Financial Policies

We are honored that you chose Heritage as your health care home. We hope to provide you with a comfortable, relaxing, and up-to-date medical experience. Feel free to contact us with any questions.

1. Insurance: Please be aware that knowing your insurance contract is your responsibility. This includes knowing which labs, hospitals, and other providers your insurance covers. Please contact your insurance company for any questions about what services are covered by your plan.

2. Co-payments: All co-payments are due at the time of service and we do not bill for copayments. For minors, all co-payments are to be paid by the party bringing them to the visit that day.

3. Non-covered services: On occasion a service may not be deemed necessary or reasonable by your insurance program. Please be aware that payments for these services are due at the time of service.

4. Proof of Insurance: Please bring your current driver's license and insurance card to each appointment for insurance verification. Delays in verification of insurance may make you responsible for any payment in full.

5. Insurance Problems: Your insurance policy is a contract between you and the insurance company. Any remaining balances are your responsibility, whether or not they are paid by your insurance. Any questions or problems with your insurance should be directed to your individual insurance company.

6. Non-payment: Any balances after 90 days may be referred to a collection agency and may unfortunately result in you and your immediate family being dismissed from the practice. If this occurs you will be notified by certified mail, and will have 30 days to find another provider. During that time we will provide urgent services only.

7. Returned checks: There is a $25.00 charge for returned checks.
Office Policies

1. Our Mission: Our primary policy is to provide our patients with the highest quality Health care within the scope of our specialty – Family Medicine.

2. Controlled Substances: Because we do not provide care for chronic pain management with controlled substances, such as narcotics, any chronic pain needs or other medical conditions requiring long-term controlled substances will be referred to providers who can offer the best care for you.

3. Appointments: Time is valuable for all of us. We want to have time to give you and your health issues our utmost attention. Therefore, we will ask for payment of $25.00 for appointments canceled inside of 24 hours. If failing to cancel and just not coming for three appointments, we may have to ask you to find another health care provider. At this time we do not offer “walk-in” appointments. However, we do have several slots during the day for “same-day” appointments for urgent problems. We strive to see you on time.

4. Prescriptions: We strive to have zero errors with your medications. Therefore, please bring all prescription bottles to each appointment. To provide the best care possible, we prefer to write new and refill prescriptions during office visits. If possible, we will write you enough refills to last until your next appointment. Also, we will not be able to prescribe medications after hours unless it proves to be an emergency. Prescriptions may be picked up by the patient, parent, guardian, or persons listed on the Disclosure Release. We are not able to call in any controlled substances over the phone.

5. Health Forms: We understand that health forms are required by many agencies, and we will be happy to fill these out during your appointment free of charge if it does not delay the care of other patients. Lengthy forms may have to be completed and picked up later. Any form completion requested outside of an office visit will be subject to a $25.00 charge as well as a $1.00 mailing charge.

6. Records: In order to insure accuracy of your medical information, all of our medical records are in digital format. Copies of your medical records are available to you with a signed medical release. We do not charge for doctor-to-doctor medical record transfers. However, to cover costs we do charge the standard $0.50 per page for personal copies of records.

7. Dismissal: We sincerely hope that we never have to part ways with a patient. However, some extreme circumstances may make this necessary. If this occurs, you will be notified by certified mail. You will have 30 days to find another doctor. During those 30 days we will continue to offer only urgent care.
New Patient Form

How did you hear about us? __________________________

Patient Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Name you go by</th>
</tr>
</thead>
</table>

Street

City, State, Zip ___________________________ Home Phone ________ Cell Phone ________

Sex ______ Birth Date __________ Age ______ SSN __________ Driver's Lic. # ________ Marital Status ______

mm/dd/yyyy

Patient's Employer ___________________________ Occupation ___________________ Work Phone __________________

Spouse's Name

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Name goes by</th>
</tr>
</thead>
</table>

Emergency Contact

Contact's Name ___________________________ Relationship __________ Phone __________________

Pharmacy Information

Pharmacy Name ___________________________ Phone __________________ Fax __________________

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 __________

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 Heritage Family Medicine 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 Heritage Family Medicine 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 __________________
Receipt of Privacy Practices; Consent to Use/Disclosure of Protected Health Information (PHI)

You will find a copy of our privacy practices posted in the lobby and in each exam room. If you would like a copy for your own records, please check here. _____

I, _________________________________, was offered a copy of Heritage Family Medicine’s Privacy Practices Notification. Heritage Family Medicine may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Heritage Family Medicine to use or disclose my PHI in conjunction with Heritage Family Medicine’s treatment, payment or healthcare option in accordance with the terms of this consent.

_______________________________ ____________________________
Signature of Patient/Guardian Date

Further I hereby authorize and give my consent to Heritage Family Medicine to leave messages on my answering machine/voicemail for the following (check all that apply)

Appointment reminders ____ Prescription Refills ____

Medical Information ____ Test Results ____

Insurance/Payment Issues ____ Mail ____

I further authorize and give consent to Heritage Family Medicine to communicate any of my PHI to the following person/persons:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________</td>
<td>______________</td>
</tr>
</tbody>
</table>

___________________________  _______________________
Signature of Patient/Guardian Date
Health History

Patient Name: ______________________________

Reason for today's visit: ______________________

Medical History

Do you have a personal medical history of (check all that apply):

- Anemia
- Cancer—please list type
- Stroke
- HIV Infection
- Eczema
- Arthritis
- High Cholesterol
- Heart Disease
- Migraines
- Hepatitis
- Substance Abuse
- Asthma
- Diabetes Mellitus
- Hypertension
- Thyroid disorders
- Psychiatric Disorder
- Glaucoma
- Allergic Rhinitis
- Seizure Disorder
- Kidney Disease
- Tuberculosis
- Peptic Ulcer

Please list any allergies:

____________________________________________

____________________________________________

____________________________________________

Please list any medications you are currently taking:

____________________________________________

____________________________________________

____________________________________________

Family History

*PLEASE LIST RELATIVES' AGE AT ONSET OF ILLNESS*

Please list any chronic health problems: (e.g. cancer—please list type, diabetes, high blood pressure, high cholesterol, heart disease, stroke, heart attack, thyroid disease, substance abuse, asthma, kidney disease, etc)

Father ___________________________ Mother ___________________________

Brothers ___________________________ Sisters ___________________________

Paternal Grandfather ____________ Paternal Grandmother ____________

Maternal Grandfather ____________ Maternal Grandmother ____________

Uncles ___________________________ Aunts ___________________________
Health History

Social History

Marital Status: ___________ Occupation: _______________ Hobbies/exercise? _______________

Do you have children? (list gender and ages) __________________________________________

Are you currently in school? __public __private __home Level completed _______________

Do you use tobacco? __Cigarettes __Chewing __Snuff How much/often? _______________

Were you previously a smoker? __Yes __No When did you quit? __________

Do you live with a smoker? __Yes __No ________________________________

Do you drink alcohol? __Yes __No Type and Amount? _______________

Do you use any recreational drugs? __Yes __No Type and Amount? _______________

Surgical History

Please list any surgeries, hospitalizations, injuries that you have had and the dates:

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Health Maintenance

Please fill in the appropriate date you had your last screening tests.

Tetanus Shot ___________ Age 65 and older; Pneumonia shot _______________

Sexually Transmitted Diseases Screening (such as HIV, Gonorrhea, Syphilis, etc.) __________

Age ≥35/male or ≥ 45/female: Cholesterol level _______________

Age 50 or older: Colon Cancer Screening _______________

Age 65-75 if ever smoked 100 or more cigarettes: Abdominal Aortic Aneurysm Screening __________

Females Only:

Age 21-65 or sexually active for 3 years: Pap test _______________

Age 40 and older: Mammogram _______________

Age 65 and older OR 60-64 and weigh less than 155 pounds: Bone Density _______________
Review of Systems

Please check the symptoms below that you have persistent problems with or are concerned about:

General
  _Feeling Tired/Poorly  _Fever  _Weight loss/gain

Skin/Hair/Nails/Lymph
  _Changes in skin color  _Easy bruising  _Dry Skin  _Rash
  _Itching  _Skin Lesions  _Swollen glands

Joints/Muscles
  _Muscle aches  _Muscle weakness  _Joint pain, localized
  _Joint swelling  _Joint stiffness

Head/Ears/Eyes/Nose/Mouth/Throat
  _Headaches  _Dizziness  _Fainting  _Worsening vision
  _Watery eye discharge  _Double vision  _Loss of hearing  _Ringing in ears
  _Mucus eye discharge  _Discharge from ears  _Earache  _Nasal discharge
  _Nasal stuffiness  _Nosebleeds  _Mouth sores  _Teeth symptoms
  _Soreness/pain in mouth  _Hoarseness  _Sore throat

Breast
  _Breast lump  _Breast pain  _Nipple discharge

Respiratory System
  _Cough  _Night Sweats  _Coughing up blood  _Exposed to TB

Cardiovascular System
  _Palpitations  _Difficulty Breathing  _Chest Pain  _Soft Tissue Swelling

Gastrointestinal System
  _Appetite  _Heartburn  _Constipation  _Difficulty Swallowing
  _Nausea  _Belching  _Flatulence  _Abdominal pain
  _Diarrhea  _Vomiting  _Stool changes
Genitourinary System

- Decreased urine volume
- Painful urination
- Blood in urine
- Sexual complaints
- Changes in urinary habits
- Urinary loss of control

Birth control method: __________

Genitourinary System - Females Only

- Vaginal discharge
- Itching/Burning
- Abnormal menses duration
- Severe menstrual pain
- Heavy Bleeding
- Postmenopausal bleeding

Age at first period: _____
Age at menopause: _____
LMP: __________

Genitourinary System - Males Only

- Testicle symptoms
- Blood in semen
- Penile lesion
- Discharge

Nervous System

- Sense of smell
- Taste disturbances
- Numbness
- Abnormality of walk
- Difficulty keeping balance
- Tingling
- Speech difficulty
- Sensitive pain/touch

Psychiatric History

- Depression
- Anxiety
- Hallucinations
- Memory Loss