PARKVIEW PRIMARY CARE PHYSICIANS
20 Losson Road, Suite 105
Cheektowaga, New York 14227
(716)558-7727 / Fax (716)558-7720

Orville Hendricks, M.D. Deirdre Bastible, M.D. John Kavcic, M.D.

WELCOME TO OUR PRACTICE

We welcome you to our office, our mission is to provide you with premium medical care. We will do our best to help you in every possible way. In return we expect full and prompt payment for our services. Please take a moment and become familiar with our office policies. Your clear understanding of the following policies and your responsibilities is important to our professional relationship.

Insurance Information
Please have your **insurance card available at every v**isit, 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.

We participate in most insurance plans; however, insurance coverage is primarily a contract between you and your carrier. We must comply with the rules and regulations of your policy. Therefore, any balance due per your insurance carrier's notification is your responsibility. Please be aware of your covered benefits to prevent billing questions later.

Co-pays
Co-payments are required with many insurance policies. These co-payments apply to every visit to the office and are collected **before** the visit. Our office **does not bill** for co-payments. There will be a **$5** processing fee for any billed co-pays. We accept cash, checks, Master Card, Visa and Discover. There are several ATM machines available in the area, where cash may be obtained. There is a processing fee of **$30.00** for returned checks.

Payment for High Deductable Insurance Plans
If you have a "high deductible" health insurance plan, and you have not yet met your deductable, 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.** After your insurance processes the claim, if there is a balance a bill will be sent to you for payment.

No Insurance Coverage
Payment must be made at the time of service unless a payment plan has been agreed upon **prior** to rendered service.

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

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.

No-Shows/Cancellations
Patients who are unable to keep their scheduled appointment are expected to cancel at least 24 hours prior to their appointment. Time freed up by appropriately cancelling appointments can be used to see other patients in need of medical attention. Patients who fail to cancel their regular 15-minute appointments will be billed our customary missed appointment fee of **$60.00**. Patients who fail to cancel their 30-minute appointments (physicals, wellness visits & pre-op appointments) will be billed **$120.00.** Patients who are **10 mins. late** to their appointment, will be considered a no show and will need to reschedule. All Dr. Kavcic patients, are required to be here 15-mins. prior to appointment time. If you

fail to show up for two scheduled office appointments, we will be unable to continue your care and will discharge you from the practice.

Forms To Be Completed

A fee of $20 per form is required for all forms including insurance and disability forms that need completion. FMLA forms are $30 per form. This charge is payable prior to the forms being completed. Paperwork is processed on a first come first served basis, please allow 7 to 10 days for completion. It is your responsibility to plan accordingly. **THE PROVIDERS WILL NOT COMPLETE ANY PAPERWORK DURING OFFICE VISITS.**

Prescription Refills

The providers routinely prescribe enough prescription refills to last until your next visit. If you find you are running low, it is 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 THAT TIME. NO MEDICATIONS WILL BE REFILLED AFTER OFFICE HOURS, WEEKENDS OR HOLIDAYS.**

Return Phone Calls

If you call the office while we are seeing patients and require a return call, all emergent calls will be handled as quickly as possible. Non-emergent calls will be returned by the end of the day. All routine calls to our office should be made during office hours. 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

All insurance / visit related questions are handled only by our billing department. Hours are Monday - Friday 8am - 4pm.

Insurance Referrals

If your insurance carrier requires a referral from our office to a specialist, it is your responsibility to contact us with complete and valid information prior to your appointment. We will need the full name and address of the physician you will be seeing, date of appointment and diagnosis (reason for seeing the doctor). If you have not seen one of the providers here for this issue, you will be required to make an appointment with our office to obtain the referral.

Medical Record Confidentiality

Your medical records are kept in strict confidentiality and are not discussed with anyone 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. **Please update your HIPAA information at every visit.**

Record Release

If you need to have a copy of your records transferred, you may request them 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.

We welcome you to our practice and look forward to providing your medical care. Please do not hesitate to ask our staff if you have any questions regarding the above information.

Respectfully,

Parkview Primary Care Physicians, PLLC.

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New Patients

Please follow the steps below to help make your initial visit run smoothly, accurately and in a timely fashion.

1. All forms **must** be completed prior to your appointment. If not completed, you may be asked to reschedule due to time constraints.

2. Contact your insurance carrier **2** to **3** days prior to your initial visit to change your primary care physician (obtain a confirmation number if possible). We will be unable to address acute issues or medication refills until after your initial visit.

3. Arrive **30** minutes prior to your appointment time. At that time, we will complete additional registration forms. Due to HIPAA, if there is someone other than yourself that we can contact in regard to your 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.

4. 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 for 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.

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: drivers license)
- 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 have a "high deductible" health insurance plan is required to pay a minimum deposit 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 2-3 days prior. As a considerable amount of time is set aside for your visit, if a message is left, 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 keep an initial appointment or arrive late for their appointment will be billed a fee of **$100** and **will not be able to reschedule until late fee is paid in full.**

I authorize the release of any medical or other information necessary to secure the payment of benefits and I authorize the payment of all medical benefits from my insurance company(s) directly to Parkview Primary Care Physicians, PLLC.

I understand that if for any reason my insurance is invalid or not given for any service, I will be responsible for the full charges incurred during my visits. I also understand that I am responsible for any charges not covered by my insurance such as copayments, deductible and coinsurance.

Please sign to acknowledge that you have read and understand our policies:

_____ _____

(Patient's signature) (Parent or legal guardian)

Date: _____ Date: _____

Parkview Primary Care Physician, PLLC

PATIENT INFORMATION

D.O. B. _____/_____/_____

_____ _____ _____
Last Name First Name M.I.

_____ _____ _____ _____
Address City State Zip

_____ _____ _____ M F _____
Home Phone Cell Phone SS# Circle Race

_____ _____ _____
Ethnicity Language Spoken Email Address

EMERGENCY CONTACT

_____ _____
Name Name

_____ _____
Address Address

_____ _____
City State Zip City State Zip

_____ _____ _____ _____
Phone Relationship Phone Relationship

INSURANCE INFORMATION

(If this is no fault injury, 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. _____

Relationship to Insured: Self _____ Spouse _____ Child _____

Identification Number: _____ Group Number _____

Employer's Name & Address: _____

Secondary Insurance

Secondary Insurance: _____

Name of Insured: _____ D.O.B._____

Relationship to Insured: Self _____ Spouse _____ Child _____

Identification Number: _____ Group Number _____

Employer's Name & Address: _____

Please be sure you have notified your insurance company that we are your

Primary Physician before your appointment!!

Name _____ DOB _____ Today's Date _____

Please list the full name of all physicians/specialist with whom you are currently under the care of:

Previous physician or referring physicians: _____

Address: _____ Phone: _____ Fax: _____

Please list surgeries and/or illness:

Date	Operation/Illness	Hospital/Physician

Have you ever had any complications with anesthesia? Please describe: _____

Please list medical conditions; including any substance addiction or abuse:

Allergies/Reaction: _____

Date of last: Tetanus _____ Flu _____ Pneumonia _____ PPD _____ Colonoscopy _____

Bone Density _____ Prostate Exam _____ Pap Smear _____ Menstrual Cycle _____

Mammogram _____ OB/GYN: _____ Children _____ How many _____

Smoke: _____ (packs per week? _____) Alcohol Use: _____; (glasses per week? _____) Drug Use: _____: (drug? _____)

Family History:

	Living / Deceased	Please list any health problems, diagnosis, mental problems or substance abuse for each
Mother		
Father		
Brother 1		
Brother 2		
Sister 1		
Sister 2		

Allergies: _____ Reaction: _____

Medications (Name / Dose):_____

_____

_____

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Who do you live with? _____

Are you currently working? ☐ Yes ☐ No
If yes, what is your occupation? _____

Hand dominance? ☐ Right ☐ Left ☐ Ambidextrous

Do you suffer from any of the following? ☐ Vision loss ☐ Blind ☐ Hearing loss ☐ Hearing impaired

Do you have / use any of the following? ☐ Glasses ☐ Contacts ☐ Dentures ☐ Hearing Aid(s)

Do you utilize any of the following? ☐ Cane ☐ Walker ☐ Wheelchair ☐ Brace ☐ Prosthesis

Do you or a family member have a history of mental illness? ☐ No ☐ Yes: _____

Does a family member have a history of alcohol or substance abuse? ☐ No ☐ Yes: _____

_____

Do you drink alcohol? ☐ Never ☐ Rarely ☐ Occasionally ☐ Weekly ☐ Daily
How many drinks per day/week? _____

Are you sexually active? ☐ No ☐ Yes - form of protection? _____

Do you use illegal drugs? ☐ No ☐ Yes: _____

Do you exercise? ☐ Never ☐ Rarely ☐ Sometimes ☐ Regularly

Do you have tattoos? ☐ No ☐ Yes (Location: _____)

What is your sun exposure? ☐ Minimum ☐ Moderate ☐ Excessive / Do you wear sunscreen? ☐ No ☐ Yes (SPF:___)
Do you utilize your seatbelt while in a car? ☐ Always ☐ Sometimes ☐ Never

Do you visit the dentist regularly? ☐ Yes ☐ No

_____ _____ _____
Signature Print Name Date

Thank you for your time!!