# New Patient Form

Heritage Family Medicine

Date_____

## Patient Information

Patient's Name _____
Last Name First Name Middle Name Name you go by

Street _____

City, State, Zip _____ Home Phone _____ Cell Phone _____
include area code include area code

Sex _____ Birth Date _____ Age ____ SSN _____ Driver's Lic. # _____ Marital Status _____
mm/dd/yyyy

Patient's Employer _____ Occupation _____ Work Phone _____
include area code

Spouse's Name _____
Last Name First Name Middle Name Name goes by

Spouse's Employer _____ Occupation _____ Work Phone _____
include area code

## Emergency Contact

Contact's Name _____ Relationship _____ Phone _____
include area code

## Referred By

Referred By _____

## Insurance Information

**Insurance #1** _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____
mm/dd/yyyy

**Insurance #2** _____

Group # _____ Contract # _____ Co-pay _____

Name of Insured _____ Relationship to Patient _____

Sex _____ Birth Date _____ SSN _____
mm/dd/yyyy

## Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

I hereby authorize Dawn Mancuso, M.D. to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Dawn Mancuso, M.D. or to the party who accepts assignment.I certify that the information I have reported with regard to my insurance coverage is correct.

Signature _____ Date _____

**Heritage Family Medicine**
12205 County Line Road, Suite B
Madison, AL 35758

# Medical History – Confidential

*Circle any medical symptoms you currently have.*

**General**
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Numbness/tingling
Sweats

**Muscle /Joint / Bone**
Pain, weakness, numbness in:
Arms, Back, Hips, Feet, Legs, Neck, Hands, or Shoulders

**Genito-Urinary**
Blood in urine
Frequent urination
Lack of bladder control
Painful urination

**Gastrointestinal**
Appetite changes
Bloating / gas
Excessive thirst
Constipation
Diarrhea
Hemorrhoids
Vomiting
Vomiting blood
Stomach pain
Indigestion
Nausea
Rectal bleeding

**Cardiovascular**
Chest Pain
High blood pressure
Irregular heart beat
Low blood pressure
Poor circulation
Rapid heart beat
Swelling in ankles
Varivose veins

**Ear, Nose and Throat**
Visual disturbances
Hay fever
Hoarseness
Difficulty swallowing
Sore throat
Ear pain or discharge
Allergies
Ringing in ears
Loss of hearing
Sneezing / runny nose
Nose bleeds
Congestion

**Skin**
Bruises easily
Hives
Itching
Changes in moles
Rash
Scars
Sore that wont heal
Boil/Abscess location____

**Men Only**
Breast Lump
Erectile Difficulties
Lump in testicles
Penile discharge
Sore on penis
Other _____

**Women Only**
Abnormal pap
Bleeding between periods
Breast lump
Extreme menstrual pain
Hot flashes
Nipple discharge
Painful intercourse
Vaginal discharge
Other _____
Date of last period _____
Date of last pap _____
Date of last mammo _____
Are you Pregnant? _____
Number children _____

**Chronic Conditions** – *Circle any previous or chronic conditions you currently have or have had.*

Asthma
Alcoholism
Allergies
Anemia
Appendicitis
Arthritis
Anorexia / Bulimia
Benign tumors
Bleeding disorders
Breast Lump
Bronchitis
Cancer
Cataracts
Cerebral Palsy
Chemical *D*ependency
Chest Pain
Chicken Pox
Chronic Pain
Diabetes
Emphysema/COPD
Epilepsy
Glaucoma
Goiter
Gout
Heart Attack
Heart Disease
Hepatitis
Hernia
High Blood Pressure
High Cholesterol
HIV Positive
Kidney Disease
Liver Disease
Migraine headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Neurological Problems
Organ Transplants
Osteoporosis
Pacemaker
Polio
Prostate Problem
Psychiatric Care
Reflux (GERD)
Spinal Bifida
Stroke
Suicide attempt
Thyroid problems
Tonsillitis
Tuberculosis
Tobacco addiction
Ulcers
Vaginal Infections
Venereal diseases
Other _____

Current Medications and dosages: _____

Drug, Environmental or Food allergies (Please specify) _____

Preferred Pharmacy _____ Phone _____

# Heritage Family Medicine

12205 County Line Road, Suite B
Madison, AL 35758

## Family History

Relation Age State of health Age at death Cause of death

Father _____
Mother _____
Brothers _____
_____
Sisters _____
_____
Grandparents _____
_____

Circle if your blood relative had any of the following:

Disease Relationship to you

Allergies/Hay fever _____
Arthritis/Gout _____
Asthma _____
Cancer (type) _____
Diabetes _____
Heart Attack _____
High Blood Pressure _____
High Cholesterol _____
Kidney Disease _____
Stroke _____
Tuberculosis _____
Other _____

**Hospitalizations & Surgeries**

Hospital Date Reason for Hospitalization

_____
_____
_____
_____
_____

**Pregnancies**

Year Sex Vaginal/C-Sect/Complicatons

_____ _____
_____ _____
_____ _____

Have you ever had a blood transfusion? Yes No
If yes, please give approximate dates. _____

**Serious illness or injuries** **Date** **Outcome**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Habits** **How Often used?**

Alcohol _____
Tobacco _____
Caffeine _____
Illicit Drugs _____
Other _____

**Occupational** *Circle if you work includes any of the following.*

Stress Hazardous Substances Heavy Lifting Others
OCCUPATION _____

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

_____ _____
Signature of patient, parent, guardian, or personal representative Date

_____
Please print name of patient, parent, guardian, or personal representative

I understand that my insurance is filed as a courtesy and that I am responsible for payment of all services rendered. I authorize this office to release to the Social Security Administration or its intermediaries or other insurance carriers any information needed to secure payment. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the practice. This authorization is valid for any claim/billing service rendered. I agree to be responsible for all attorney and/or collection fees in the event such costs are incurred in the collection of the debt. The total balance is due at time services are rendered with allowance for insurance coverage approval and verification.

_____ _____
Signature of patient, parent, guardian, or personal representative Date

# Heritage Family Medicine

12205 County Line Road, Suite B
Madison, AL 35758

## Information and Policies

Thank you for your interest in our services. In order to make your transitions to our practice as simple as possible there are policies that you will need to read and sign. We look forward to serving you as our patient. We prefer good quality medical care for you and your family. Please make every effort to establish with a provider a standard routine for medical care appropriate for your age and medical history. We are familiar with up-to-date quality of care standards for good health care for our patients

**Office Hours** are from 7:30am to 5:00pm Monday thru Friday. We provide on-call services after hours. In the event of an emergency please call 911.

**Prescription requests require 48 to 72 hour notice.** Any routine medication refills will be called in during business hours **only**. We make every effort to provide enough medication/refills to last until the next medically necessary appointment. If a patient has not been seen in an appropriate timeframe an office visit may be required. **After hour prescription requests** will be called in at the discretion of the provider. **No narcotics or controlled substances will be call in.** A called in medication may be subject to a $25.00 fee.

**Appointment cancelation fee** Appointments canceled without a 24 hour notice are subject to a $25 cancelation fee. This charge is not covered by the insurance company, but by you.

**Financial responsibility** You are ultimately responsible for all charges associated with your care regardless of insurance coverage. **Your insurance will be filed as a courtesy.** Please be familiar with the term and policies of your insurance plan. If you have a deductible, which has not been met, it will be due at the time of service. If your insurance deems your visit as a non-covered service you will be responsible for the balance. **The terms of your insurance policy are between you and your insurance company.** Patients are expected to pay all co-pays, co-insurance, and deductibles at the time of service. If you have a high deductible plan, **be prepared to pay for your services in full as you incur them.** Monthly statements are mailed to each patient family with balance due on receipt. If you fail to pay the balance in full within 30 days, fail to contact the collection department to make payment arrangements, or fail to pay after making agreed upon financial arrangements, your account may be sent to an outside collection agency. You will be responsible for fees assessed by the collection agency. This outstanding debt may also be listed with local, regional, or national credit-reporting agencies and may have a negative effect on your credit rating and the granting of future credit.

**Financial agreement** The undersigned agrees that in consideration for the services rendered to the patient, he/she individually agrees to be totally responsible for all charges for services rendered and associated fees. The undersigned agrees to assign payment for the unpaid charges from the services provided by Heritage Family Medicine is authorized to bill. The undersigned accept the fee(s) charged as a legal and lawful debt. I understand the fees charged are due at the time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including 50% collection fee, attorney fees, and/or court costs, if such be necessary. The undersigned also authorizes the release of any information pertinent to any insurance company, adjuster, or attorney involved in their case. Also authorizing the doctor to initiate a complaint to the Insurance Commissioner for any reason on their behalf.

**Medicare Policy** As a courtesy our patients, Heritage Family Medicine accepts Medicare assignment. We will file your claims to Medicare for you and hold billing until Medicare has responded to the claim. Medicare will pay 80% of their allowable, and the patient or their secondary insurance is responsible for the remaining 20%. **Your Medicare deductible must be met first**. If you supply our office with the correct billing information, we will file with your secondary insurance carrier on a one-time basis. If your secondary insurance carrier does not pay within 60 days, you will be responsible for the balance.

**Worker's Compensation, Third party, Auto Insurance Policies** These claims are not covered by your regular insurance. Our offices does not do worker's compensation claims. We are not in network with these types of policies. You will be responsible for payment at time of service.

Additional Charges

| | |
|---|---|
| All Forms including PAs - $25 (each form) | Co-pays and Co-insurance not paid at time of visit - $15 |
| Retuned Checks - $40 | Telephone consultations - $25 and up |
| X-ray disks - $25 | Medications requests not during appointments - $25 |

Having read the above, I agree to abide by the policies set by Heritage Family Medicine. My signature below confirms by reading and understanding of the Patient Privacy Statement.

Patient Signature _____ Date _____

Print Name _____

# Heritage Family Medicine

12205 County Line Road, Suite B
Madison, AL 35758

Consent for Use and Disclosure of Health Information

1. This is to inform you that Heritage Family Medicine may use and disclose your health information that identifies you and that consists of your past, present, and future physical or mental health or condition, the provision of your health care, and the past, present or future payment for the provision of your healthcare (this health information is referred as "Protected Health Information."(PHI))
2. The use and disclosure of your PHI will be to carry out treatment, payment, and healthcare operations of Heritage Family Medicine.
3. For a complete description of how Heritage Family Medicine may use and disclose your PHI, please refer to the attached Patient Privacy Statement. The terms of this statement may change from time to time, therefore, to obtain a revised Patient Privacy Statement, please contact the Privacy Officer.
4. You have the right to request that Heritage Family Medicine be restricted from using or disclosing your PHI in requested restrictions. If Heritage Family Medicine does agree to your requested restrictions, then it will comply with your request.
5. You have the right to revoke this consent. The revocation must be made in writing to Heritage Family Medicine. This revocation will be valid except to the extent that Heritage Family Medicine has taken action in reliance on this consent.

By signing this document, you acknowledge that you have read and understand the Consent. Further, you hereby consent and authorize Heritage Family Medicine to use or disclose your PHI in conjunction with Heritage Family Medicine's treatment, payment or healthcare operations in accordance with the terms of this consent.

_____ _____
Signature (patient) Signature (witness)

_____ _____ _____
Date Date of Birth Account Number

I have received a copy of the Patient Privacy Statement. _____ (patient initials)

Further, I hereby authorize and give my consent to Heritage Family Medicine to leave messages on my answering machine/voicemail system for the following:

_____ Appointment reminders _____ Prescription refills

_____ Medical Information (including returned telephone calls) _____ Test results

Further, I hereby authorize and give my consent to Heritage Family Medicine to communicate any of my PHI to the following persons:

| Contact Name | Relationship |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Heritage Family Medicine**
12205 County Line Road, Suite B
Madison, AL 35758

# Patient Privacy Statement

Effective October 1, 2013

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED**
**PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact the practice manager.

**OUR OBLIGATIONS:**

We are required by law to:

- Maintain the privacy of protected heath information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:**

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

**Treatment**- We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**Payment**- We may use and disclose Health Information so that we or others may bill and receive payment from you, an Insurance company, or a third party for treatment and services you received. For example, we may give your health insurance company your health information so that they will pay for your treatment.

**Health Care Operations-** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure that care that you receive is of the highest quality care. We may also share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment reminders, Treatment Alternatives and Health related Benefits and Services-** We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. Your primary phone number designated in your demographic file will be used.

**Individuals Involved in Your care or Payment for your Care-** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research-** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even with special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

**SPECIAL SITUATIONS:**

**As Required by Law-** We will disclose Health Information when required to do so by International, Federal, State or Local law.

**To Avert a Serious Threat to Health or Safety-** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**Business Associates-** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to over read our X-rays. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Organ and Tissue Donation-** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

**Military and Veterans-** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

**Worker's Compensation-** We may release Health Information for worker's compensation or similar programs. These programs provide benefits for work related injuries or illness.

**Public Health Risks-** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or are required or authorized by law.

**Health Oversight Activities-** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliances with civil rights laws.

**Lawsuits and Disputes-** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement-** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors-** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

**National Security and Intelligence Activities-** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others-** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody-** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

**YOUR RIGHTS:**

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy-** you have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the practice manager. If you request a copy of the information, we may charge a fee for the costs of printing, copying, mailing or other supplies associated with your request.

**Right to Amend-** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the practice manager. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend the information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the Health Information kept by or for us.
- Is not part of the information which you would be permitted to inspect and copy.

**Right to an Account of Disclosures-** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provide written authorization. To request an accounting of disclosures, you must make your request, in writing to the practice manager. Your request must state a time period, which may not be longer than three years and may not include dates before February 2008. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, during such twelve-month periods, we may charge you for the costs of providing the lists. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

**Right to Request Restrictions-** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for care, such as a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the practice manager. **We are not required to agree to your request**. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Right to Request Confidential Communication-** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to the practice manager. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Paper Notice-** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have received this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website www.heritagefamilymed.net. To obtain a paper copy of this notice please send the request in writing to the practice manager.

**CHANGES TO THIS NOTICE:**

We reserve the right to change this notice and make the new notice apply to health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

**COMPLAINTS;**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the practice manager. All complaints must be made in writing. **You will not be penalized for filing a complaint**.