SMITHSON VALLEY FAMILY MEDICINE

WELCOME TO OUR PRACTICE!

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Gender _____ Social Security # _____ Marital Status _____ Date of Birth _____ Race _____ Language Preferred _____

Home Address _____ Zip Code _____ City _____

Home Number (_____)_____ Cell Number (_____)_____ Work Number (_____)_____

Best Phone # to reach patient _____

Email Address: _____

GUARANTOR / POLICY HOLDER INFORMATION (if other than the patient)

Last Name _____ First Name _____ Relationship _____

Date of Birth _____ Gender _____ Social Security # _____ Marital Status _____ Drivers License # _____ Exp.Date _____ State _____

Home Number _____ Work Phone Number _____ Cell Phone Number _____

Home Address _____ Zip Code _____ City _____

INSURANCE INFORMATION (Please provide our office with a copy of your insurance card(s)

Primary Insurance Company _____ Secondary Insurance Company _____

EMERGENCY CONTACT

Name _____ Relationship _____ Home Phone Number (_____)_____ Cell Phone Number (_____) _____

PREFERRED PHARMACY: _____

MEDICATION REFILL POLICY :. **PLEASE CALL YOUR PHARMACY DIRECTLY FOR REFILLS.** They will contact us for approval. Allow 48 hours to process your refill. Additional time may be needed should your insurance company require pre-authorization. We will file to your mail order pharmacy as a courtesy to you. It is the patient's responsibility to keep the medication list current and notify us of any changes made by other physicians.

FINANCIAL POLICIES:

PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, personal check, Visa and MasterCard. We require you to pay your estimated cost share at the time services are rendered. Any remaining balance will be billed to you once your insurance company has processed your claim. **If any amount is left unpaid and collection fees are incurred, you agree to reimburse us the fees of any collection agency, which is based on a percentage of the balance, with a maximum of 33% of the debt. Interest of 6% of the balance may also be charged and is your responsibility.**

If you have insurance coverage, the insurance information must be supplied at the time of service. We will file up to 2 insurance claims, primary and secondary, as a courtesy for you. **You are also responsible for any non-covered items or services. Not all services and supplies are covered by insurance. If you are not clear on the coverage and benefits of your plan, please call your insurance company to inquire what your out of pocket expenses will be for the services you receive.** Your policy is between you and your insurance company and coverage varies per policy, we can not be involved in disputes over non-covered services or supplies. If your insurance has not paid our claim within 45 days from the date of service, we ask that you call your insurance company to expedite payment. After 60 days of non-payment, you will become responsible for the balance.

CANCELLATION POLICY: Please give 24 hour advanced notice if you are unable to keep an appointment so that we may open a slot for other patients in need. Failure to do this may result in a $25 cancellation fee.

PATIENTS WITH INSURANCE / RELEASE OF INFORMATION

I hereby authorize my insurance company to pay medical benefits directly to SMITHSON VALLEY FAMILY MEDICINE LLP. I authorize the release of any medical information necessary to process my medical claims to my insurance company. I agree to pay for any non-covered services or supplies.

Signature: _____ Date: _____

ALL PATIENTS – Please read and sign:

I will be responsible for any supplies or services which are provided to me.
I have been provided an opportunity to review the Notice of Privacy Practices regarding this office's HIPAA compliance. I also have read the financial and cancellation policies listed above and agree to these terms.

Patient Name: _____ Birth Date:_____

Patient Signature (Guarantor if a minor): _____ Date: _____

Physician Assistant
Consent for Treatment

This facility has on staff Physician Assistants to assist in the delivery of your medical care.

A Physician Assistant is not a doctor. A Physician Assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a Physician, a Physician Assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising Physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Physician Assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a Physician Assistant for my health care needs.

I understand that at any time I can request to see a Physician, based on availability of the Physician at the time of my request.

Name:	Date
Signature:	Witness: (optional)

MEDICAL AND SURGICAL HISTORY

Patient Name: _____ Date of Birth: _____

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Medical Allergies :

_____ Penicillin _____ Codeine ____ Injectable Dye _____ Sulfa _____ Aspirin

Other: _____

Past Medical History: Please check all that apply

_____ Diabetes _____ Hypertension _____ Heart Disease

_____ Thyroid Disorder_____ Stroke_____ Asthma / COPD

Other: _____

Past Surgical History: Please list dates of surgeries on all that apply-

_____ Appendectomy _____ Gall Bladder_____ Tonsils _____ Hysterectomy

Other: _____

Preventative Health -- If completed, what date was your last:

Mammogram _/___/___ Bone Density __/__/__ Colonoscopy __/____/___

Pneumonia Shot __/__/____

Current Medications: (Or attached list ____)

_____

_____

Family History:

_____ Diabetes_____ Heart Disease_____ High Blood Pressure

Cancer: _____ Other:_____

Social History: Married___ Single____ Divorced____ Widowed___

Tobacco use: Y or N Alcohol use: Y or N

Occupation: _____

Current Specialist(s)

_____ _____ _____ _____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

Printed name of patient _____ Date of Birth _____

1. Authorization
I authorize ***SMITHSON VALLEY FAMILY MEDICINE*** (healthcare provider) to disclose the protected health information described below to:
Name :_____(spouse / child/ other)
_____

2. Effective Period
This authorization for release of information covers the period of healthcare from:

a. ☐ all past, present, and future periods.

OR

b. ☐ _____ to _____. (specify dates)

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment
☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or legal representative: _____ Date: _____