___CAD/**disease of heart arteries**
___Stroke **___**TIA's/**mini strokes**
___CHF/**heart failure**
___ Edema/**swelling**
___ Peripheral vascular disease/**narrowing of blood vessels outside of the heart**
___Embolism, lower extremity/**DVT (deep vein thrombosis)**
___ Carotid artery stenosis/**blockage of neck arteries**
___Hyperlipidemia/**high lipids or cholesterol**

Respiratory/Lungs/Breathing

___TB/**tuberculosis**
___COPD/**chronic lung disease**
___ Asthma
___Emphysema
___Pleural effusion/**fluid on the lungs**
___Sleep apnea/**stop breathing for short periods while sleeping**
___Allergic rhinitis/**hay fever**
___Pneumonia
___ Chronic sinusitis/**frequent sinus infections**

Gastrointestinal/Digestive

___Peptic ulcer/**stomach ulcer**
___Irritable bowel syndrome
___GERD/**stomach reflux**
___Nutritional deficiencies
___Diverticulosis of the Colon/**weak spots in large intestines**
___Diverticulitis of the Colon/**weak spots become inflamed**
___Ulcerative Colitis/**inflammation of the colon**
___ Chron's Disease/**Inflammation of digestive tract**
___GI bleed/**bleeding from stomach or intestines**
___Hemorrhoids

Kidneys/Liver/Endocrine/Cancer/Blood/Immune System

___Renal Failure**/kidney failure**
___Polycysctic kidney/**cysts in the kidneys**
___ Nephritis/Nephropathy**/Disease of kidneys**
___Chronic Liver Disease
___Hepatitis
___Cirrhosis/**scarring in the liver**
___DM I/**Diabetes childhood onset**
___DMII/**Diabetes adult onset**
___Hypothyroidism/**low thyroid**
___Cancer (bladder, breast, colon, lung, prostate, skin) please circle one
___Melanoma/**the most serious skin cancer**
___Prostate specific antigen elevation**/high PSA or prostate cancer test**
___Anemia/**low blood, iron poor blood**
___ Chronic **leukemia**
___SLE/**Lupus**

Musculoskeletal

___Walking difficulty
___Osteoporosis/**fragile bones**
___OA, generalized/**Osteoarthritis, degenerative joint disease**
___TMJ disorder/ **problems with the jaw joint**
___Spinal stenosis/**narrowing in the backbone**
___ Spinal stenosis, cervical/**neck area**
___Spinal stenosis, thoracic/**back area**
___Spinal stenosis, lumber/**low back area**
___Back pain with radiation
___Cerebral Palsy
___Multiple Sclerosis
___Rheumatoid Arthritis
___Gout

Genitourinary

___Nephrolithiasis**/kidney stones**
___Urinary incontinence**/uncontrolled bladder wetting**
___ Herpes simplex**/sexually transmitted disease**

___UTIs/Kidney infection

Male

___Impotence/**sexual dysfunction**
___Prostate hypertrophy/BPH/**enlarged prostate gland**

Female

___Breast lump
___Fibrocystic breast disease/**non cancer lumps in breasts**
___Dysmenorrhea/**painful monthly periods**
___Endometriosis/**uterus tissue outside of the uterus**
___Stress incontinence/**uncontrolled bladder when coughing etc**
___Amenorrhea/**no period**
___Contraception/**birth control**
___Menapausal disorder
___Miscarriages

Neurology/Nerves

___Seizures
___Herpes zoster/**shingles**
___Peripheral neuropathy/**nerve damage and pain**
___Trigeminal neuralgia/**pain in face nerves**
___Bell's palsy
___Parkinsonism, primary/**Parkinson's Disease**
___Restless leg syndrome
___Essential Tremor

General/Mental/Psychiatric

___Migraine headaches
___Chronic Fatigue Syndrome
___Fibromyalgia
___Chronic pain
___Insomnia
___Depression
___Anxiety
___ADD without hyperactivity/**Attention Deficit Disorder**
___ADD with hyperactivity
___Panic disorder
___Alzheimer's disease
___Senile dementia ___Memory loss
___Mental Retardation
___Schizophrenia
___Bipolar disorder
___Post traumatic stress

Skin/Eyes

___Acne
___Eczema, dermatitis
___Rosacea

___Cataracts/**clouding of the eye lens**
___Glaucoma/**pressure in the eye**
___Psoriasis

Please put check next to any Surgeries/Procedures you have had (√)

Health Maintenance: It is very important to enter date

Male and Female	Female	Male
Bone Density (DEXA) _____	Last Mammogram_____	Digital Rectal Exam_____
Colonoscopy _____	Last Pap smear_____	
EGD_____		
TB/PPD-(tuberculosis skin test) date _____		

Eyes, Ear, Nose Throat and Neck

___Adenoidectomy/**Adenoids removed**
___Cataract removed Circle Right eye, Left eye, Both eyes
___Last Eye Exam: Date_____
___Glaucoma surgery Circle Right eye, Left eye, Both eyes
___Laser Surgery of Eye for Diabetes
___Myringotomy/**Eardrum opening**
___Reconstruct/surgery for cleft palate
___Repair of nasal septum/**Nose Surgery for deviated septum**
___Sinus surgery procedure
___T & A/ Tonsils and Adenoids removed
___Thyroidectomy/Removal of thyroid gland
___Tonsillectomy/**Tonsils removed**
___Tympanostomy tube/**Ear tube(s)**

Skin

___Drainage of skin abscess location_____
___Removal of skin lesion location_____
___Skin graft ___Treatment of burn(s)

Cardiovascular

___Blood transfusion
___CABG/**Coronary Artery Bypass Surgery**
___Cardiac Angioplasty
___Carotid Endarectomy
___Coronary artery stent/**Cardiac stent**
___Insertion of heart **Pacemaker**
___Repair abdominal aneurysm/**repair of bulging blood vessel**
___Repair arterial blockage location_____
___Replace heart valve, aortic
___Replace heart valve, mitral
___Cardiac Cath ___Cardiac Echo
___Cardiac stress test
___Holter Monitor

Chest/Lung/Breast

___Breast Lumpectomy/**Remove Breast Lump__Right___Left___Both**
___Breast reduction
___Enlarge breast with implant
___Mastectomy/Removal of breast___Right___Left___Both
___Removal of lung, partial
___Treatment of collapsed lung
___Breast biopsy/**breast tissue for exam**
___Chest X-ray
___Mammogram, diagnostic
___PFT/Pulmonary Function Test

Gastrointestinal

___Appendectomy/**Removal of appendix**
___Cholecystectomy/**Gallbladder removal**
___Colostomy/**Bag to empty large intestines, bowels**
___Gastrectomy/**Remove portion of stomach**
___Gastric bypass for obesity ___Laporoscopic Band (Gastric Band for weight loss)
___Hemorrhoidectomy/**Hemorrhoid surgery**
___Ileostomy/Jejunostomy/**Bag to empty small intestines, bowels**
___Nissen fundoplication/**Surgery for gastric reflux**
___Paracentesis**/Removal of fluid from abdominal cavity**
___Polypectomy**/Removal of polyp with colonoscopy**
___Hernia repair ___Abd ___Inguinal ___Umbilical ___Diaphragm
___Splenectomy/**Spleen removal**

Kidney/Urinary

___Cystoscopy/**doctor looks at bladder**
___Dialysis
___Kidney transplant
___Removal of kidney ___Laparoscopic ____Partial
___Removal of kidney stone

Reproduction

Female ___Abortion, induced
___Amniocentesis
___C-Section Delivery/how many___
___Colposcopy/**Visual exam of cervix**
___Coniz cervix (LEEP)/**Excision of abnormal cervical tissue**
___D&C/ **remove residual from uterus**
___Hysterectomy and bladder procedure
___Hysterectomy/**Remove uterus__Abd__Vaginal__**
___Oophorectomy/**Removal of ovary(s)**
___Tubal sterilization/**Tubes tied**
___Vaginal Delivery/how many____

Male ___Circumcision
___Orchiectomy/**Remove testicles**
___Prostatectomy/**Remove prostate gland**
___Prostatectomy (TURP)/**Trim prostate gland**

___Vasectomy/**Tubes cut for sterilization**

Musculoskeletal

___Amputation ___at thigh ___lower leg, other_____
___Disk surgery ____Back ____Neck
___Fusion of spine location_____
___Joint Replacement ____Knee ____Hip
___Lumbar Laminectomy/**Relieve pressure on nerves in spine**
___Treatment of Bone Fracture/location(s)_____
___MRI____Neck___Back____Low back

Other Diagnostic Tests

___CT Abd ___CT Head
___EEG/**Test brain waves**
___Lumbar puncture/**Spinal tap**
___Moter/Nerve Conduction study
___Sleep study

Immunizations: It's very important to enter date if possible

Flu_____ Pneumonia_____ Tetanus_____ Zostivax_____

Medications List: (please include over the counter and oral contraceptives)

Medication **Dose** **Frequency**

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Physician Practices

Today's Date:	
Home # :	
Birth date:	
☐ M ☐ F	
***Name** (Last, First, M.I.):*	

SOCIAL HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Smoking:
Type: ☐ cigarette ☐ cigar ☐ pipe
Start Date:_____
Amount of cigarettes:
☐ less than 1 cigarette/day
☐ light (1-9 cigs/day)
☐ moderate (10-19 cigs/day)
☐ heavy (20-39 cigs/day)
☐ very heavy (40+ cigs/day)
Interested in quitting smoking: ☐ yes ☐ no

Smokeless:
Type: ☐ chew ☐ snuff ☐ powder
Start Date:_____
Amount:_____
Interested in quitting smokeless:
☐ yes ☐ no
STOP DATE:_____

Comments:_____
_____

Alcohol use:
☐ Current alcohol user
☐ Non-drinker
Type: ☐ beer ☐ hard liquor ☐ wine
Average drinks/week:_____
Drinks/day on typical drinking day:_____

High risk alcohol use: ☐ yes
Binge drinker: ☐ yes
Past heavy use: ☐ yes
Patient has been in an alcohol treatment program: ☐ yes ☐ no

Comments:_____
_____

Caffeine use:
☐ Uses caffeine
☐ No caffeine use
Type: ☐ coffee ☐ tea ☐ soda
☐ energy drinks ☐ caffeine supplements
Total Amount:
☐ excessive (equiv to 10+ 8oz coffee/day)
☐ heavy (equiv to 4-9 8oz coffee/day)
☐ moderate (equiv to 1-3 8oz coffee/day)
☐ minimal (equiv to < 1 8oz coffee/day)

Comments:_____
_____

Diet Nutrition:
Difficulty chewing: ☐ yes
Difficulty swallowing: ☐ yes
Hx of eating disorder: ☐ yes
Financial issues affecting the ability to buy the needed food: ☐ yes

Special diet:
☐ diabetic ☐ gluten free ☐ low fat
☐ low sodium ☐ renal ☐ vegan
☐ vegetarian ☐ weight reduction ☐ other

Comments:_____
_____

Cancer Environmental Risk (other than tobacco:
☐ Has known environmental risk factors for cancer
☐ No known environmental risk factors for cancer

Uses sun protection consistently: ☐ yes ☐ no
Hx of excessive sun exposure: ☐ yes ☐ no
Melanoma high risk: ☐ yes ☐ no
Hx of radiation exposure to neck: ☐ yes ☐ no

Comments:_____
_____

Home Safety Risk:
☐ Has significant home safety risk factors
☐ No significant home safety risk factors

Abusive home environment: ☐ yes ☐ no
Guns, rifles, or other firearms in home: ☐ yes ☐ no
Seat belt worn consistently: ☐ yes ☐ no
Smoke detectors in home: ☐ yes ☐ no

Child safety seat use: ☐ yes ☐ no
Helmet worn consistently: ☐ yes ☐ no
Fall risk: ☐ yes ☐ no
Knows how to swim: ☐ yes ☐ no

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FAMILY HISTORY

Please check the box and circle the family member's code that had any of the items listed below.

M=Mother **F**=Father **B**=Brother **S**=Sister **MGF**=Maternal Grandfather **MGM**=Maternal Grandmother **PGF**=Paternal Grandfather **PGM**=Paternal Grandmother

Heart/Cardiovascular										**Mental Health**									
Angina/Chest Pain/CAD:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Alcoholism:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Heart Attack/Heart Disease:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Attention Deficit Disorder:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
High Cholesterol:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Bipolar Disorder:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
High Triglycerides:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Depressive Disorder:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
High Blood Pressure:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Mental Disorder:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Ischemic Heart Disease:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Schizophrenia:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Sudden Death:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	☐ Other:		M	F	B	S	MGF	MGM	PGF	PGM
PVD/AAA	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	**Musculoskeletal**									
Blockage of Arteries Location(s):_____	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Osteoarthritis:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
										Rheumatoid Arthritis:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Aneurysm:_____	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Osteoporosis:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Endocrine/Metabolic										Multiple Sclerosis:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Diabetes Mellitus:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Scleroderma:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Thyroid Disorder:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Lupus:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
☐ Other:		M	F	B	S	MGF	MGM	PGF	PGM	☐ Other:		M	F	B	S	MGF	MGM	PGF	PGM
Eyes/Ears/Nose/Throat										**Neurologic**									
Glaucoma:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Alzheimer's disease:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Hearing Loss:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Dementia:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Loss of Vision:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Migraine:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
☐ Other:		M	F	B	S	MGF	MGM	PGF	PGM	Stroke:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Genetic/Birth										☐ Other:		M	F	B	S	MGF	MGM	PGF	PGM
Birth Defects:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	**Oncologic**									
☐ Other:		M	F	B	S	MGF	MGM	PGF	PGM	Melanoma:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Genitourinary										Ovarian Cancer:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Endometriosis:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Prostate Cancer:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Kidney Disease:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Skin Cancer:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Ovary Disease:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Stomach Cancer:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Toxemia of Pregnancy:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	☐ Other:		M	F	B	S	MGF	MGM	PGF	PGM
☐ Other:		M	F	B	S	MGF	MGM	PGF	PGM	**Respiratory**									
Blood/Hematologic										Asthma:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Clotting Disorder:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Pulmonary Embolism:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Anemia:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	COPD/Emphysema:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Leukemia:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Cystic Fibrosis:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Lymphoma:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Sleep Apnea:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Hemophilia:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	Tuberculosis:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM
Sickle Cell Anemia:	☐Y ☐N	M	F	B	S	MGF	MGM	PGF	PGM	☐ Other:		M	F	B	S	MGF	MGM	PGF	PGM

Additional Comments:_____

_____

_____

Person Completing Form:_____

Revision date: 01.21.2014

FINANCIAL POLICY

COLLECTION OF PATIENT AMOUNTS DUE

Insurance companies require that we collect any co-pay or co-insurance amounts at the time of service. We will collect the co-pay amounts at the time of check-in to avoid a wait at check-out. All co-insurance amounts will be collected at the time of check-out. Please understand that you will be responsible for any amounts not paid by your insurance company.

We understand that temporary financial problems may effect timely payment of your balance. We encourage you to communicate any such problems so that we may assist you in the management of your account.

We understand that there may be special agreements between parents regarding a child's medical expenses. However, the parent that brings the child in for a visit is responsible for making payment on that date of service.

PRESCRIPTION REFILL REQUESTS BY PHONE

We will generally need to see an existing patient back in the office prior to calling in a prescription. However, in rare cases where it's appropriate to write the prescription, there will be a $15.00 charge in order to cover operating costs. This is not generally covered by your insurance.

DISMISSAL OF PATIENTS FOR FINANCIAL REASONS AND MISSED APPOINTMENTS

Patients can be dismissed from the practice for a number of reasons, including the following financial situations:

1. Collection Agency Turnover will result in a dismissal from the practice if a patient fails to pay his or her balance within thirty days of turnover.
2. Expedited dismissal occurs when a patient is not honoring his or her financial responsibilities.

All patients should be given at least thirty days notice before being dismissed from practice unless instructed otherwise by physician.

After a patient is late by more than 15 minutes to the scheduled appointment then the appointment will be considered a "missed" appointment. If a patient arrives after 15 minutes, the practice will follow the physician preference for seeing or rescheduling the patient. If a patient fails to arrive without notice, then it will be considered a "no show." After the second "no show" the patient will be charged a $15 fee that will need to be paid in full before rescheduling the next non-emergent appointment.

A patient "no showing" for three appointments within a 12 month period may be dismissed from the practice under the discretion of the provider.

Absences may be excused by the provider or office manager under extenuating circumstances.

This notice is yours to keep.

Revision date: 01.21.2014