AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State & Zip: _____

Phone #: _____ **Current Primary Care Physician(records from):**_____

Maiden Name or Other Name Known By: _____

Disclose Info To (Name): Prime Care Providers

Address: 1013 Menoher Blvd

City: Johnstown, PA State & Zip: 15905

Phone #: 814-254-4885 Fax #: 814-254-4533

Reason for Release: ___ Continuity of Care ___ Insurance ___ Self Other:_____

1. I authorize the use of "Discloser of Information" to be used or disclosed of the above named individual's health information, as described below.
2. The type and amount of information to be used or disclosed is as follows:
   - ___ Problem List
   - ___ Medication List
   - ___ List of Allergies
   - ___ Immunization Record
   - ___ Progress Notes
   - ___ Most Recent History & Physical
   - ___ Most Recent Discharge Summary
   - ___ Laboratory Results from _____ to _____
   - ___ X-ray and/or imaging reports from _____ to _____
   - ___ Other (please describe) _____
3. Authorization of release of the above information by means of:
   ____ Photocopy ____ Verbal ____ Inspection ____ Fax
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.
5. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to my physician. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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.
6. Unless otherwise revoked, this authorization will expire automatically in six (6) months or on the following date, event, or condition:

   _____
7. I understand that once this information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and is therefore not protected by federal privacy regulations. Also, there will be a fee required for my records once produced. An invoice will be received by me once records are completed.
8. I understand that I need not sign this form in order to ensure health care treatment.

_____

Signature of Patient and/or Guardian (if patient is a Minor) Date

_____

Witness Signature Date

Office use only
Date Completed: _____

Effective 9/1/2019

NEW PATIENT REGISTRATION FORM

Please be sure the office has a copy of your insurance card(s).

Patient's First Name: _____ MI: __ Last Name: _____

Address: _____

City: _____ State: ____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Sex: Male ____ Female ____ Marital Status: Married Single Widowed

Insurance Carrier:_____ Member ID:_____

Secondary Insurance: _____ Member ID:_____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Employment Information (Please circle one): Full-time Part-time Self employed

Retired Student Unemployed Disabled

If Employed, Employer Name: _____

Employer Address: _____

Work Phone Number: _____ Ext: _____

Pharmacy: _____ Phone: _____

How did you become aware of Prime Care Providers?

- ☐ Referral?
  - If referred, by who? _____
- ☐ Radio
- ☐ Billboard
- ☐ Flyer
- ☐ Newspaper/Insert
- ☐ Other: _____

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN AND RELEASE OF MEDICAL INFORMATION

I hereby assign all medical and/or medical surgical benefits, to include major medical benefits, to which I am entitled to Prime Care Providers, LLC (PCP). I authorize PCP to submit claims to my insurance company on my behalf. I request payment of authorized benefits to be made on my behalf of PCP for any services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all allowed charges, non-covered and/ or co-payments whether or not paid by my insurance. I hereby authorize said assignees to release all information necessary for determination of benefits to my insurer or the Healthcare Financing Administration. In the event that I am denied coverage, I will make arrangements to pay all bills within 30 days.

Signature of Patient and/or Guardian, if Patient is a Minor Date

MEDICARE & MEDIGAP (SECONDARY) AUTHORIZATION

I authorize Prime Care Providers, LLC (PCP), to submit claims to my insurance company on my behalf. I request that payment of authorized Medicare benefits be made on my behalf to PCP for any services furnished to me by that provider of service. I authorize holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization will remain in effect until revoked by me in writing.

Signature of Patient and/or Guardian, if Patient is a Minor Date

MEDIGAP – I authorize Prime Care Providers, LLC (PCP), to submit claims to my insurance company on my behalf. I request that payment of authorized Medigap benefits be made on my behalf to PCP for any services furnished to me by that provider of service. I authorize any holder of Medicare information about me to release to the secondary insurer listed above any information needed to determine these benefits payable services.

Signature of Patient and/or Guardian, if Patient is a Minor Date

PCP
prime care providers

CONSENT FORM

Patient's Name: _____ Date: _____

I voluntarily consent to the care and treatment, which is prescribed by my physician and is deemed necessary in his/her judgment. I understand that as part of my healthcare, this practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatment.

I understand that as part of this practice's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

My signature below constitutes my acknowledgement that I have read, understand, and agree to the above and that I give consent.

_____

Signature of Patient and/or Guardian, if Patient is a Minor Date

I understand that by checking any of the information below, I waive my rights to confidentiality and I cannot hold Prime Care Providers, LLC responsible for any information that my be overheard or repeated.

I authorize Prime Care Providers, LLC to:

- ☐ Leave treatment/advice/instructions/results on my voicemail or answering machine.
- ☐ Give treatment advice/instructions/results to:
  (mark EACH that you are consenting to)
  - Children
  - Siblings
  - Parents
  - Other: _____
- ☐ To mail/fax information at my verbal request.

_____

Signature of Patient and/or Guardian, if Patient is a Minor Date

FINANCIAL POLICY

Thank you for choosing us as your health care provider. The best medical care can be provided on the basis of mutual understanding. We, therefore, encourage our patients to discuss any questions you may have regarding our policies. The following is a statement of our Financial Policy that we will require that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

We accept Cash, Check and Major Credit Cards. We offer an extended payment plan with prior credit approval that may be obtained by speaking with the Office Manager.

Credit Policy

Our requirements for maintaining your account in good standing are as follows:

1. All charges for any co-payment amounts or non-covered services are due and payable at the time of service.
2. Under certain circumstances, a payment in advance may be required.
3. Other circumstances may warrant an extended payment plan. The Office Manager will assist you in these special instances at your request.

To avoid misunderstanding, the Office Manager invites early discussion of financial problems or questions regarding fees, payments from insurance carriers, etc. You may contact the Office Manager at 814-539-0798.

BILLINGS

A billing statement covering all outstanding medical services rendered will be mailed 4-8 weeks after services are rendered. Charges and payments for services received during the last few days before your billing date may appear on the following statement. If you have not paid your account in full after 90 days, have not made regular monthly payments as agreed, or have not made any other arrangements with the Office Manager, we may turn your account over to a Collection Agency.

Minor Patient (Under 18 Years of Age)

The parent/guardian/adult accompanying a minor child is responsible for full payment. We must have pre-approval from a parent/guardian for an unaccompanied minor. Any child over 18 is legally an adult and responsible for his/her bill. (Regardless of attending college, living at home, or being covered by a parent's insurance.) We, therefore, cannot release financial or medical information to a parent/guardian without the patient's written permission. If both parents have insurance, the parent with the first birthday in the calendar year is most often the primary insurer. Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, the parent who brings the child in for services is ultimately the responsible party.

Collection Balances

If you have previous collection balance or are presently in collection, the physician may use his discretion as to seeing you again. It may be required that you pay your previous balance prior to being seen. If seen by the doctor, we must verify current insurance coverage. You will be responsible for payment of the office visit, co-payments, deductible, etc. on the day of the visit.

Cancellation Policy

Please help us serve you better by keeping your scheduled appointment. Notify us at least 24 hours in advance if unable to keep your scheduled appointment. ***Should you need to cancel or reschedule an appointment, please contact our office at least 24 hours prior to your scheduled appointment. If an appointment is not cancelled at least 24 hours in advance, you will be charged a $25.00 late cancellation fee. This will not be covered by your insurance.**

Failure to show and/or notify us may jeopardize your next visit to our office.

A $25.00 fee will be charged if you cancel less than 24 hours in advance or do not show up for your appointment.

INSURANCE

We require a copy of your health insurance card. Please be sure to have your insurance card available when requested. **If you fail to bring your health insurance card(s) at the time of service you will be considered a self-pay patient and will be require to *pay in full* at the time of service.** We cannot accept pieces of paper with name and numbers or expired insurance cards.

Reduction or Rejection of Your Claim

Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance company does not relieve the financial responsibility you have incurred.

We accept assignment for most insurance companies such as Pennsylvania Blue Shield, Medicare, Medicaid, and some other selected HMO and PPO programs; however, you may be responsible for payments of the office visit, deductible, coinsurance, or non-covered services.

Usual and Customary Rate

Our practice is committed to providing quality care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company being unwilling to pay for the quality of care you choose.

Medicare Insurance

We accept assignment of Medicare and will submit the charges to Medicare for you and payment will be made directly to Prime Care Providers, LLC. However, we require that you pay at the time of service at the beginning of each new year until you meet your Medicare deductible. Also, the patient is responsible for the 20% coinsurance that we will bill you when payment is received from Medicare. Medicare requires that you sign an authorization form for benefits to be paid directly to the physician. If you have other insurance, in addition to Medicare, please inform our office so that we can file a claim for you.

Blue Shield

We participate in most Pennsylvania Blue Shield programs. Therefore, payment will be made directly to us for covered services. The subscriber, however, is responsible for any applicable deductible or coinsurance amount. We will require that you pay for your office visit at the time of service unless you inform our office that you have a Comprehensive Plan, which covers all or part of your visit.

Other Insurance

Most insurance plans only provide payment once a yearly deductible is met and or only pays a percentage of the fee. The portion of the fee not paid by your insurance company is your responsibility. We will submit a claim to your insurance carrier for payment to be made directly to us. Since insurance companies vary greatly in types of coverage, we must look to you to be responsible for payment of your account after 60 days for all open charges. We suggest you keep in close contact with your insurance company regarding your claim to insure prompt payment. Please do not allow your account to become delinquent.

HMO/PPO or Contracted Insurance Coverage

We require that you pay for all co-payments at the time of service. We reserve the right to refuse medical care to you for non-emergent problems if you fail to pay for your co-payment at the time of service.

Medicaid

Prime Care Providers is a non-participating Medicaid provider not in network with Medicaid plans with the exception of UPMC FOR YOU. No copay for office visits with UPMC FOR YOU. Patients are held responsible for understanding and abiding by the terms of their plans. Patients must understand that their policies may fully cover only in-network providers and must additionally know who is in-network and who is not.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read all the information above and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

Please Print Patient's Name _____ Date of Birth _____

Signature _____ Date _____

HEALTH HISTORY
(Confidential)

NAME: _____ TODAY'S DATE: _____

AGE: _____ DATE OF BIRTH: _____ DATE OF LAST PHYSICAL EXAM: _____

SYMPTOMS: Check for any current symptoms, otherwise leave blank.

GENERAL/NEURO
___ Chills
___ Depression
___ Fainting
___ Fever
___ Forgetfulness
___ Headaches
___ Loss of Sleep
___ Loss of Weight
___ Nervousness/Anxiety
___ Numbness
___ Sweats

SKIN
___ Bruise Easily
___ Hives
___ Itching
___ Change in Moles
___ Rash
___ Scars
___ Sore That Won't Heal

GASTROINTESTINAL
___ Appetite Poor
___ Bloating
___ Constipation
___ Diarrhea
___ Excessive Hunger
___ Excessive Thirst
___ Gas
___ Indigestion
___ Nausea
___ Rectal Bleeding
___ Stomach Pain
___ Vomiting
___ Vomiting Blood

URINARY
___ Blood in Urine
___ Frequent Urination
___ Lack of Bladder Control
___ Painful Urination
___ Kidney Stones

EYE, EAR, NOSE, THROAT
___ Bleeding Gums
___ Blurred Vision
___ Crossed Eyes
___ Difficulty Swallowing
___ Double Vision
___ Earache
___ Ear Discharge
___ Hay Fever
___ Hoarseness
___ Loss of Hearing
___ Nosebleeds
___ Persistent Cough
___ Ringing in Ears
___ Sinus Problems
___ Vision Flashes
___ Vision Holes

MUSCLE/JOINT/BONE
Pain, numbness, or weakness in:
__Arms __Hands __Neck
__Back __Hips __Shoulders
__Feet __Legs

ENDO/IMMUNO
___ Excessive Thirst
___ Heat Intolerance
___ Cold Intolerance
___ General Weakness
___ Lymph Nodes
___ Easy Bruising

CARDIOVASCULAR
___ Chest Pain
___ High Blood Pressure
___ Irregular Heart Beat
___ Low Blood Pressure
___ Poor Circulation
___ Rapid Heart Beat
___ Swelling of Ankles
___ Varicose Veins
___ Wheezing
___ Shortness of Breathe
___ Difficulty Breathing

CONDITIONS: Please check all that apply that you have or have had in the past.

___ AIDS
___ Alcoholism
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bleeding Disorders
___ Breast Lump
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___ Chemical Dependency
___ Chicken Pox
___ Diabetes
___ Emphysema
___ Epilepsy
___ Glaucoma
___ Goiter
___ Gout
___ Heart Disease
___ Hepatitis
___ Hernia
___ High Blood Pressure
___ High Cholesterol
___ HIV Positive
___ Kidney Disease
___ Liver Disease
___ Measles
___ Migraine Headaches
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Pacemaker
___ Pneumonia
___ Polio
___ Other: (List)
___ Prostate Problems
___ Psychiatric Care
___ Rheumatic Fever
___ Scarlet Fever
___ Stroke
___ Thyroid Problems
___ Tonsillitis
___ Tuberculosis
___ Typhoid Fever
___ Ulcers
___ Vaginal Infections
___ Venereal Disease

MEDICATIONS: List medications you are taking	ALLERGIES to any medications?

FAMILY HISTORY: Fill in information about your family to the best of your knowledge.

	AGE/AGE AT DEATH	STATE OF HEALTH	CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
SISTERS			

	Check if your blood relations had any of the following:
	Arthritis, Gout
	Asthma, Hay Fever
	Cancer (list type)
	Diabetes
	Heart Disease
	High Blood Pressure
	Kidney Disease, Dialysis

HOSPITALIZATIONS / SERIOUS ILLNESS

YEAR	HOSPITAL (if applicable)	REASON FOR HOSPITALIZATION / OUTCOME

SOCIAL HISTORY

HEALTH HABITS: Check which substances you use and Describe how much you use.

___ Alcohol _____
___ Caffeine _____
___ Drugs _____
___ Tobacco _____
___ Other _____

___ Married ___ Single ___ Widowed _Divorced

List type of work you do:

Describe your current household situation:

I certify that the above is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____