Stonecrest Family Medicine

# HEALTH HISTORY QUESTIONNAIRE – ADULT

Name:_____ Date:_____

Date of Birth:_____ ☐ Male ☐ Female Occupation:_____

Preferred Pharmacy:_____

## YOUR MEDICAL HISTORY

Please indicate if **YOU** have a history of the following:

☐ Alcohol Abuse
☐ Anemia
☐ Anesthetic Complication
☐ Anxiety Disorder
☐ Arthritis
☐ Asthma
☐ Autoimmune Problems
☐ Birth Defects
☐ Bladder Problems
☐ Bleeding Disease
☐ Blood Clots
☐ Blood Transfusion(s)
☐ Bowel Disease
☐ Cancer of:
_____
☐ COPD
☐ Depression
☐ Diabetes
☐ Growth/Development Disorder
☐ Hearing Impairment
☐ Heart Attack
☐ Heart Disease
☐ Heart Pain/ Angina
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Hives
☐ Kidney Disease
☐ Liver Disease
☐ Lung / Respiratory Disease
☐ Mental Illness
☐ Migraines
☐ Osteoporosis
☐ Reflux / GERD
☐ Seizures / Convulsions
☐ Severe Allergy
☐ Sexually Transmitted Disease
☐ Stroke / CVA of Brain
☐ Suicide Attempt
☐ Thyroid Problems
☐ Ulcer
☐ Visual Impairment
☐ Other Disease or Significant Medical Condition
☐ NONE of the Above

List other past medical problems:_____

## PERSONAL HEALTH HISTORY

**Surgeries and/or hospitalizations** ☐ I have had no surgeries or hospitalizations

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

Year_____ Reason_____ Hospital_____

**Have you ever had a blood transfusion?** ☐ **Yes** ☐ **No**

Date of last colonoscopy: _____ ☐ N/A

**Please list other physicians you have seen in last 12 months.**

Physician_____ Reason_____

Physician_____ Reason_____

Physician_____ Reason_____

Stonecrest
Family Medicine

# HEALTH HISTORY QUESTIONNAIRE – ADULT

Name:_____ Date:_____

## MEDICATIONS

Drug_____ Dose_____ Drug_____ Dose_____

Drug_____ Dose_____ Drug_____ Dose_____

Drug_____ Dose_____ Drug_____ Dose_____

Drug_____ Dose_____ Drug_____ Dose_____

☐ Additional medications listed on the back of this form
☐ I take no medications

## ALLERGIES

☐ Drug Allergy Drug Name_____ Reaction_____
☐ Latex Allergy
☐ No known drug allergies

## SOCIAL HISTORY

Smoker ☐ Never ☐ Former - Quit Date_____ ☐ Current – Packs Per Day_____
Alcohol ☐ Never ☐ Socially ☐ Frequent – Drinks Per Week_____
Coffee/Tea/Energy Drinks ☐ No ☐ Yes – Cups per Day_____
Personal Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow Children: ___ boys ___ girls
Illicit / Illegal Substance Use: ☐ Never ☐ Past ☐ Current:_____

## FAMILY MEDICAL HISTORY

Only include **YOUR** parents, grandparents, siblings and children.
☐ I am adopted and do not know biological family history

| | | |
|---|---|---|
| ☐ Family History Unknown | ☐ Colon Cancer | ☐ Migraines |
| ☐ Alcohol Abuse | ☐ Depression | ☐ Osteoporosis |
| ☐ Anemia | ☐ Diabetes | ☐ Other Cancer |
| ☐ Anesthetic Complication | ☐ Heart Disease | ☐ Rectal Cancer |
| ☐ Arthritis | ☐ High Blood Pressure | ☐ Seizures/Convulsions |
| ☐ Asthma | ☐ High Cholesterol | ☐ Severe Allergy |
| ☐ Bladder Problems | ☐ Kidney Disease | ☐ Stroke/CVA of the Brain |
| ☐ Bleeding Disease | ☐ Leukemia | ☐ Thyroid Problems |
| ☐ Breast Cancer | ☐ Lung/Respiratory Disease | ☐ NONE of the Above |

**Females Only: Gynecological History**

How many times have you been pregnant?_____ Ever have an abnormal PAP Smear ☐ Yes ☐ No

Number of live births?_____ Date of last Mammogram_____

Date of last PAP Smear_____ Have you ever had a breast biopsy ☐ Yes ☐ No

**By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.**

Patient Signature_____ Date_____


# Patient Information Sheet (Please Print)

| Patient Full Name | Date of Birth | Social Security Number |
|---|---|---|
| | | |

| Address (Including: city, state & zip code) | Marital Status<br>☐ Married ☐ Single ☐ Widow ☐ Divorced |
|---|---|
| | |

| Primary Language ☐ Not Disclosed<br>☐ English ☐ Spanish ☐ Other | Ethnicity ☐ Not Disclosed<br>☐ Hispanic ☐ Not Hispanic | Race ☐ Not Disclosed ☐ American Indian ☐ White<br>☐ Black ☐ Asian ☐ Pacific Islander ☐ Other |
|---|---|---|
| | | |

| Home Phone | Cell Phone | Email Address May we add you to our email list? ☐ Yes / ☐ No |
|---|---|---|
| | | |

| Work Status<br>☐ Full Time ☐ Part Time ☐ Student ☐ Retired ☐ Other | Employer | Work Phone |
|---|---|---|
| | | |

| Full Name of ☐ Spouse ☐ Partner ☐ Guardian | Cell Phone | Work Phone |
|---|---|---|
| | | |

| Emergency Contact (Not in household) | Relationship | Cell / Home Phone |
|---|---|---|
| | | |

| Responsible Party Name (if other than patient) | Relationship to Patient<br>☐ Spouse ☐ Parent/Guardian ☐ Power of Attorney ☐ Other |
|---|---|
| | |

| Responsible Party's Date of Birth | Please List Other Members of Household Seen at this Practice |
|---|---|
| | |

| **Primary Insurance Information** | | **Secondary Insurance Information** | |
|---|---|---|---|
| Insurance Plan | Subscriber | Insurance Plan | Subscriber |
| | | | |
| Subscriber SSN | Date of Birth | Subscriber SSN | Date of Birth |
| | | | |

- I consent Stonecrest Family Medicine to render treatment of medical care. I consent Stonecrest Family Medicine to disclose my protected health information for payment and coordination or management of my healthcare needs.
- I understand that Stonecrest Family Medicine will file primary and secondary insurance claims electronically and by signing this form I am giving permission to do so. I understand that it is my responsibility for knowledge of my individual or group insurance policy coverage or exclusions.
- CONTRACT TO PAY FOR MEDICAL SERVICES: I have read and I understand the Financial Policy of Stonecrest Family Medicine. I understand that I am responsible for payment of all co-pays, deductibles and non-covered and/or administrative services. I understand that I am fully responsible for payment of professional services rendered to me by Stonecrest Family Medicine.

Patient Signature:_____ Date: _____

Patient Signature:_____ Date: _____

Patient Signature:_____ Date: _____

Patient Signature:_____ Date: _____

Updated 9-2014


# Financial Policy

- Copayments: All copayments are due at the time of service. If you are unable to pay your copayment at the time of service, your appointment may be rescheduled.
- Deductibles/Co-Insurance: You may be asked to pay a down payment toward your insurance deductible or co-insurance at the time of service. Any overpayments will be held on the account as a credit and applied toward future visits.
- Patient Balances: Prior patient balances will be collected before you are seen. If you are unable to pay the balance in full, you will be required to set-up a payment plan with our billing office.
- Family Billing: Our practice tracks balances by households. You may be asked to make payment on an account for someone in your household.
- Self-Pay: A down payment of $100.00 is required before services are rendered. Payment of all services rendered is due at checkout.
- Nurse Visit: A nurse visit will be billed when certain services are rendered by a medical assistant that do not have a specific CPT code attached. This includes blood pressure checks. A nurse visit is subject to co-payment, co-insurance and deductible liability designated by your particular insurance plan. (Injections will not be billed as a nurse visit.)
- Medical Records / Form Completion: There is a $1.00 per page or $25.00 charge for a disk of medical records after the first free copy. Completion of disability, FMLA, life insurance and other forms will be subject to a $25.00 charge. Unless specified, medical records will be issued on a disk.
- Returned Checks: There is a $50.00 charge for any returned check to our office. You will be required to pay previous balance and return check fee before future services are rendered. Failure to pay the balance and fee will result in a summons from Shelby County Attorney's office.
- Bankruptcy: If a balance is written-off due to bankruptcy, then any future visit(s) by any member of the household will require a $100.00 down payment on account before being seen.
- Collections: Our office will make several attempts to contact you regarding an unpaid balance. If our attempts fail, your account may be placed with an outside collection agency. If your account is forwarded to a collection agency, up to a 40% collection fee will be added to your outstanding balance, and you may be dismissed as a patient from our practice.
- Insurance Information: Our office will charge a $20.00 fee to re-file claims with a correct insurance carrier that was not given to our practice at the time of service.
- Controlled Substance (Green Script) Refill(s): Due to requirements mandated by the State of Kentucky, a $10.00 administrative charge will be applied to every controlled substance (green script) refill(s) outside of an office visit. The charge must be paid before green script(s) will be released to patient.
- Medication Prior Authorization Charge: Medications that require a Prior Authorization Form by your insurance company will be subject to a $20.00 administration fee. The fee must be paid before forms are filled out. Collection of the fee does not guarantee approval of the medication through your insurance company.
- Credit Card Authorization: Due to increasing billing expense and patient financial responsibility, Stonecrest Family Medicine is asking to keep your credit card information on file. The credit card information is stored securely.
- No-Shows: Our practice requires a 24-hour notice to cancel an appointment or it is considered a 'No-Show.' Three 'No-Shows' may result in dismissal from the practice. Arrival to appointment time more than 15 minutes late will be counted as a 'No-Show.'

I have read and understand the Financial Policy of Stonecrest Family Medicine, PLLC. If I have any questions regarding this policy, I will contact the Stonecrest Billing Department. I agree to the terms put forth in this policy.

| Patient Signature | Date | Date of Birth |
|---|---|---|

# Stonecrest Family Medicine

## HIPAA Notice of Privacy Practices

Stonecrest Family Medicine
101 Stonecrest Rd, Ste 3
Shelbyville, KY 40065
(502) 633-5565

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

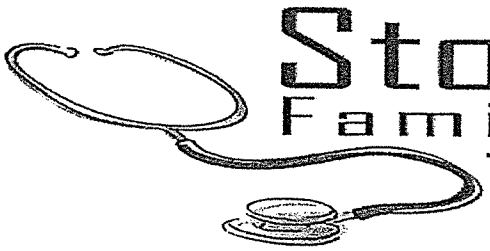
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:**
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:**
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:**
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.



# Stonecrest Family Medicine

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply)** – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You have the right to request an amendment to your protected health information** – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

## COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Stonecrest
Family Medicine

## Notice of Privacy Practices Acknowledgment

Stonecrest Family Medicine
101 Stonecrest Rd, Ste 3
Shelbyville, KY 40065

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date:_____ Attempt:_____

Staff Name:_____

Stonecrest
Family Medicine

# Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

Stonecrest Family Medicine, PLLC is authorized to release protected health information about the above named patient to the entities named below.

| Authorized Person to Receive Information: Please check each person that is authorized to receive information. | Description of Information to be released: Please check what information the person on the left is able to receive. |
|---|---|
| ☐ SELF ONLY<br>(No one else is authorized to receive medical or financial information.) | |
| ☐ VOICEMAIL<br>Phone Number:_____ | ☐ General Medical<br>☐ Lab / X-Ray Results<br>☐ Financial Information |
| ☐ SPOUSE (Provide Name)<br>_____ | ☐ Medical Information<br>☐ Financial Information |
| ☐ PARENT (Provide Name)<br>_____ | ☐ Medical Information<br>☐ Financial Information |
| ☐ Other (Provide Name)<br>_____ | ☐ Medical Information<br>☐ Financial Information |

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy protected health information to be disclosed as described in this document. I understand that revocation is not effective in cases where information has already been disclosed, but will be ongoing. I understand that information used or disclosed as a result of this authorization maybe subject to disclosure by the recipient and may no longer be protected by federal or state law. Authorization will remain in effect until revoked by patient.

_____ _____

Patient or Guarantor Signature Date

Stonecrest Family Medicine

11-2014

## CREDIT CARD ON FILE AUTHORIZATION

At Stonecrest Family Medicine, PLLC, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure in an off-site portal, and payments to your card are processed only after the claim has been filed and processed by your insurance, and the insurance portion of the claim has paid and posted to the account. If an email address is provided, you will be sent an email when we run a payment.

I (we), the undersigned, authorize and request Stonecrest Family Medicine to charge my credit card, indicated below, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Stonecrest Family Medicine. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30 day notification to Stonecrest Family Medicine, PLLC in writing and the account must be in good standing.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

Internal Use: Stored in Vault: Date_____ Initials_____
Billing ID_____ Alert Added to _____

**I authorize Stonecrest Family Medicine to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

☐ Visa ☐ Mastercard ☐ Discover

**Expiration Date** _____ / _____ / _____

**Credit Card Number** _____

**Cardholder Name** _____

**Signature** _____

**Billing Address** _____

**City** _____ **State**_____ **Zip** _____

**Phone #:**_____

**Email:**_____ **Your receipt will be emailed.**

**Family Members attached to this account:**_____