Welcome to Usborne Family Medicine. Please fill out these four pages to the best of your ability. You will be asked to provide a copy of your insurance card and driver's license. **All co-pays will be due on the date of service.** If you are a cash patient, be sure to discuss the fee schedule prior to visit. Thank you for choosing Usborne Family Medicine! We look forward to building a long relationship with you!

New Patient Questionnaire

Date: _____

Name (first middle initial & last): _____

Address (***include city, ST, & zip***): _____

Home phone: _____ Cell Phone: _____

Email address: _____

SSN: _____ Date of Birth: _____

Marital status: _____

Primary insurance: _____

Secondary insurance: _____

Emergency contact's name and phone number #: ( ) _____

Emergency contact's relationship to you: _____

Reason for today's visit:

Allergies or drug reactions (Specify drug and reaction):

Current or recent medications (Include over-the-counter products, aspirin and vitamins:

Please list current medical problems:

Please list other doctors who are also currently treating you:

Past medical history: Please list all hospitalizations, major illnesses and surgeries:

How did you hear about us?

Your occupation:

Birthplace:

Have you recently traveled outside the country? Yes No

Smoking history: Never smoked___ Started (age) Stopped (age)

On average, how many packs per day?

Do you drink alcoholic beverages?

If yes, how many times in the last year have you drank 4 more drinks on one occasion?

Do you use marijuana, cocaine, any street drugs or prescription drugs not prescribed for you? Yes No

The following are voluntary for insurance reporting:

Race?

Language?

Religion?

Ethnicity?

(Leave blank if you would rather discuss with doctor)

It is OUR responsibility to reserve your appointment time. It is YOUR responsibility to keep the appointment or call us to cancel within 24 hours. Failure to do so could end up in a $25 no-show charge.

Patient's Name_____

Please check any of the following that apply to you:

- ____ Weight change
- ____ Fever or chills
- ____ Fatigue
- ____ Poor appetite
- ____ Blurred vision
- ____ Eye Pain
- ____ Double vision
- ____ Eye itching
- ____ Earache
- ____ Hearing problem
- ____ Hoarseness
- ____ Ringing in ears
- ____ Runny nose
- ____ Nosebleeds
- ____ Mouth sores
- ____ Sore throat
- ____ Irregular heartbeat
- ____ Heart murmur
- ____ Fainting
- ____ Shortness of breath
- ____ Cough
- ____ Wheezing
- ____ Snoring
- ____ Abdominal pain
- ____ Nausea
- ____ Vomiting
- ____ Diarrhea
- ____ Increased thirst
- ____ Constipation
- ____ Heartburn
- ____ Difficulty swallowing
- ____ Rectal bleeding
- ____ Black, tarry stool
- ____ Blood in urine
- ____ Painful urination
- ____ Urinating too often
- ____ Not enough urination
- ____ Muscle pain
- ____ Joint Pain
- ____ Swelling in arms or legs
- ____ Decreased joint mobility
- ____ Skin rash
- ____ Itching
- ____ Dry Skin
- ____ Breast pain or lump
- ____ Headache
- ____ Dizziness
- ____ Weakness
- ____ Pain (location)_____
- ____ Numbness
- ____ Stroke or seizure in past
- ____ Depression
- ____ Anxiety
- ____ Stress
- ____ Hallucinations
- ____ Increased hunger
- ____ Swollen glands
- ____ Bruising
- ____ Easily bleeding
- ____ Anemia
- ____ Asthma
- ____ Runny nose
- ____ Nasal congestion
- ____ Tuberculosis in past
- ____ Positive skin test for TB
- ____ Blood clot in past
- ____ Asbestos exposure
- ____ Pancreatitis
- ____ Gall bladder problems
- ____ Colon polyps
- ____ Radiation treatments
- ____ Previous herpes
- ____ Previous Gonorrhea
- ____ Previous Syphilis
- ____ Previous Chlamydia
- ____ Diabetes

IF NO SYMPTOMS, INITIAL HERE_____

Women Only:

- ____ Last Period: _____
- ____ Abnormal vaginal bleeding
- ____ Vaginal discharge
- ____ Previous abnormal Pap
- ____ Sexual difficulties

Men Only:

- ____ Pain or lump on testicle
- ____ Discharge from penis
- ____ Prostate problems

Patient's Name_____

Family History

	Age if living	Age at death	Health Problems or cause of death
Mother			
Father			
Brothers			
Sisters			
Grandma			
Grandpa			

Please include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other important illnesses.

Check if you've had	VACCINATIONS	Date
	Tetanus	
	Influenza (FLU SHOT)	
	Pneumonia	
	Hepatitis A	
	Hepatitis B	
	Shingles	
	Other (List)	

Check if you've had	TESTS	Date of Last One:
	Stool card for colon cancer	
	Colonoscopy	
	Sigmoidoscopy	
	Bone Density	
	Mammogram	
	Pap Smear	
	PSA (men only)	
	Eye exam by eye doctor	

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Patient's Name_____

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provided penalties for covered entities that misuse personal health information.

We may use and disclose your medical records only for each of the following purposes:

1. **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
2. **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
3. **HEALTH CARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except for the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The right to inspect and copy your protected health information.
4. The right to amend your protected health information.
5. The right to receive an accounting of disclosure of protected health information.
6. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of our protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint: The U.S Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, (202) 619-0257

Usborne Family Medicine, Inc.

Assignment of Benefits Form

Name of Insured (print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Usborne Family Medicine, Inc. for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization for any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____

Attention Valued Patients:
Because we care about your health and do not want you to be without your needed medications, we have devised the following prescription policies:

For **new prescription requests,** please understand that our providers are seeing patients all day and usually will not be able to tend to the prescription requests until the end of the day/evening. Please remember that they may have to review chart notes in order to assess your current medical condition and take into consideration any other medications you may be on before he authorizes a new prescription. Unfortunately, it is not an instant process. Due to this, the turn-around time for a new prescription to be called into your pharmacy could take up to 24 hours.

For **refill prescription requests,** kindly give us a 48 hours notice for this request.

For **NARCOTIC PRESCRIPTIONS**:

- ✓ Once provider prescribes pain medications, you agree that our office will SOLELY manage those pain medications; in other words, you agree NOT to take pain medications prescribed by other physicians.
- ✓ In order to continue to receive medications, you must keep scheduled appointments. Non-compliance will result in narcotic medications not being refilled.
- ✓ Take the medication only as prescribed and do not alter your dose without discussing this with provider. A prescription will not be filled early for any reason.
- ✓ Pain medications and prescriptions should be kept in a safe place.
- ✓ **No** medication that is lost or stolen will be replaced.
- ✓ Absolutely no street drugs or alcohol are to be used while taking pain medications.
- ✓ Prescription pain medications will not be ordered in dosages that exceed the recommended levels listed in the Physicians' Desk Reference

Most medications require regular monitoring of lab work therefore a 6-month follow-up is required for most refills.

It is our main goal to keep all of our patients' health a priority.

Always remember: Poor planning on your part does not constitute an emergency on our part. Do not wait until the last minute to call us and expect us to interrupt other patients' care because you procrastinated.

I have read, understand and will comply with the Prescription Policy

_____

Print Name

Patient/Guardian Signature **Date**

I have read and understand the Privacy Policy presented to me by Usborne Family Medicine

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Patient/Guardian Signature **Date**

I understand that I must provide 24-hour notice of cancelling an appointment or I may be charged a $25 no-show fee

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Patient/Guardian Signature **Date**