Maineville Family Physicians

Patient Registration

Patient Name: _____ DOB:_____Age:____SS#:_____SEX:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work:_____Cell:_____

Emergency Contact:_____ Relationship:_____ Phone: _____

Primary Insurance**:**_____Policy Holder Name:_____

SS#of Policy Holder_____ DOB of Policy Holder:_____ Relationship to Pt:_____

Secondary Insurance:_____Policy Holder Name:_____

SS#of Policy Holder_____ DOB of Policy Holder:_____ Relationship to Pt:_____

If Patient is a minor please provide the responsible party (Guarantor) information below:

Guarantor Name (Print): _____ SS# _____ DOB _____

Address if different than above: _____

City_____ State_____ Zip_____ Phone_____

I agree to be responsible for the above patient financial until written notice is provided to the office to notify otherwise. Written notice must provide a 30 day notice of change in financial guarantor status. Under no circumstance will the 30 day period be waived for guarantor.

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier. I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on insurance carrier. Copays and balance is payable at the time of services I will be responsible for any fees incurred for non-covered services, as each service has been individually financially counseled prior to completion of office visit or service. I will be responsible for all fees that are depicted in the financial policy, and I hereby agree that I have read and understand the financial policy. I understand if I am a Medicaid or Medicare participant that I will be responsible for non-covered services and agree to pay such charges. Initial that you agree with above information ____

I have received a copy of the HIPPA Policy/ Privacy Practice. Initial _____

A copy of the signature is a valid as the original.

Print Name_____ Signature_____ Date _____

Maineville Family Physicians HIPPA Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USE AND DISCLOSED HOW YOU CAN GET ACESS TO THIS INFORMATION

General Rule

We respect our legal obligations to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices.

Generally, we cannot use your health information in our office or disclose it outside of our office without your written permission. Sometimes the written permission will be called a consent form and sometimes it will be called and authorization form. The type of permission form will depend upon the kinds of uses or disclosures that are involved. In some limited situations, the law allows or requires us to disclose your health information without either a written consent or authorization.

Uses or Disclosures with Consent

We will ask you to sign a consent form allowing us to use and disclosed your health information for purposed of treatment, payment and health care operations of this office. We are allowed to refuse to treat you if you do not sign the consent form.

We use information for treatment purposes, when, for example, we set up an appointment for you with another physician or specialist. We may disclose your health information outside of our office for treatment purposes, if, for example, we send you to another doctor or clinic for consultation or other medical services or when we provide a prescription for medications to a pharmacist. Sometimes we may ask for copied of your health information from another professional that you may have seen before us.

We use your health information for payment purposes when, for example, our staff asks you about health care plans that you may belong to or about other sources of payment for our services, when we prepare bills to send to you or your health care plan, when we process payments by credit card and when we try to collect unpaid amounts due. We may disclose your health information outside of our office for payment purposes when for example, bills or claims for payment are mailed, faxed or sent by computer to you or your health plan or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for health care operations in a number of ways. Health care operations mean those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans for the defense of legal matters, to develop business plans and for outside storage of our records.

Unless you object, we may disclose to a member of your family, a relative, close friend or any other person your identity your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such disclosure we may disclose

such information necessary if we determine that it is in your best interest based upon our professional judgment. We may disclose such health information to notify or assist in notifying said identified person that is responsible for your care, of your location, general condition or death.

We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Uses and Disclosures without Consent or Authorization

In some limited situations the law allows or requires us to use or disclose your protected health information without your permission. Not all of these situations will apply to us. Some may never come up at our office at all. Such potential uses or disclosures are:

when a state or federal law mandates that a certain health information be reported for specific purpose

for public health purposes, such as contagious disease reporting, investigation or surveillance and notices to and from the Food Administration regarding drugs or medical device

to government authorities about victims of suspected abuse, neglect or domestic violence

for health oversight activities such as for the licensing of doctors for adults by Medicare or Medicaid, or for investigation of possible violations of health care laws

for judicial and administrative proceedings, such as in response to subpoena or orders of courts or administrative agencies

for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere

to a medical examiner to indentify a dead person or to determine the cause of death, or to funeral directors to aid in burial or to organizations that handle organ or tissue donations

for health related research

to prevent a serious threat to health or safety

for specialized government functions, such as for the protection of the U. S. President or other high ranking government officials, for lawful national intelligence agencies, for military purposes or for the evaluation and health members of the foreign service

relating to worker compensation programs

to business associates who perform health care operations for us and who agree to keep your health information private

if you are an inmate of correctional facility and your healthcare provider creates or provides information in the course of providing care to you

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you. We may also call to notify you of the results of special testing that have been ordered for any ongoing treatment.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. If you sign one, you may revoke it any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information. You can:

Ask us to restrict our uses and disclosures for purposes of treatment except emergency treatment, payment of health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the Office Manager at the address or fax number shown at the beginning of this notice

Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at your home, by mailing health information to a different address. We will accommodate these requests if they are reasonable and if you pay us for any extra cost. If you want to ask for confidential communications, send written request to the Office Manager at the address or fax at the beginning of this notice

Ask to see or to get photocopies of your health information. By law there are few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the Office Manager at the address or fax shown at the beginning of this notice

Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60-days from when you ask us. We will send the corrected information to persons who we know received the wrong information and others that you specify. If we do not agree you can write a statement if your position and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of

Position and or our rebuttal is included in your health information we will send it along whenever we make a permitted disclosure of your health information. By law we can have one 30day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request including your reasons for the amendment to Office Manager at the address or fax shown at the beginning of this notice

Get a list of the disclosures that we have made of your health information within the past six years (of a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60-days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send written request to the Office Manager at the address or fax shown at the beginning of the notice

Our Notice of Privacy Practices

By, law we must abide by the items of this Notice of Privacy Practices until we choose to change it. We respect the right to change this notice at any time in compliance with and as allowed by law. If we change this notice the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office and post it on our website.

Complaints

If you think that we have not properly respected the privacy of your health information you are free to complain to us or the U.S. Department of Health and Human Services Offices for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send written complaint to the Office Manager at the address or fax shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices call or visit the Office Manager at the address or phone number shown in the beginning of this notice.

This notice was published and becomes effective January 1, 2008. This does not have a termination date.

Maineville Family Physicians

Patient Name (Print) _____ , I have received, read, and understand the HIPPA Policy that Maineville Family Physicians have in place. I do not have any questions regarding said policy.

Patient Signature _____ Date: _____

Maineville Family Physician

History and Review of Systems

Name:_____ DOB_____

History of Medical Problems: Please circle the conditions which you have been diagnosed with by a physician and the year or age you were when diagnosed.

Condition/Year or age at diagnosis

ADHD, with or without hyperactivity (please circle which one)
Alcoholism
Allergic rhinitis
Alzheimer's disease
Anemia
Asthma
Cancer, what type?
Carotid Stenosis (narrowing of the arteries in the neck)
Cataracts
Cerebrovascular Accident (stroke)
Cervical disc disease (herniated discs in neck)
Congestive Heart Failure (CHF)
COPD (emphysema)
Colonic polyps (ployps in the colon)
Coronary artery disease (clogged heart arteries)
Myocardial infarction (MI or heart attack)
Crohn's disease
Deep Venous Thrombosis (DVT) (blood clot in leg requiring Coumadin)
Dementia
Diabetes mellitus, type 2 (adult onset)
Diabetes mellitus, type 1 (child onset)
Eczema
Fibromyalgia
GERD/hiatal hernia/PUD (ulcers)
Glaucoma
Gout
Hemorrhoids
Hyperlipidemia (high cholesterol)
Hypertension (high blood pressure)
Hypothyroidism (low thyroid function)
Irritable Bowel Syndrome (IBS)
Kidney disease
Kidney Stones
Liver disease
Lumbar Disc Disease (herniated discs in low back)
Lumbar Spinal Stenosis (narrowing of spinal canal in low back)

Name:_____ DOB_____

Condition/Year or age at diagnosis

Lupus (SLE)
Macular Degeneration
Migraine headache
Obesity
Osteoarthritis (arthritis form overuse or aging)
Osteoporosis
Parkinson's Disease
Peripheral artery disease (arterial blockage in legs or aorta)
Pulmonary Embolism (blood clot to the lung)
Psoriasis
Rheumatoid arthritis
Seizure disorder (epilepsy)
Sleep apnea
Subarachnoid hemorrhage (bleeding brain aneurysm)
TMJ syndrome
Ulcerative Colitis
Venous Stasis (swelling in legs due to poorly functioning veins)

Mental Illness
Condition/Year or age at diagnosis
Bipolar disorder (manic depressive disorder)
Depression
Suicide attempt(s)
Generalized Anxiety disorder
Mental retardation/ Developmental Delay
Obsessive Compulsive Disorder (OCD)
Panic Disorder
Post-traumatic stress disorder (PTSD)
Schizophrenia
Other mental illness

Conditions for Men Only
Condition/Year or age at diagnosis

Benign Prostatic Hypertrophy (BPH)
Elevated PSA
Erectile dysfunction (ED or impotence)
Genital Herpes
Prostatitis
Other

Name:_____ DOB_____

Conditions for Women Only
Condition/Year or age at diagnosis

Benign breast lump
Cervical Dysplasia
Dysmenorrhea (abnormally painful periods)
Endometriosis
Fibrocytic breast change
Genital herpes
Premenstrual Dysphoria Disorder (PMDD)
Other

Surgical History

Please circle the surgeries you have had and write the year completed or your age when surgery was performed.

Never had any surgery (Skip to Family History)

Orthopedic Surgery Age or time of surgery

Arthroscopic surgery (scope of the knee? Shoulder? Elbow? Which side Right, Left, or Both?
Bunionectomy (removal of bunions) Right? Left? Or Both?
Carpal Tunnel release? Right? Left? Or Both?
Ganglion Cyst surgery? Right, Left, or Both
ORIF (open reduction and internal fixation-plates, screws or pins for broken bones) which bone? Right, Left or both
Spine surgery of neck? Low Back?
Total Joint Replacement of Knee? Hip? Right? Left? Both?
Other orthopedic surgery not mentioned?

Surgery for Women Only/ Year or age at diagnosis

Breast biopsy Benign (no cancer)? Right or left or both?
Brest augmentation or reduction
Bilateral Tubal Ligation: (tubes tied)
C-Section for what reason?
D&C (cleaning out uterus) why?
Endometrial ablation? (Burning out the lining of the uterus to stop periods)
Laparoscopic surgery why?
LEEP surgery (partial removal of cervix for abnormal PAP smears)
Total Abdominal Hysterectomy with or without removal of right or left or both ovaries? Why? Any Cancer?
Vaginal Hysterectomy with or without removal of
Other female surgery?

Name:_____ DOB_____

Surgery for Men Only/ Year or age at diagnosis

Breast biopsy
Prostatectomy (removal of prostate)
Prostate biopsies?
TURP (remaining procedure of enlarged prostate)
Testicular surgery
Vasectomy
Other male surgery

General Surgeries/Year or age at diagnosis

Appendectomy (appendix out)
Angioplasty with/ without coronary artery stent?
CABG (cardiac bypass surgery) If so, how many vessels were bypassed?
Cancer Surgery
Carotid Endarterectomy (removing plaque buildup in carotid arteries due to blockage)
Cataract Surgery, Right, Left, or Both?
Cholecystectomy (gallbladder removed) laparoscopic or open?
Gastric bypass, which kind?
Hemorrhoidectomy
Hernia repair, right or left or both sides? Inguinal or ventral or umbilical?
Surgical procedures to pen up blocked blood vessels in the arteries? Which kind?
Ear tubes?
Sinus surgery to pen up sinuses? Deviated septum?
Tonsillectomy
Adenoidectomy
Thyroidectomy
Wisdom teeth extraction under general anesthesia (put totally asleep)
Other surgery not mentioned?

Non-Surgical Testing Procedures/ Year or age procedure was completed

Cardiac Catheterization (angiogram)
Cardiac stress test
Colonoscopy
Dexascan (bone density scan)
EGD (stomach scope)
MRI of brain? Neck? Low back? Other?

Occupational Injuries
BWC cases? Date of Injury? Is the Case Open?

Name:_____ DOB_____

Allergies please list below

Medications please list below

Family History

Please complete your family's medical history. Please write in any significant medical conditons for each family member. Conditions could include cancer (indicate which kind), heart attack or heart disease, high cholesterol, high blood pressure (HTN), diabetes, adult onset vs child, COPD (emphysema), etc

If your family member is deceased, please circle that option and indicate at what age they died and what medical condition they died of.

Mother: Conditions? If deceased what age and condition?

Father: Conditions? If deceased what age and condition?

Maternal Grandmother: Conditions? If deceased what age and condition?

Paternal Grandmother: Conditions? If deceased what age and condition?

Maternal Grandfather: Conditions? If deceased what age and condition?

Paternal Grandfather: Conditions? If deceased what age and condition?

Name:_____ DOB_____

Family History Continued

Brothers: Conditions? if deceased, at what age?

Sisters: Conditions? If deceased, at what age?

Sons: Conditions? If deceased, at what age?

Daughters: Conditions? If deceased at what ager?

Other?

Social History

Do you smoke? Yes No Use to

Years Smoking?

Packs per day?

When did you quit?

Symptoms of nicotine addictions? Yes or No

Desire to quit? Yes or No

Do you drink alcoholic beverages?

Never

Occasional (1-2 drinks per day or less)

Moderate (>14 drinks per week)

Heavy (> 6 drinks per day)

Do you use illicit drugs? No/ marijuana/cocaine/hallucinogens/narcotics

Occupation? Student/homemaker/retired/employed part-time/employed full time/ unemployed

If applicable What kind of work do you do?

Where do you work?

Name:_____ DOB_____

Social History Continued

Marital Status:

Single

Married

Engaged

Widowed

Divorced

Involved in an opposite sex relationship/ Involved in same sex relationship.

Children: None or Names and month/ year born

Who do you live with?

I live alone

Spouse

Children

Siblings

Parents

Father

Mother

Significant Others

Maineville Family Physicians Financial Policy

Our Goal is to keep the cost of health care to a minimum while offering you maximum value. By choosing a family physician like us who can manage a multitude of medical conditions for your entire family, you are already making a cost effective choice for your health care needs. To keep your experience positive and your costs low, Please read and sign your acknowledgement of the following policy:

- **You** are responsible with presenting up to date insurance information at each office visit. Regardless of if the staff has requested the information you must inform us of all updates and changes to your insurance plans. If a medical service is denied by an insurance company you will be responsible for the bill, including Medicaid participants. Proof of eligibility lies with you the patient and you must keep us informed to ensure we can bill appropriately**. By initialing I understand that Maineville Family Physicians will bill me for any denied service and I accept financial responsibility for said service._____**
- Please notify us at check in of any demographic changes such as address, phone number, or name change.
- Please pay your copay or insurance stated deductible at the time of your service, as required by the terms of your insurance. We accept credit cards, personal checks, and cash. If we have to bill you for a copay that is not paid at the time of service we reserve the right to charge a $10 processing fee**. I understand the processing fee and agree to pay said fee understanding it is my responsibility to provide payment at the time of service: _____**
- If you are self-pay, then please be prepared to pay at the time of service. Maineville Family Physicians will grant you a 15% discount if you pay your balance in full on the day of service. If you are unable to make full payment at the time of service, a payment plan must be established with the biller at the time of service.
- **It is your responsibility to understand how your insurance works! Maineville family physicians does not know what is covered or not under your particular policy. We are happy to bill services; however, you the patient are ultimately responsible for the charge for the service regardless of whether it is considered covered by your insurance. Please initial that you understand and agree to be financially responsible for all medical services and charges associated with the practice of medicine that was rendered to you as a patient or to dependent you are financially responsible. _____**
- Divorce: In case of divorce or separation, **the parent authorizing treatment for a child or children will be the parent responsible for those subsequent charges.** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is still the authorizing parent's responsibility to collect from the other parent, not ours. **I understand by initialing I assume responsibility of my dependent child (the patients) medical expenses and agree to pay promptly. _____**
- Billing Procedures: Services are billed promptly to the insurance if you have not received an Explanation of Benefits (EOB) from your insurance or a rendering bill from MFP within 30 days please contact our offices.
- Payments: Your account **MUST** be current and payments made regularly each month to continue as established patients. Maineville Family Physicians reserves all rights to terminate a patient/physician relationship if your account is delinquent, you fail to adhere to your payment

policy, if your payments are late, or if you are referred to collection. Once that relationship is terminated you will not be allowed back into the practice for any circumstance, by initialing you understand the written policy and agree to adhere._____

- **Pat Due Accounts:** If your account becomes past due, we will take the necessary steps to collect the debt. We will refer all debits to a collection agency which **WILL** negatively affect your credit. When your debit is submitted to the collection agency all collections costs that are incurred are transferred to the patient or responsible party. **By initialing the following you agree to be financially responsible for all debt incurred with the collections, including but not limited to collection agency fees, attorney fees, court costs, and all other miscellaneous fees._____**

Miscellaneous fees:

1. Returned Checks: There is a $25.00 fee for any check returned by the bank.
2. Transfer of Records: There is a $25 charge to offset the expenses of sending your medical records to another doctor, insurance company, attorney, etc. The fee must be paid prior to the records request being completed.
3. No Show/ Late Cancellations Charge: On the second missed appointment or late cancellation within less than 24 hours' notice, there is a $25 charge that must be paid before the next appointment may be scheduled. Patients with 3 or more no shows/ late cancellations will be terminated from practice. **By initialing you understand it is your responsibility to provide at least 24 hours' notice, if not you will be subject to the stated policy and agree to be financially responsible. _____**
4. Prescription Refill Policy: **There is a $25 charge for the second or subsequent time that a scheduled appointment at the requested interval, a patient losing his or her prescription, or a patient requesting his or her prescription to be sent to another pharmacy than originally intended. By Initialing I agree to adhere to this policy and be financially responsible. _____**
5. Forms, FMLA, Disability Paperwork completion etc: There is a $25 charge to complete forms outside of an office visit because of the significant amount of time required to do this extra work.
6. Copay Processing Fee: As mentioned prior there is an additional $10 fee charged if you do not make payment at the time of service.

Therefore, having read and knowing the details of the Maineville Famiy Physicians Financial policy, I request that services be performed and I agree to be responsible for any charges incurred.

_____	**_____**	**_____**
Guarantor's Name	**Patients Name**	**Relationship to Patient**
_____	**_____**	**_____**
Signature of Guarantor	**Guarantor's SSN or DL#**	**Date**