Holmes Family Medicine, Inc.

Authorization for Disclosure of Health Information

Patient Name: ____

Date of Birth: ______________________ Phone: ______________________

Address: ____

City: ______________________ State: ____________ Zip: __________

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:* ***(example doctor, hospital, transferring facility, etc)***

Name: ____

Address: ____

City: ______________________ State: ____________ Zip: __________

Phone: ____________________ Fax: ______________________

Professional relation to patient: (doctor, hospital, etc.): ______________________

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   _____ Complete health records   _____ Lab results/X-ray reports

   _____ Physical exam   _____ Consultation reports

   _____ Immunization record

   _____ Other (please specify):______________________

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

   ______initials

5. *This information may be disclosed to and used by the following individual or organization.*

HOLMES FAMILY MEDICINE, INC.
151 Parkview Drive
Millersburg OH 44654
Phone: 330-674-1200 Fax: 330-674-3320

For the purpose of: ____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________ .

7. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

Scott Brown, M.D., Privacy Officer for Holmes Family Medicine, Inc.

______________________   ______________________

Signature of patient or legal representative   Signature of witness

Date:______________________   Date: ______________________

Holmes Family Medicine
151 Parkview Dr
Millersburg, OH 44654

Patient Information Form

Date

Patient last name: ______________________

Patient first name: ______________________

Patient middle initial: ________ Nickname: ______________

Patient maiden name: ______________________

Mailing address: ______________________

Street address: ______________________

City: ______________ State: ________ Zip: __________

Home Telephone: ______________________

Cell Phone: ______________________

E-mail:______________________

Gender: ______________________

Date of Birth:______________________

Patient SSN: ______________________

Work phone: ______________________

Work extension: ______________________

Spouse's name: ______________________

Father's name: ______________________

Mother's name: ______________________

Payment (please check one):

- ☐ Self-Pay
- ☐ Insurance

As part of the government's electronic medical records program, we are now expected to record your race and ethnicity. Like the rest of your chart, this information is protected and private under HIPAA, but if you do not wish us to record it, simply check "Prefer not to report."

Thank you for understanding.

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer not to report

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ More than one race
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Prefer not to report
- ☐ White

In case of emergency, notify:

____

(Name) (Relationship) (Phone Number)

I hereby authorize Holmes Family Medicine to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed either above or below.

I authorize payment for these services to be made directly to Holmes Family Medicine.

I also understand that I am responsible for payment of services not covered by my insurance company and that payments for co-pays are required at the time of service.

Signature of responsible party ______________________Date ______________

Printed name (if other than patient) ______________________________

Other Family Members	Date of Birth	Relationship	Is payment type same as above?
____________	________	________	Yes / No
____________	________	________	Yes / No
____________	________	________	Yes / No
____________	________	________	Yes / No

If you need more room for additional names, circle yes and write them on the back of this sheet: Yes / No

Holmes Family Medicine Medical History Form

Name:______________________________ Date of Birth:_____________ Family Doctor:___________

Past Medical History

Medical Problems/Conditions:	**Yes**	**No**
Arthritis	☐	☐
Coronary Artery Disease	☐	☐
High Cholesterol	☐	☐
Hypertension (high blood pressure)	☐	☐
Heart Attack	☐	☐
Congestive Heart Failure	☐	☐
Stroke	☐	☐
Asthma	☐	☐
Emphysema/COPD	☐	☐
Ulcers	☐	☐
Acid Reflux/GERD	☐	☐
Kidney Disease	☐	☐
Kidney Stones	☐	☐
Diabetes	☐	☐
Thyroid Disease	☐	☐
Seizures	☐	☐
Cancer (if yes, give type)	☐	☐

Other: ______________________________________

Family History

Condition:	**Yes**	**No**	**Family Member:**
Heart Disease	☐	☐	____________________
High Blood Pressure	☐	☐	____________________
Stroke	☐	☐	____________________
Diabetes	☐	☐	____________________
Cancer (if yes, give type)	☐	☐	____________________
Arthritis	☐	☐	____________________
Autoimmune Disease	☐	☐	____________________
Thyroid Disease	☐	☐	____________________
Bleeding Disorder	☐	☐	____________________

Other: ______________________________________

Surgical History:

Surgical History:	**Year:**	**Hospital:**
Colonoscopy/Endoscopy		
Anesthesia Complications		

Social History

Marital Status ____________________

Employment ____________________

Alcohol Consumption ____________________

Caffeine Consumption ____________________

Exercise ____________________

Smoking History ☐ Never ☐ Current ☐ Ex-smoker

Packs Per Day ________ ________

\# years (smoker or smoke free) ________ ________

Medication Use (dosage and frequency):

____

Childbirth History

Number of Children ____________________

Number of Pregnancies ____________________

Vaginal Deliveries ____________________

Cesarean Deliveries ____________________

Allergies

Medication	Reaction

Review of Systems (Current Symptoms)

GENERAL	***YES***	***NO***
appetite changes		
awake from sleep choking/gasping		
excessive daytime sleepiness		
SKIN	***YES***	***NO***
new/changing lesions/moles		
itching or painful lesion		
HEENT	***YES***	***NO***
vision changes		
hearing changes		
snoring or apnea (stop breathing)		
sore throat		
vertigo (dizziness)		
difficulty swallowing		
NEUROLOGIC	***YES***	***NO***
numbness		
weakness		
passing out		
unsteady gait		
CARDIAC	***YES***	***NO***
chest pain		
palpitations		
irregular heartbeat		
sleep sitting up		
wake up short of breath		
RESPIRATORY	***YES***	***NO***
cough		
shortness of breath		
wheezing		

GASTROINTESTINAL	***YES***	***NO***
abdominal pain		
acid reflux		
vomiting		
black stool		
diarrhea		
constipation		
MALE GENITO-URINARY	***YES***	***NO***
blood in urine		
increased urinary frequency		
hesitancy		
Dribbling/leaking		
lack of bladder control		
FEMALE GENITO-URINARY	***YES***	***NO***
blood in urine		
increased urinary frequency		
hesitancy		
Dribbling/leaking		
lack of bladder control		
pain or bleeding with intercourse		
still having periods		
last menstrual period		
last pelvic exam		
HEMATOLOGIC	***YES***	***NO***
easy bruising		
excessive bleeding		
anemic		

NEW SURGERIES	***Date***

Holmes Family Medicine, Inc.
Payment Policy — Effective June 1, 2004

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in many insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't show us an up-to-date insurance card at each visit, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage, including co-pays, deductibles, and co-insurances.

2. **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. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you refuse to pay your co-payment at the time of service, you will be charged a $10 rebilling fee.

3. **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 must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims 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. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted except in special cases of financial hardship approved by the physicians. Please be aware that if your balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and/or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

8. **Missed appointments.** You may be charged a No-Show fee of $25 - $75, depending on the type of visit, for missed appointments that are not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointments.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding the 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:

______________________________ Signature of patient/responsible party

________________ Date of birth

____________ Today's date

****List ALL family members (with their date of birth) under the age of 18 residing in your home who attend this office:**

____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Holmes Family Medicine, Inc.
151 Parkview Drive
Millersburg, OH 44654

I understand that, under the Health Insurance Portability and Accountability act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third party payers (like your health insurance company)
- Conduct normal health-care operations such as quality assessment and physician certifications
- Notify me of upcoming appointments

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain the current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health-care operations. I understand you are not required to agree to my requested restrictions but if you do then you are bound to abide by such restrictions.

Print Patient Name ____________________________________

Date of Birth ____________________________________

Relation to Patient (self) ____________________________________

Signature ____________________________________

Date ____________________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason