

PRACTICE POLICIES SUMMARY

As a new patient, you need to be aware of how your care will be delivered. It may vary from that of other medical practices. Be aware that:

- **We may not have all of your medical records on file before your first visit.** In order to facilitate getting you into the practice quickly, we may not have received all of your records from your previous provider. If you would like us to wait for all of your records to arrive prior to the first visit, please communicate this to the receptionist that is scheduling your appointment. As such, we request that you are thorough as you fill out this packet.
- **Generally, we do not prescribe chronic pain medications.** Our practice is determined to prevent prescription drug abuse and dependency. As a result, no refills or new prescriptions for narcotic pain medications will be given to a new patient in our practice without meeting with you and reviewing your history/records. Continuation of narcotics is not likely, but may occur in rare circumstances, such as cancer-related pain, at discretion of your new provider. Furthermore, we reserve the right to dismiss patients who fail to adhere to guidelines laid out in pain medication agreements.
- **We have adopted a collaborative care model.** You will be assigned to one provider who will oversee the coordination of your care and act as your primary care provider. However, sick, urgent care, inpatient, or other circumstances may require you to be seen by any available or “on call” providers, including nurse practitioners. This model ensures that your needs are met promptly.
- **Communicating changes to your insurance is your responsibility.** If you fail to communicate changes in insurance, you may be responsible for paying your medical bill out of pocket. Insurance companies often have particular requirements for documentation and billing and failure to meet these requirements may result in your claim being denied. If we don’t meet requirements because you failed to communicate a change in benefits, you will be required to pay that bill.
- **Failure to show for an appointment may result in fees.** We strive to be accessible and on-time for our patients. We ask that you are respectful of our time by arriving early for your appointment and by informing us if you are unable to come. Failure to show for appointments without prior notification *may* result in fees and, eventually, termination from the practice.
- **You may be billed for items that fall outside the scope of ‘preventive’ during a wellness visit.** Many insurance plans now cover an annual ‘preventive care’ or ‘wellness’ visit that is different than a traditional ‘physical.’ Our practice is preventive and wellness focused and we do these visits regularly. We discourage use of the wellness visits to discuss acute illnesses or chronic concerns as such items fall outside of what insurers define as preventative and may result in additional charges that your insurance may not cover. If you have non-preventative items you wish to discuss, please notify the scheduler and they can set up a separate appointment dedicated to these concerns.

PATIENT NAME (PRINT)

SIGNATURE

DATE

PERSON SIGNING ON BEHALF OF PATIENT

RELATIONSHIP TO PATIENT



NEW PATIENT PERSONAL HISTORY

DATE: _____

DEMOGRAPHIC AND INSURANCE INFORMATION						* means required field
LAST NAME		FIRST NAME			MIDDLE NAME	
NICKNAME	BIRTHDATE	SEX	*SOCIAL SECURITY NUMBER			
*RACE (CIRCLE) AFRICAN AMERICAN/BLACK AMER INDIAN/ALASKAN NATIVE ASIAN CAUCASIAN/WHITE NATIVE HAWAIIAN/PACIFIC ISLANDER DECLINED UNKNOWN OTHER: _____						
*ETHNICITY (CIRCLE) HISPANIC/LATINO NON-HISPANIC UNKNOWN DECLINED				PRIMARY LANGUAGE		
MARITAL STATUS		DRIVERS LICENSE		RELIGION		
ADDRESS		ZIP CODE	CITY		STATE	
PRIMARY PHONE	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	OTHER PHONE	<input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> WORK	EMAIL		
FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)		RELATIONSHIP TO PATIENT	PHONE (IF DIFFERENT)	ADDRESS (IF DIFFERENT)		
PRIMARY INSURANCE		INSURANCE ID OF POLICY NUMBER		GROUP NUMBER		
OTHER INSURANCE/SUPPLEMENT		INSURANCE ID OR POLICY NUMBER		GROUP NUMBER		

PERSONAL INFORMATION			
LAST SCHOOL GRADE COMPLETED	OCCUPATION	START DATE (MONTH/YEAR)	RETIRED?
EMPLOYER NAME	EMPLOYER ADDRESS		
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER	
REASON FOR CURRENT VISIT		HOBBIES/INTERESTS	
DATE OF LAST PHYSICAL EXAMINATION	PREVIOUS DOCTOR/REFERRING DOCTOR	PREFERRED PHARMACY	

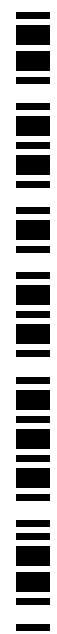
HEALTH OF FAMILY				
	GOOD	POOR	DEAD	COMMENTS (Note Medical Conditions plus age and cause of death if applicable.)
FATHER (NATURAL, BIOLOGICAL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MOTHER (NATURAL, BIOLOGICAL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BROTHERS/SISTERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHILDREN (NATURAL, BIOLOGICAL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



NEW PATIENT PERSONAL HISTORY

PATIENT NAME: _____

PERSONAL HEALTH HISTORY	
MEDICAL ILLNESSES	SURGICAL PROCEDURES – List dates when able
REASONS FOR HOSPITALIZATION	
ARE YOU SEEKING TO BECOME AN OB PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	(IF YES) DATE OF LAST MENSTRUAL PERIOD: _____ / _____ / _____



MEDICATIONS AND ALLERGIES			
ALLERGIES – List all allergies to medications and what reaction occurred.			
MEDICATIONS – List all medications, birth control, vitamins, herbs, or supplements you take with or without a prescription; include dose and frequency.			
VACCINATIONS – Indicate when you most recently received each vaccination if applicable.			
FLU	PNEUMONIA	TETANUS	SHINGLES



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete this form to authorize Cedar Point Health (CPH) to request your personal health information on your behalf. You may revoke this authorization in writing or by contacting medical records at CPH. Once health information is disclosed, the organization that receives it may re-disclose it. Privacy laws may no longer protect it.

PATIENT INFORMATION:	Patient Name: _____ Date of Birth: _____ Phone Number: _____								
AUTHORIZATION TO:	<input type="checkbox"/> Send Information <input type="checkbox"/> Request Information								
INFORMATION MAY BE RELEASED FROM:	Organization: _____ City/State: _____ Phone Number: _____ Fax Number: _____								
INFORMATION MAY BE RELEASED TO:	Organization: _____ City/State: _____ Phone Number: _____ Fax Number: _____								
INFORMATION TO BE RELEASED:	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> All health information</td> <td><input type="checkbox"/> Radiology</td> </tr> <tr> <td><input type="checkbox"/> Office Notes</td> <td><input type="checkbox"/> Labs</td> </tr> <tr> <td><input type="checkbox"/> Pathology Reports</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Immunization Records</td> <td></td> </tr> </table> Optional <input type="checkbox"/> Health information between the following dates: _____ to _____ <input type="checkbox"/> Include psychotherapy notes. To authorize, initial here _____ <input type="checkbox"/> Exclude:	<input type="checkbox"/> All health information	<input type="checkbox"/> Radiology	<input type="checkbox"/> Office Notes	<input type="checkbox"/> Labs	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Immunization Records	
<input type="checkbox"/> All health information	<input type="checkbox"/> Radiology								
<input type="checkbox"/> Office Notes	<input type="checkbox"/> Labs								
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Other: _____								
<input type="checkbox"/> Immunization Records									
AUTHORIZATION ENDS:	<input type="checkbox"/> On (date): _____ <input type="checkbox"/> When the following occurs: _____ *If no date provided, authorization ends one year from signing.								
PURPOSE:	<input type="checkbox"/> Transfer to New Provider <input type="checkbox"/> Consult/Referral <input type="checkbox"/> Other: _____								

PATIENT NAME (PRINT)	SIGNATURE	DATE
PERSON SIGNING ON BEHALF OF PATIENT	RELATIONSHIP TO PATIENT	



AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Please complete this form to authorize Cedar Point Health (CPH) to discuss your health information with specified persons. This does not authorize those listed herein to make medical decision on your behalf. Medical Power of Attorney forms are available upon request. You may revoke this authorization in writing or by contacting medical records at CPH. Once health information is disclosed, the person that receives it may re-disclose it. Privacy laws may no longer protect it.

PATIENT INFORMATION:	Patient Name: _____ Date of Birth: _____ Phone Number: _____								
INFORMATION MAY BE DISCUSSED WITH:	Name: _____ Relationship: _____ Phone Number: _____								
INFORMATION TO BE RELEASED:	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> All health information</td> <td><input type="checkbox"/> Radiology</td> </tr> <tr> <td><input type="checkbox"/> Office Notes</td> <td><input type="checkbox"/> Labs</td> </tr> <tr> <td><input type="checkbox"/> Pathology Reports</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Immunization Records</td> <td></td> </tr> </table> Optional <input type="checkbox"/> Health information between the following dates: _____ to _____ <input type="checkbox"/> Include psychotherapy notes. To authorize, initial here _____ <input type="checkbox"/> Exclude:	<input type="checkbox"/> All health information	<input type="checkbox"/> Radiology	<input type="checkbox"/> Office Notes	<input type="checkbox"/> Labs	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Immunization Records	
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<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Other: _____								
<input type="checkbox"/> Immunization Records									
AUTHORIZATION ENDS:	<input type="checkbox"/> On (date): _____ <input type="checkbox"/> When the following occurs: _____ If no date is provided, authorization ends one year from signing.								

PATIENT NAME (PRINT)	SIGNATURE	DATE
PERSON SIGNING ON BEHALF OF PATIENT	RELATIONSHIP TO PATIENT	

