



**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 31% 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 and not covered by my insurance.*

*Any forms or letters that are completed by the provider on behalf of the patient will be assessed a fee.*

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)

# 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)\*\*

## 1. Authorization

I authorize **SMITHSON VALLEY FAMILY MEDICINE** (healthcare provider) to disclose the protected health information described below to:

Name : \_\_\_\_\_ (individual seeking the information).

Address: \_\_\_\_\_

## 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 revoked in writing.

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: \_\_\_\_\_

Printed name of patient or personal representative and his or her relationship to patient :

\_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

# Health History Questionnaire

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_

Sex: Male Female

Personal Health History		Previous Surgical Procedures	
Please check past or current problems or conditions		Please check if you have had any of the following	
Condition	Condition	Procedure	Year
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Surgery	
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Headaches	<input type="checkbox"/> Carotid Artery Surgery	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Vascular Surgery/Stent	
<input type="checkbox"/> Heart attack or angina	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Abdominal aneurysm repair	
<input type="checkbox"/> Irregular heart rhythm	<input type="checkbox"/> Breast problem	<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Urinary tract infections	<input type="checkbox"/> Gallbladder removal	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Appendix removal	
<input type="checkbox"/> Emphysema or chronic bronchitis	<input type="checkbox"/> Cancer- type:	<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Joint replacement	
<input type="checkbox"/> Gastroesophageal reflux disease	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Breast Surgery	
<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Addiction Issues	<input type="checkbox"/> Prostate Surgery	
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Depression or Anxiety	<input type="checkbox"/> Hernia	
<input type="checkbox"/> Liver disease/Hepatitis	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Other (please describe)	<input type="checkbox"/> Other (please describe)	
<input type="checkbox"/> Bowel/digestive problems			

**Females-Please Complete**

Menstrual Flow: (circle)	Number of Pregnancies _____ Live Births _____
Regular Irregular Pain/Cramps	Birth Control Method _____
Days of Flow _____ Length of Cycle _____	History of Abnormal Pap _____ Date _____
1 <sup>st</sup> Day of last period _____	History of Abnormal Mammo _____ Date _____

**Family Medical History**

Relationship	
Father	
Mother	
Siblings	

**Allergies**

Please list any allergies to medications or foods


Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<b>Medications</b>	
Please list any medications that you take including over the counter medications, herbs, and supplements. Include dose and frequency.	

<b>Health Maintenance</b>							
Please circle whether you have had the following preventative services and enter the year of the service							
Immunizations	Yes	No	Year	Test	Yes	No	Year
Tetanus vaccine/ Tdap				Pap Smear/Pelvic			
Pneumonia Vaccine				Mammogram			
Influenza Vaccine				Bone DEXA			
Shingles Vaccine				Colonoscopy			
				PSA			

<b>Specialty Providers</b>	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice and list the doctor's name	
<input type="checkbox"/> Eye doctor	<input type="checkbox"/> Nephrologist
<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Oncologist	<input type="checkbox"/> Allergist
<input type="checkbox"/> Urologist/Gynecologist	<input type="checkbox"/> Vascular
<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> Endocrinologist	<input type="checkbox"/> Other

<b>Health Behaviors</b>	
Tabacco use: ___ Never ___ Quit (when) _____ ___ Current Smoker	
If current smoker how many packs per day and for how many years:	
Alcohol intake No Yes If yes how many drinks/how often:	
Illicit drug use (including marijuana, cocaine, steroids): Never Past Current	
If past or current drug use describe:	
Exposure to second hand smoke: Yes No	Get 30 minutes of exercise 5xs week: Yes No

<b>Special Communication Needs</b>	
<input type="checkbox"/> Cognitive Impairment	<input type="checkbox"/> Hearing Impairment