

# PATIENT INFORMATION FORM

**Date:** \_\_\_\_\_ **Doctor:** \_\_\_\_\_ **Acct No.** \_\_\_\_\_ **Referred by** \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last) (First) (MI)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext. \_\_\_\_\_ Work Hours: \_\_\_\_\_

Cell #: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Male  Female Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital status:  Single  Married Spouse's Name: \_\_\_\_\_ Spouse DOB: \_\_\_\_\_

Name(s) and DOB of family members who live with you that are patients here: \_\_\_\_\_  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_ **Co-payment: \$** \_\_\_\_\_

**Policy Holder's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Policy Holder SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## The following will be in effect until any written changes are provided by patient/responsible party:

If unavailable, is it O.K. that our automated "Housecalls" system leaves appointment reminders at your home#?  Yes  No

May we leave detailed information on your answering machine or voice mail concerning referrals or appointments?  Yes  No

May we give detailed information to other residents at your home concerning referral or appointment information?  Yes  No

**\*\*With whom may we share your lab or test results? Name:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Whom do you authorize to pick-up medical information for you such as: prescriptions, samples, X-Ray's, and other paperwork from our office: \_\_\_\_\_ and \_\_\_\_\_

Are you disabled or unable to communicate clearly --- if so, who may speak on your behalf?: (Additional authorization required)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\* More extensive authorization for us to discuss or release your medical information requires a separate authorization form.**

In case of an emergency and if unable to communicate at an office visit due to illness, list a family member we may contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## This privacy plan is a working draft, which became effective on April 14, 2003

I hereby give my consent for Family Physicians of Gahanna to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care options (TPO). By signing this consent, I acknowledge that I have been given the opportunity to review and retain the Notice of Privacy, that Family Physicians of Gahanna presented to me with this paperwork. Central Ohio Primary Care Physicians reserves the right to revise its Notice of Privacy at any time. A revised Notice of Privacy may be obtained by forwarding a written request to Central Ohio Primary Care Physicians, Attention Privacy Officer. With this consent, Family Physicians of Gahanna may mail to my home any items that assist the practice and the patient in carrying out TPO, such as patient statements. I have the right to request that Family Physicians of Gahanna restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions.

By signing below I am giving Consent for Treatment & acknowledgement and receipt of above Privacy Plan Notice:

**Patient (Responsible Party) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**(If patient is 18 years or older, his/her signature is required in addition to the responsibility party)**

# FAMILY PHYSICIANS OF GAHANNA PAYMENT POLICY

Print Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Thank you for choosing us as your primary care providers. We are committed to providing you with quality and affordable health care. This payment policy explains your financial responsibilities, so please read it, let us know if any questions, and sign below.

**1. Insurance.** We participate in most insurance plans. It is your responsibility to determine with your specific plan whether we are in-network providers and knowing your benefit coverage (deductibles, coinsurance, non-covered services, etc). If your insurance does not pay your claim within 45 days; the balance will be your responsibility. Please contact your insurance company with any questions you may have regarding your coverage or to dispute uncovered claims.

\* I request that payment of authorized Medicare and/or other insurance company benefits be made to Central Ohio Primary Care Physicians, on my behalf for any services furnished me by Family Physicians of Gahanna. I authorize any holder of medical information about me to release any information needed to determine those benefits or to pay for related services.

**2. Proof of Insurance.** It is necessary that you present your insurance card at each visit. We must have a current copy on file every 6months – 1 year. In addition, if your insurance changes, you must notify us immediately so that we can make the appropriate changes to help you receive your maximum benefits.

**3. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Co-payments must be paid at each visit.

**4. Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers, you would be responsible to pay balance in full.

**5 Claim Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**6. Self Pay.** Self pay patients are required to pay 100% fee for service at time of visit.

**7. Nonpayment.** If your account is over 60 days past due, you will receive a letter stating you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and your immediate family will be discharged from this practice. We would notify you by certified mail and provide emergency care during the next 30 days while you find alternative medical care.

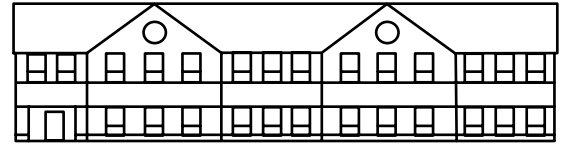
**8. Missed Appointments.** It is important to notify us if you are unable to keep an appointment. Our policy is to charge for missed appointments that are not cancelled prior to 24 hours of the appointment time. These charges will be your responsibility and billed directly to you. Help us serve you better by keeping your scheduled appointment.

**9. Evening/Weekend Services.** Effective 1/1/06 an additional charge (\$25.00) is being billed to your insurance company (per implementation of new insurance codes) for office visits performed after 5:00 p.m. weekdays and during our Saturday office hours. We have found that some insurance plans cover this charge based on the plan contract; however, non-covered expenses are patient responsibility.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges in our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

**Patient (Responsible Party) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(If patient is 18 years or older, his/her signature is required in addition to the responsibility party)



## Notice of Privacy Policy

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information. This is also a consent for treatment, consent for release of information by payment and healthcare operations, and consent for contacting you by mail or by the telephone. Please review this notice carefully!**

**I** This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice. It is important that all patients and staff understand the importance of guarding patient information. This practice has a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard patient information. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results, and other information that may be of a confidential nature, such as having someone on your behalf come to our office to pick up prescriptions, samples, x-rays, and other paperwork. Patient information about health care is identified as "PHI" or protected health information.

This change in policy requires that you, the patient, identify and clarify at the time of registration or re-registration with this practice, who we can talk to, how we can leave information on your behalf, who can pick up material that contains your PHI and the process for ongoing continuity of your medical care. **You can change this information at any time by written notification.** Changes can only impact the care or information from that point in time forward.

**II** I, with my signature, authorize **Family Physicians of Gahanna, Inc.**, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) blood draws, allergy shots, preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with are prescription. This consent includes and discussion with other health care professional for care and treatment, such as but not limited to outside X-Ray interpretations, photographed evidence of illness if necessary. I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities.

**III** Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:

- For your treatment in this practice and other locations under the physicians immediate care. This may include any referral for services and treatment related to your condition or medical care needs such as blood draws, x-rays, mailings, faxing, or e-mailing of your PHI. This may also include conversations with other physicians or their staff, and physicians in training.
- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes or operative notes. This would include eligibility verification, prior authorization, and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders, confirmations, re-scheduling needs and health related services.
- Disclosure to your family and friends concerning any health care information with your consent on the registration form which can be modified at any time **in writing.**
- **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician or medical entity requiring immediate and full information for care on your behalf.**

These items can be disclosed without your consent:

- Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds, domestic violence, and victims of abuse or neglect.
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking such as immunization records and communicable diseases.
- Information used for health care oversight, such as site review by an insurance program
- Information related to organ donation
- Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Information provided to **avoid harm** if there is a threat to patient or other person.
- Specific governmental functions
- Workers compensation review

Your rights with respect to your protected health information:

- The right to request limits on the uses and disclosure at registration or any time during your care
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of this information within a reasonable time frame set by the physician, but there may be a copy and postage fee.
- The right to get a listing of who we have made disclosures to about your PHI that is not treatment, payment, or operations related.
- The right to correct and update your file through an amendment process if appropriate.

**IV** This practice reserves the right to modify or change this Privacy statement and Consent process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice and Consent. An updated Privacy Notice and Consent will be posted in the office within 90 days of the revision.

**V** If you have any concern or complaint about how your protected health information is being used, from this time forward you should first contact our office to see if we can resolve your concerns.

- Contact the Supervisor and complete a complaint form for review and discussion:

Dawn or Jodie  
535 Offcenter Place Suite A  
Gahanna, Ohio 43230  
614 - 471 - 9654

- If you are not satisfied with this response, you may report the practice to:

Office of Civil Rights  
Regional Manager  
Department of Health and Human Services  
233 N. Michigan Ave. Suite 240  
Chicago, Illinois 60601

Or the local Medicare Part B Intermediary

GBA Palmetto  
Part B Operations – HIPAA Compliance Concern  
P.O Box 182957  
Columbus, Ohio 43218