HEALTHPLEX FAMILY CLINIC

PATIENT INFORMATION

Last Name__________________________ First Name_______________ Middle Name_____________ Male / Female (Circle)

Address ____City_____________________ State ______Zip ____________

Home Phone (______) _______-________ Work Phone (_____) _______-_________ Cell Phone (______) _______ -______

Marital Status________________ DOB _____/ _____ /_________ SSN _______-______-__________

Email:__________________________@__________________________ (please initial here if you would like to be able to log into your own records____)

Preferred Language______________________ Race ________________________ Ethnicity _______________________________

Place of Employment____

Emergency Contact: Name____ Relationship__________________ Phone#_________________

Guarantor/Responsible Party Name____ Male / Female (Circle)

Address ____City_____________________ State ______Zip ____________

Home Phone (______) _______-________ Work Phone (_____) _______-_________ Cell Phone (______) _______ -______

Marital Status________________ DOB _____/ _____ /_________ SSN _______-______-__________

Healthplex Family Clinic values their patients and we will take reasonable steps to maintain the confidentiality of patient's health information. Protected health information refers to individually identifiable information (including demographic information) relating to a person's health, to the healthcare provider to a person or to payment for healthcare. In effort to serve our patients, we are asking that you review and sign below indicating your preference of how we should provide you with any medical information that you should need which could include test/lab results or appointment/referral information.

Please list any names and telephone numbers that we may leave or discuss information with about your health care which could also include test/ lab results or appointment/referral information:

Name **Relationship** **Phone**

1.____

2.____

Please initial that you have received a copy of the ADA Information Sheet______ Please initial that you have received a copy of the Protected Health Information Sheet______

INSURANCE INFORMATION

Insurance Company ____ Address ____

Employer______________________ Group Number ________________ Policy Number ____

Policy Holder Name ____ Relation to patient ________________________

SSN of Policy Holder ________________________________Policy Holder's DOB ____

Secondary Insurance

Insurance Company ____ Address_______ _______________________________

Policy Holder Name ____ Relation to patient ______________________________________

SSN of Policy Holder ________________________________Policy Holder's DOB ____

Healthplex Family Clinic will gladly submit you bill to your insurance company as a courtesy to you, however if we haven't received a response from them within 30 days of the billed date this bill will become your responsibility. All co pays and co insurance are due at time of service.

I consent to services, treatment, and diagnostic procedures, including but not limited to medications, lab tests and other studies which may be ordered by my physician and consultants as selected by my physician at the Healthplex Family Clinic. I have the right to ask questions about any services that I may receive.

Patient Signature____ Date______________________________________

Responsible Party____Date______________________________________

PATIENT/GUARANTOR ASSIGNMENT OF BENEFITS

AND

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, ____(patient or guarantor's name)

Full Address (if different from patient):____

SSN:____,

hereby agree to accept financial responsibility for the medical treatment provided to me, or to
_________________________________(name of patient), by the physicians and other employees and agents of Healthplex Family Clinic (the "Practice"). I agree to cooperate fully with the employees and agents of the Practice in order for the Practice to obtain payment from any available third party sources, including insurance carriers, for the services provided by the Practice and hereby assign any benefits payable by such payor sources as a result of services rendered by the Practice's agents and employees to the Practice. I acknowledge that the Practice will file claims on my behalf with the applicable payor as a courtesy only and I hereby agree to be fully responsible for any balance of the Practice's charges not covered by any applicable payor source, to the extent permitted by applicable federal and state law. By signing this consent, you assign all rights, title, and interest and authorize direct payment to Healthplex Family Clinic, LLC of any insurance benefits or benefits under the Social Security Act for services.
If your visit is the result of an injury at work and is covered under workers compensation, we must obtain written authorization from your employer before treatment. If we file a claim to a workers compensation carrier and the injury is considered not to be the result of your employment, you will be held financially responsible for the services that you received.
In the event that collection services are required, I agree to be responsible for the collection fees and a collection service charge.

Release of Information:
I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement, Healthplex Family Clinic may disclose my records ro any person. Social Security Administration, insurance or benefit payor, health care service or plan, workers compensation carrier which is, or may be liable for all or any of the charges. I also give my permission for both personal and medical information to be released to other treating physicians, healthcare providers, audit committees for the purpose of quality improvement and applicable state and federal agencies.

My signature acknowledges that I have been given the right to ask questions and receive information about my treatment, financial obligation, and the release of my personal and medical information. This authorization shall remain in effect for one year after the termination of the patient/physician relationship. This authorization may be revoked at any time in writing.

____
Signature of Patient or Guarantor

Signed this ________ day of _________________, 20___.

Day Month

HEALTHPLEX FAMILY CLINIC

Healthplex Family Clinic ***New Patient Information***

Patient Name:_________________________________ DOB________________________ Date: _________________
Person filling out form, and relationship to patient:____

Please list all Medications you take, **including vitamins and supplements**: (if you have a list, let us make a copy)

Medicine name and dose (mg)	Times per day	Reason for medicine	When did you start it?

Your preferred pharmacy:____
(Please initial here if you would like us to import your medications from Surescripts_____)

Please list any **Medication ALLERGY** below:

ALLERGY	REACTION

Are you allergic to LATEX? YES NO (circle one)

Medical History

Do you have, or have you had, any of the following conditions? (circle YES or NO):

High Blood Pressure YES NO **Diabetes** YES NO **High Cholesterol** YES NO

Cancer YES NO if yes, please explain____

Depression YES NO **Arthritis** YES NO **Chronic Pain** YES NO If yes, where?________________________

Mental Health Condition YES NO please explain____

Heart Problems YES NO if yes, please explain____

Lung Problems YES NO if yes, please explain____

Stomach/Intestinal Problems YES NO if yes, please explain____

Any Other Medical Problem: if yes, please explain____

____

Have you had **Chicken Pox, or the vaccine**? YES NO (Please state which)______________________________ __________

When was your last tetanus booster? (if over age 11)____

Have you ever had a **blood transfusion**? YES NO if yes, when and why? ____

Patient Name:____ DOB __________________

Have you had ANY Surgery of any type? If so, please list below

Check if you have had: Please list Date (year)

( ) Appendectomy _________ ( ) Hysterectomy _________

( ) Gall Bladder removed _________ ( ) Tonsils removed _________

Other operations:

Date	Surgery	Reason	Comment

Any **Hospitalizations** other than those above? YES NO

If YES, please explain____

Family History	Living, Yes/No	If living, Date of Birth	Any medical problems?	If deceased, at what age?	Cause of death?
Father					
Mother					
Sister					
Brother					
Other siblings					
Children					

Are there any other conditions that seem to run in the family? If so, please explain:

Heart Problems?____

Cancer of any sort?____

Diabetes____

Other?____

____

Do you see any other doctors on a regular basis (OB-GYN, Cardiologist, etc.)? If so, please list their name(s) and the reason for treatment, and initial if you give permission for us to send information:

____Init_____

____Init_____

____Init_____

More:

HEALTHPLEX FAMILY CLINIC

Patient Name: ____DOB___________________

Are you: Married Single Divorced Separated Widowed

Who lives with you at home?____

Do you have a Living Will or Advanced Directive? Yes No If so, please provide copy for your records.

Do you use tobacco? YES NO If so how much? _________ What type? ______________ For how many years?___________

Are you interested in quitting? YES NO

Do you exercise? YES NO If yes, what form?_____________________________ How many times per week? ____________________

Do you drink alcohol in any form? YES NO If yes, how much in one week?____

Do you use illegal drugs? YES NO If yes, what type? ______________________ Past or present use? _________________________

Occupation? ___________________________________ Employer? ____

Are you exposed to hazardous chemicals at work? YES NO if yes, explain____

For Children:

Attend daycare: YES NO

Up to date on immunizations? YES NO Please provide a copy of shot records, as soon as possible.

Any reactions to past shots? YES NO if yes, please explain____

Ladies Only

Age when you first had your period? ____________

Have you gone through menopause? YES NO If yes, at what age? __________________

Did you take hormone replacement? YES NO if YES, for how long? ___________________________________

Are your periods regular? YES NO if no, please explain ____

When was your last Pap smear/ Well Woman Exam? ____

Have you ever had an abnormal Pap smear test? YES NO if “yes” please explain____

If you are over 40, when was your last mammogram? ____________ Was it normal? YES NO

if not, please explain____

Any family member with breast cancer, or breast disease? ____

Do you use contraception? YES NO If YES, what form?____

Obstetrical history:

Have you EVER been pregnant? YES NO if yes, how many times? __________________

How many deliveries/births? ________ Any problems? ____

Do you have any concern for your safety at home?____

Some useful information about insurance, our charges, and your bill:

The world of health insurance is complicated and confusing. Here are some explanations of a few important topics that apply to how much you pay for medical care.

What exactly is a "co-pay"?

If you have a co-payment (co-pay), this is set by your insurance company. Your insurance company pays us a set amount for a specific service, and the co-pay is subtracted from this amount. It is your portion of the total payment.

****Your co-pay is not an added payment for us.***

We are not allowed, by your insurance company's rules, to change or reduce the co-pay amount. If your co-pay increases, it means your insurance company has decreased how much they pay us by the same amount. We are required to collect the co-pay at the visit.

What is "co insurance"?

In some cases, instead of a co-pay, your insurance company states that you must pay a percentage of the charges. In this case, the amount will depend on the particular service.

Preventive Health services

Some insurance plans do not pay for preventive services, such as physicals, vaccinations, or blood tests such as cholesterol levels. It is the patient's responsibility to check if the services are covered. **If the services you want are not covered, you will be responsible for the charges.**

Deductibles

Some insurance companies, or employers, have included a "deductible" in your insurance coverage. A deductible is a set amount that your insurance company says that you have to pay first before they will start to pay for any services. Usually, this is a yearly arrangement which means it starts over every year. If you have not paid this amount yet, you are responsible for the full charge until you have.

We have no control over the amount of your deductible, or your charges. This is decided solely by your insurance company and your employer.

If you have questions regarding your bill, co-pay, or deductible please contact your insurance company, or your employer’s Human Resources department. As I have outlined above, they tell us what your charges will be. We do not have any control over your bill.

This information does not apply to “self-pay”, or those patients who do not have insurance. These charges are due in full on the day of the service.

Physicians of Healthplex Family Clinic

HEALTHPLEX FAMILY CLINIC

Information for new patients to our practice:

1. Same-day Appointments.

We always reserve some space each day for “same-day” appointments, but please call as early as possible. We cannot guarantee that you will be seen that day if we are already full, but will make every effort possible.

2. Refills

Please ask your pharmacy to send us a refill request, and give us 24-48 hours to process it. We will usually get to it sooner, but give us a little time. If it is urgent, please call us first. We will not do refills after hours for any controlled medication (pain medication, etc.).

3. Physicals

Please call to make an appointment. There are often forms that you will need to bring with you when you come for your exam.

4. X-rays

Yes, we can do most regular X-rays here in the office

5. Laboratory

Yes, we can do most laboratory test here in the office. There are certain laboratory tests than need to be sent to a reference laboratory. Please allow ample time for laboratory test to be processed. Our staff will contact you with any abnormal laboratory results.

6. Payments due before seeing the doctor

We ask that you have your standard insurance co-pay ready when you check in, as required by your insurance company. If you have a deductible, we will check and will ask for that amount if you have not met it yet.

7. Missed appointments

We ask that you give us at least 24 hours’ notice if will not be able to keep a scheduled appointment. If you miss an appointment without notice, there will be a charge: usually $20 for a routine appointment, and $40 for a physical or procedure appointment

8. Appointment Times

Your appointment time only guarantees that I have reserved time for you that day. It does not guarantee that you will be seen at that exact time. We do the best we can to be timely, but sometimes issues require more time than expected and you may have to wait. Just remember that it may be you that requires that extra time someday.

9. Phone calls

All of our time during the day is scheduled with patients in the office. As a general rule, we do not communicate with patients by phone due to time constraints. If you need our input about a medical issue, please schedule an office visit. If it is a simple question, our staff can help you, or will ask us and then get back to you,

10. If You Need to be Hospitalized:

We have arranged for Hospitalist to care for our patients that need to be treated in the hospital. We communicate closely with these doctors who practice exclusively in the hospital.

11. After-Hours Needs

We operate a First Care Clinic in our building if you need assistance after hours please present to the First Care for medical care. Of course, if it is an emergency, please call 911.

Physicians of Healthplex Family Clinic