Office Policy (revised 03/27/2015)

We welcome you to our office and appreciate the fact that you have chosen to be treated here. We will do our best to help you in every possible way. Please, take a moment to become familiar with our basic office policy. These common sense rules improve the efficiency with which we can bring you the best medical care you need. Since different offices may have different policies on certain common issues, please be sure to familiarize yourself with our policies. Please do not hesitate to ask about any issues not mentioned below. Once again, thank you for placing your confidence in our services.

Appointments
Please plan your appointment well ahead of time for elective or follow-up visits. If you know that a visit will be required to have your medications continued, schedule one ahead of time so you don’t run out of your medications. If a follow-up appointment was advised by your provider, please schedule this prior to leaving the office.

Insurance Information
Please have your insurance card available at every visit, since it contains up-to-date information about your co-pays, coverage etc. We also need to know if there are any changes in your insurance, address, telephone number, etc.

Co-pays
Co-payments required with HMO insurance policies apply to every visit to the office and are collected before the visit. Our office does not routinely bill for co-payments. There will be a $5 service fee for any billed co-pays. We accept cash, checks, Master Charge, Visa and Discover. A number of ATM machines are available in the vicinity where cash may be obtained. There is a charge of $30.00 for personal checks returned to us for “insufficient funds” or similar reasons.

Payment for High Deductible Insurance Plans
If you have a new “high deductible” health insurance plan, and you have not yet met your deductible, you are required to pay a minimum fee of $75 at the time of the visit. The final charge will depend on the nature of the visit and the services provided. If requested, we can bill you or your responsible party for the remaining balance.

No-Show/Cancellations
Patients who are unable to keep their scheduled appointment are expected to cancel it by calling our office 24 hours prior to their appointment or earlier. Time freed up by appropriately canceling appointments can be used to see other patients who otherwise may not be able to see the doctor for a long time. Patients who fail to cancel their regular 15 minute appointments will be billed our customary missed appointment fee of $40.00. Patients who fail to cancel their 30 minute appointments (physicals & pre-op appointments) will be billed $75.00. Patients, who are more than 15 min. late for their appointment, will be considered a no show and will need to reschedule.

Forms to be Completed
A fee of $20 per form is required for all forms including insurance and disability forms that need completion. This charge is payable prior to the forms being completed. The physician, nurse and or secretary may be unable to complete forms during office hours. Please allow 7 to 10 days for completion.
Medications
If you are on multiple medications and are seeing other physicians in addition to your primary care physician, we recommend that you bring all your medications with you in a bag to each office to review and update our records.

Prescription Refills
We aim to provide enough prescription refills to last until your next visit. If you are running low it may be time to call for an appointment. If you should run out, please have your pharmacy call or electronically contact our office with the name of the medication needed. When calling our office for prescription refills, please call during your physician’s office hours.  **WE WILL NEED AT LEAST 24 – 48 HRS NOTICE. WALK IN REQUESTS WILL NOT BE HONORED AT THE TIME.**

Telephone Calls to the office
While we are happy to assist you in answering important questions about your treatment, medications etc. please note that our staff is typically very busy in helping patients in the office. Any detailed medical questions should be addressed directly to the doctor during your next visit. Similarly, if concerned family members would like to speak to the doctor about your condition, they should accompany you to your next visit to the office.

Billing Questions
These questions are handled only by our billing department. On certain days the billing manager may not be available but your call will be returned promptly after reviewing your account information.

Medical Record confidentiality
Your medical records are kept in strict confidentiality and are not discussed even with closest family members without your explicit written authorization. We cannot discuss any aspect of your treatment with your spouse, parents or children unless you first give us your written permission to do so.

Multiple Problems
While we always try to help you in any way we can, it is often impossible to address all of a patient’s problems during a single visit if multiple issues are present. You should not expect to have all problems handled in one visit. Each problem requires adequate time for correct diagnosis, evaluation and treatment. In addition, many insurance companies cover only a limited number of services and only certain kinds of services in a single visit, even if adequate time is available. Office visits will be limited to three problems.

Services not covered by insurance/No insurance coverage
Payment for services not covered by insurance is expected before the services are rendered. If you do not have insurance coverage, a minimum payment is also due before services are rendered.

Record Release
If you need to have a copy of your records transferred, you may request that by signing a release form.  **The fee for copying and mailing your records is .75 cents per page.** Please note that considering the cost, it is rarely essential for a new physician to have a complete copy of your old records. A release of records can be accomplished much faster and at a lesser cost to you if your new physician specifically requests which information is required.

Referrals
With many HMO’s a valid referral from a primary physician is required for your visit to a specialist to be covered. The specialist generally cannot see you without a referral with these insurance policies. While we manage many conditions here in the office, in some situations your primary care physician may decide to refer you see a specialist. In order for us to issue a referral to another physician, HMO’s require that we provide a referring diagnosis. This means that we must be familiar with the problems for which you are receiving the referral for, and will generally mean that you will have to be evaluated by your primary care physician in this office. **We do require at least one weeks’ notice to obtain the referral from your insurance provider once it has been approved by your primary care physician.**
“Office Policy for New Patients”
(effective 2/13/2015)

To help make your initial visit run smoothly, accurately and in a timely fashion we have listed some suggestions as well as a brief description of our financial policies for new patients.

1. Please contact your Insurance Company approximately 2 to 3 days prior to your visit to change your primary care physician. Please obtain a confirmation number. We are not responsible for your care until your initial visit and we will not be able to see you for a sick visit or be able to refill prescriptions until after your initial visit.

2. Please arrive 30 minutes prior to your appointment time to complete additional paper work. At that time we will complete additional registration forms including HIPAA information. If there is someone other than yourself that we can contact with medical or financial information, please have their names and phone numbers available. If someone is your Power of Attorney or designated HealthCare Proxy, please bring these documents with you so that we can enter them into your medical record.

3. If you are under 18 years of age, it will be necessary for you to have a parent or legal guardian present to sign your consent to treatment. If you do not have someone present with you, you will need to reschedule your initial visit and may be charged a service fee.

4. Although we accept most insurance’s, we do not accept Medicaid. If at any time you acquire Medicaid after being an established patient with our practice, we ask that you inform us of this insurance change. Since we do not accept Medicaid, we will only be able to continue to provide you with medical care for an additional 30 days. This will allow adequate time to find another health care provider. We will be happy to assist you with this transition. If you have any insurance pending it is also important that you inform us.

5. We also do not accept Workers’ Compensation Insurance. We will try to assist you in finding an appropriate physician for your type of work related injuries.

We have enclosed forms that need to be filled out prior to your visit. Please complete them and bring them to your initial visit along with:

- your insurance cards and Photo ID (ex: driver’s license)
- name, address, phone and fax number of previous physician
- name and phone number of your pharmacy
- all current medications you are currently taking (original bottles)
- list & dates of all immunizations received if available

New patients who are uninsured or have a new “high deductible” health insurance plan are required to pay a minimum fee of $75 at the time of the visit. The final charge will depend on the nature of the visit and the services provided. We can bill you or your responsible party for the remaining balance. Your appointment will be confirmed 3 days prior. If we leave a message on an answering machine, or with a family member, we ask that you confirm you received this message within 24 hours. If we do not hear back from you, your appointment will be cancelled and you will need to reschedule. If for some reason you cannot make this appointment and need to reschedule, we ask that you give us 24 hours’ notice. New patients who fail to keep an initial appointment or arrive late for their appointment will be billed a fee of $75 and will not be able to reschedule until late fee is paid in full.

Please sign to acknowledge that you have read and understand this policy:

________________________________________  _______________________________________
(Patient’s Signature)                                      (Parent or legal guardian)

Date: _______________________________
Date: ___________________

PATIENT INFORMATION

Patient Name: ____________________________________________________________
(First) (Middle) (Last)

Address: __________________________________________________________________________________

City: ___________________________ State: ___________ Zip Code: ___________

Home Phone: (   ) ______________ Work Phone: (   ) ______________ Cell Phone: (   ) ______________

Sex: (Male / Female) Date of Birth: ____________________________ SS# __________________

EMERGENCY CONTACT

Name: _____________________________________________________________

Address: __________________________________________________________________________________

City: ___________________________ State: ___________ Zip Code: ___________

Home Phone: (   ) ______________ Work Phone: (   ) ______________ Cell Phone: (   ) ______________

INSURANCE INFORMATION *(If this is No Fault related, please notify the front desk for a separate form to complete or visit our website at Parkviewpcp.com under forms)*

Primary Insurance: __________________________________________________________________________

Name on Insured: __________________________________ D.O.B. __________________

Identification Number: ___________________________ Group Number __________________________

Relationship to Insured: Self ______ Spouse ______ Child ______

Employer’s Name & Address: __________________________________________________________________

Secondary Insurance
Secondary Insurance: __________________________________________________________________________

Name of Insured: __________________________________ D.O.B. __________________

Identification Number: ___________________________ Group Number __________________________

Relationship to Insured: Self ______ Spouse ______ Child ______

Employer’s Name & Address: __________________________________________________________________
Patient Medical History

Name: ___________________________________________ Age: _______ Date of Birth: ______________

Occupation/former occupation if retired: ____________________________________________________________

Marital Status (circle): Married Single Divorced Separated Widowed Live Alone: Y / N __________

List any past illnesses/chronic diseases:
________________________________________________________
________________________________________________________
________________________________________________________

Have you ever suffered from any of the following conditions?

<table>
<thead>
<tr>
<th>anemia</th>
<th>pneumonia</th>
<th>liver disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>thyroid disease</td>
<td>asthma</td>
<td>hay fever/eczema</td>
</tr>
<tr>
<td>diabetes</td>
<td>emphysema</td>
<td>chronic back pain</td>
</tr>
<tr>
<td>rheumatic fever</td>
<td>chronic bronchitis</td>
<td>Depression</td>
</tr>
<tr>
<td>high blood pressure</td>
<td>stomach ulcers</td>
<td>chronic anxiety</td>
</tr>
<tr>
<td>heart disease</td>
<td>chronic heartburn</td>
<td>drug/alcohol abuse</td>
</tr>
<tr>
<td>tuberculosis</td>
<td>hernia</td>
<td>Seizures</td>
</tr>
</tbody>
</table>

Yes / No Yes / No Yes / No

List any surgeries or hospital admissions you have had:

<table>
<thead>
<tr>
<th>Date</th>
<th>Operation or Illness</th>
<th>Doctor and/or Hospital</th>
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<tbody>
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</table>

Name of specialist you may have seen and reason for visit:
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________


List all current medications you are taking (prescription and over the counter):

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Strength (mg)</th>
<th>How many times per day?</th>
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</table>

Allergies and reaction:

__________________________________________________________________

__________________________________________________________________

Family Health:

<table>
<thead>
<tr>
<th>Age</th>
<th>Health Problems</th>
<th>Living?</th>
<th>Y</th>
<th>N</th>
<th>Age/Cause of death</th>
<th>Family History</th>
<th>(✔)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>High blood pressure</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Mother</td>
<td>Heart attack</td>
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<tr>
<td>Brothers</td>
<td>Breast cancer Colon cancer/polyps</td>
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<tr>
<td>Sisters</td>
<td>Diabetes Epilepsy</td>
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<td></td>
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<tr>
<td>Maternal Family</td>
<td>Asthma/hay fever</td>
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<tr>
<td>Paternal Family</td>
<td>Mental illness</td>
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</table>

Women: LMP: _________ Pregnant? _____Yes _____No If yes, Weeks? _______

Mammogram: _______________ Bone Density: _______________ Pap Smear: _______________

Colonoscopy/Sigmoidoscopy: _______________ Eye Exam: _______________

Men: Colonoscopy/Sigmoidoscopy: _______________ Abdominal Aortic U/S: _______________

Eye Exam: _______________
Have you ever used? Cigarettes ______ E-Cigarettes ______ Cigars ______ Pipe ______

If yes, when and how much? ______________________________________________________

Do you drink alcohol? ______ Yes ______ No If yes, how many glasses per week? ______

Are you on long or short term disability? _____Yes _____No Reason: ______________________________

Immunizations/Vaccinations:
(Date)
Tetanus __________
Influenza __________
Pneumococcal ________

Thank you for your co-operation.

_________________________________________ (Patient’s signature) (Date)

_________________________________________ (Physician’s signature) (Date)