Jill M. Laureano-Surber, D.O Steven Tiernan, PA

Physician/ Owner

22670 Summit Dr., Bldg 6, Suite 3 Tel: 315-755-2560

Watertown, NY 13601 Fax: 315-755-2597

[www.familymedicineofnny.com](http://www.familymedicineofnny.com)

***Patient Information***

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_\_ Gender: M / F Marital Status: Married / Divorced / Single / Widowed / Child

Spouse / Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: Caucasian / African American / Hispanic / American Indian / Asian / Other

Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to Email you? YES / NO Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: Full Time / Part Time / Retired / Not Employed

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

Student Status: Full Time / Part Time

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

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Primacy Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

(Always bring your current card with you)

Primary Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Holder’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Medical History***

Medications (please include: prescriptions, over -the-counter, vitamins & Supplements): NONE [ ]

|  |  |  |
| --- | --- | --- |
| Name | Dose | Reason for taking |
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Do you have any allergies to any medications, x-ray dyes or other substances? YES / NO

 If yes, please list name and type of reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries/Hospitalizations:

|  |  |  |
| --- | --- | --- |
| Surgery / Hospitalization/ Severe Injury | Date or Age | Reason/Details |
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***Health Maintenance***

 Date Date

Colonoscopy: \_\_\_\_\_\_ Menstrual period: \_\_\_\_\_\_

Mammogram: \_\_\_\_\_\_ Pap smear: \_\_\_\_\_\_

Eye exam: \_\_\_\_\_\_ Bone density: \_\_\_\_\_\_

Wellness exam: \_\_\_\_\_\_ Tetanus/Diphtheria: \_\_\_\_\_\_

Pneumococcal (Pneumonia): \_\_\_\_\_\_ Influenza (flu): \_\_\_\_\_\_

***Past Medical History***

 X X

High Blood Pressure \_\_\_\_\_\_ Thyroid trouble \_\_\_\_\_\_

Heart Disease \_\_\_\_\_\_ Stomach hernia \_\_\_\_\_\_

Diabetes \_\_\_\_\_\_ Ear infections \_\_\_\_\_\_

Anemia \_\_\_\_\_\_ Nervous break down \_\_\_\_\_\_

Tuberculosis \_\_\_\_\_\_ Nasal Polyps \_\_\_\_\_\_

Stomach Ulcer \_\_\_\_\_\_ Congenital Problem \_\_\_\_\_\_

Diverticulitis \_\_\_\_\_\_ Glaucoma \_\_\_\_\_\_

Migraine \_\_\_\_\_\_ Heart Murmur \_\_\_\_\_\_

Asthma \_\_\_\_\_\_ Chicken Pox \_\_\_\_\_\_

Home Oxygen \_\_\_\_\_\_ Sleep Apnea \_\_\_\_\_\_

 C-Pap or Bi-Pap

Other Medical Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Family History***

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Maiden Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you adopted? YES / NO

Father (age \_\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother (age\_\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister (age\_\_\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister (age\_\_\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother (age\_\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother (age\_\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daughter (age\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daughter (age\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Son (age\_\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Son (age\_\_\_\_\_) Living / Deceased Cause of Death: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



***Family History Continued***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Illness | Father | Mother | Sibling | Child | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather |
| Heart Disease |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |  |
| Liver Disease |  |  |  |  |  |  |  |  |
| Bleeding/ Clotting disorders |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |  |
| Colon/ Bowl Problems |  |  |  |  |  |  |  |  |
| Cancer/ Type |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |
| Anesthesia Complications |  |  |  |  |  |  |  |  |
| Genetic Disorder |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |

***Social History***

Do you consider yourself: Underweight / Normal Weight / Overweight / Obese

What kind of exercise do you do: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you Smoke? YES / NO How many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever quit? YES / NO When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use other tobacco products? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



***Social History Continued***

Do you currently use recreational drugs? YES / NO What types? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a problem in the past? YES / NO What types? Prescription / Illegal

Do you drink alcohol? YES / NO How much per day? \_\_\_\_\_\_\_\_\_\_\_ How much per week? \_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a problem with alcohol use? YES / NO

Are you sexually active? YES / NO Are your partners: MEN / WOMEN / BOTH

Have you ever had a sexually transmitted disease? YES / NO Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of birth control do you use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have difficulty Reading? YES / NO

Do you have difficulty Writing? YES / NO

Do you wear your seat belt? YES / NO

Do you feel safe in your home? YES / NO

Do you drink coffee /soda /tea? YES / NO

 If yes, how many cups per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use sunscreen? YES / NO

Do you text while driving? YES / NO

Pearson (s) that completed this form: Patient / Parent / Spouse / Other (specify)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to discuss with the doctor today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Authorization to Release Medical Records**

Patient Information (please Print):

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/state/zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please release a copy of all of my Medical Records including but not limited to:

Progress notes, operative notes, laboratory results, diagnostic tests

From: To:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: Family Medicine of NNY

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: 22670 Summit Dr, Bldg 6, Suite 3

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: Watertown

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: New York

Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: 13601

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: 315-755-2560

Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: 315-755-2597

I hereby authorize the release of my medical records as noted above:

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

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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Patient Authorization for Disclosure of Protected

 Health Information to Family Members and Others

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Family Medicine of NNY to disclose my protected health information for the purpose of communicating with the family members or others I have designated below. I specifically authorize any current employee or physician of Family Medicine of NNY to use or disclose the protected health information as described on this form to the recipients listed below.

Description of the information to be disclosed (check all that apply):

[ ] Sections of my medical record that is relevant to my treatment or payment

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Medical information/date related to:

 [ ] Specific Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Specific Testing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Specific Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] My billing/payment information

 [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized recipients of the protected health information (list individuals to whom Family Medicine of NNY may disclose): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information will be used/disclosed for the following purposes:

1. To coordinate my care/treatment
2. To assist in my billing
3. As directed by the patient

[ ] This authorization permits Family Medicine of NNY to discuss the above designated information in

 Person, telephone or fax.

This authorization has been given voluntarily; I understand that unless otherwise permitted by law, Family Medicine of NNY will not condition treatment or payment on this authorization. I further understand that I have a right to inspect or copy the information to be used or disclosed and my refuse to sign this authorization.

I understand that I my revoke this authorization at any time by notifying Family Medicine of NNY’s Privacy Officer in writing, except that revocation may not be valid if Family Medicine of NNY has taken action in reliance on the authorization. In order for the revocation to be effective it must include:

* Patient name, address, patient number
* The effective date of this authorization, and the recipients of the protected health information according to this authorization
* The patient’s desire to revoke this authorization and
* The date of the revocation, and the signature of the patient or authorized representative.

This authorization will expire \_\_\_\_\_\_\_\_\_\_\_\_\_\_, After this date, Family Medicine of NNY can no longer use or disclose the protected health information without first obtaining a new authorization form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient or person representative



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FINANCIAL POLICY

We would like to thank you for choosing Family Medicine of Northern New York as your health care

Providers. Our goal is to provide and maintain a good provider-patient relationship. Please review the

following Financial Policy and sign, indicating you have read and are aware of and agree to these

conditions.

**PAYMENT**

Payment is required at the time of service. We accept cash, check or credit card (Visa, Master Card,

Discover). There is a service charge of $20.00 for returned checks.

**INSURANCE**

Payment is required at the time of service. This is an insurance company rule. This includes co-payments

or co-insurance for participating insurance companies. Insurance plans vary considerably, and we cannot

predict or guarantee what part of our services will or will not be covered. It is the responsibility of the

patient to provide accurate and timely insurance information. Inaccurate or untimely information given

to the staff that results in denial or non-coverage by your insurance company results in the guarantor

being responsible for payment.

Insurance cards must be presented each visit. If your plan requires, you must name one of our providers

as your Primary Care doctor prior to your first visit. If this is not done, your appointment may need to be

rescheduled.

**BILLING**

Each Patient or accompanying parent or adult is responsible for full payment at the time of service. We

realize that temporary financial problems may affect timely payment arrangements and assistance in the

management of your account.

Should your account balance become uncollectible due to bankruptcy, we will continue to see you

or your child on an emergency basis only for the next 30 days, giving you time to find a new source

of medical care.

If we participate with your insurance company:

\*All services performed in our office will be submitted as a courtesy to your insurance. All co-payments

are due at time of service. Deductibles and co-insurance are your responsibility and will be billed to you

by our office. All insurance carriers have a fee schedule from which they will reimburse. However, our

provider's fee may be higher than what the insurance company reimburses, or it may not be a covered

service. Any balances not covered by insurance become the responsibility of the patient.

If we do not participate with your insurance company:

\*We may courtesy bill your insurance company for you, but please be aware that you are responsible

for the full amount of the visit.

**REFERRALS**

If your insurance plan requires a written referral for you or your child to see a specialist, or for

procedures or laboratory tests, you must allow us 3-5 business days to complete the appropriate form(s)



**REFERRALS CONTINUED**

prior to obtaining services. Only emergency referrals will be completed the same day. It is your

responsibility to know if a selected specialist participates in your plan. In most instances you must be

seen and examined prior to the referral.

**CANCELLED APPOINTMENTS**

If you are unable to make your appointment, kindly give our office 24 hours notice. No shows for

appointments represent a cost to us, and to other patients who could have been seen in the time set

aside for you. We reserve the right to charge a fee ($25.00) for cancelled or missed appointment.

Families who no-show more than twice may be discharged from the practice.

**PAST DUE ACCOUNTS**

Failure to pay your bill in a timely manner may result in turning your account over to a Collection Agency.

If this occurs, a 30% charge may be added to the amount sent to the Collection Agency to cover the extra costs of collection.

**THE FINANCIAL AGREEMENT**

We must emphasize that as Primary Care providers, our relationship is with you, not your insurance

company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges

are strictly your responsibility from the date services are rendered. Therefore, it is necessary for you to

know what benefits your insurance plan provides for you.

I HAVE READ AND AM FULLY AWARE OF THE FINANCIAL POLICY SET FORTH BY FAMILY MEDICINE OF

NORTHERN NEW YORK. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A

COLLECTION AGENCY, I MAY ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE

COSTS OF THE COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE

THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITH

OUT PRIOR NOTIFICATION TO THE GUARANTOR.

Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Attendance Policy

Please be aware of the following attendance policy created to best serve you and all of our patients. We look forward to providing high-quality care for you and we need your full participation in order for you to achieve the maximum benefit from our practice.

1. Please arrive on time for your scheduled appointment. Please call if you will be more than 10 minutes late. If you are more than 15 minutes late for your appointment, we may be required to reschedule.
2. Please call 24 hours in advance if you know you have to cancel an appointment. It is our policy that if notice is not given; a charge of $25.00 per visit may be applied to your account.
3. After 3 consecutive cancellations (with less than 24 hrs. notice) or 2 missed appointments (no notice), we reserve the right to dismiss you from our practice.

I have read and understand the above policy.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Controlled Substance Policy

Refills of controlled substances must be requested at least 48-72 hours in advance. These prescriptions must be printed on paper and picked up in our office.

I have been advised of the Controlled Substance Policy.

Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Thank you for choosing Family Medicine of Northern New York. We are eager to work with you and together we can achieve all of your health goals.

Please return this packet to our office once you have filled it out completely.

You my return it via:

Mail, Fax, or Drop it off

Thank you and we look forward to caring for your health

Family Medicine of NNY