Patient Data

Name: ____ ________________ **Gender**: M F TG
(Last) (First) (Middle) (Suffix or title)
Date of Birth: ______/ ______/______ **S.S.N.** ______-______-_______
Marital Status: S M D W Separated

Street & Apt #: ____
City: ________________________**State**: _______ **Zip**: _______-_______

Phone Numbers: **Preferred** ☐ ☐ ☐ **contact number?**
Home: ( )_______-____________
Work: ( ) _______- ___________
Cell: ( ) _______- ___________

E-mail: ____

Emergency Contact Person:

Name: ________________________
Relationship: ____________________
Phone: ________________________

Is this person your Care Giver? Y or N

Do you have an Advanced Directive? Y or N

Race (check applicable): ☐ ***Asian*** ☐ ***Black or African American*** ☐ ***American Indian or Alaska Native*** ☐ ***White***
☐ ***Native Hawaiian or other Pacific Islander*** ☐ ***Other*** ☐ ***Unknown/undetermined***
Ethnicity (check applicable): ☐ ***Hispanic/Latino*** ☐ ***Non-Hispanic/Non-Latino***
Preferred language (check applicable): ☐ ***English*** ☐ ***Spanish*** ☐ ***Portuguese*** ☐ ***Korean*** ☐ ***Other***

Responsible Party

The Responsible Party is the person who will be responsible for any unpaid balances after insurance payments.

Name: ____ ________________
(Last) (First) (Middle) (Suffix or title)
Street: ____
City: ________________________**State**: _______ **Zip**: _______-_______

Preferred Phone Number :( )_______-_____________
Date of Birth: ______/ ______/______ **S.S.N.** ______-______-_______
Relation to Patient: ____

Power of Attorney Information:

Name: ________________________
Addr: ________________________
Phone: ________________________

The Insurance Subscriber is the person who is the "holder" of the insurance policy covering the patient.

Name: ____ ________________
(Last) (First) (Middle) (Suffix or title)
Street: ____
City: ________________________**State**: _______ **Zip**: _______-_______

Preferred Phone Number :( )_______-_____________
Date of Birth: ______/ ______/______ **S.S.N.** ______**-**______**-**_______
Relation to Patient: ☐ ***Self*** ☐ ***Spouse*** ☐ ***Parent*** ☐ ***Other*** **Employer:** ____________________________

Other

	Insurance Carrier	Policy Number	Group Number	Subscriber Name / Relationship to Patient
Primary				
Secondary				

Preferred Pharmacy Name & Phone :______________________________

Prescription Plan Name, Phone and ID # : ______________________________

____

(Please provide a copy of your prescription plan card if applicable)

Other Physicians you see: ______________________________

Updated 12/2018 - Family Practice Associates of Upper Dublin

Please sign below. This is required for your benefits to be paid directly to the practice.

REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I request payment and authorize any healthcare benefits that are otherwise payable to me by any insurance provider, benefit plan or other third-party payer, under the terms of the insurance policy or benefit plan be paid directly to FPUD Health Providers I understand that:

* I may be responsible for payment in full of any amount due that is not covered or paid for by any insurance policy or benefit plan.
* If my account is referred to an attorney or agency for collection of any unpaid balances for which I am responsible, that I will also be responsible for reasonable attorney's fees and collection expenses.
* My obligation to pay may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.

RELEASE OF INFORMATION

I authorize AHP and/or their agents:

* To give the insurance provider, benefit plan, or other third-party payer, or their agents, any medical or other information necessary to receive payment or obtain authorization for services, supplies and equipment.
* To request and receive directly, on my behalf, any information related to my insurance policy or benefit plan (including, but not limited to, proof of my healthcare benefits).
* To file, on behalf of themselves or on my behalf, claims for benefits and/or appeals of any denied claims or authorization and to take action in my name against any insurance company, benefit plan or other third party payer, to receive any benefits that may be due or payable under the insurance policy or benefit plan.
* To give medical or other information to any healthcare practitioner providing healthcare services to me or receive information from them.

STATEMENT OF ASSISTANCE

I agree:

* To assist FPUD in collecting benefits that may be due or payable under my insurance policy or benefit plan for the services, supplies and equipment provided.
* To provide any additional information needed to process the claim for payment.
* That a photocopy or other reproduction of this document shall be considered as valid as the original.

______________________________ ______________________________ ______________________________

Signature of Patient / Signature of Person Authorized to Consent for Patient ***Relationship to Patient*** ***Date***

______________________________ ______________________________

Signature of Witness ***Date***

____

If the patient is unable to sign upon arrival, state the reason and initial

I certify that the information on this form is correct and current:

Date: ____________________ **Signature:** ____

Date: ____________________ **Signature:** ____

Date: ____________________ **Signature:** ____

For office use only:
Authorization Number________________________________ Dates _____________________ Review necessary? ____

Form should be completed at patient's first visit, whenever changes are indicated or at least annually per policy.

Updated 12/2018

Family Practice Associates of Upper Dublin
Medical Health History Form

Name: ______________________ **Date:** ___/___/___

Occupation: ______________________ **Birthdate:** ___/___/___ **Age:** _____ **Gender:** ☐ Male ☐ Female

Allergies to Medications, X-ray Dyes or other Substances: ☐ None

______________ ______________ ______________ ______________
______________ ______________ ______________ ______________
______________ ______________ ______________ ______________

Current Medications, Vitamins, Supplements, Herbs - Prescription and Over-the-Counter: ☐ None ***** List Name and Dose *****

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Past Medical History and Review of Symptoms

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight loss/gain	☐ Osteoporosis
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Low back problems
☐ Anemia	☐ T.B.	☐ Gall bladder disease	☐ Numbness of arms or legs
☐ Heart Disease	☐ Hay fever	☐ Colitis	☐ Skin diseases
☐ Chest Pain or tightness	☐ Abdominal discomfort	☐ Bruise easily	☐ Blood disorders
☐ Shortness of Breath	☐ Indigestion	☐ Thyroid Disease	☐ Sexually Transmitted Disease
☐ Swollen ankles	☐ Nausea / Vomiting	☐ Head or neck radiation	☐ Anxiety
☐ Palpitations	☐ Diarrhea	☐ Headache	☐ Depression
☐ Lightheadness	☐ Constipation	☐ Kidney disease	☐ Alcohol abuse
☐ Frequent urination	☐ Blood in stool	☐ Kidney stones	☐ Drug abuse
☐ Rheumatic Fever	☐ Ulcers	☐ Difficulty passing urine	☐ Gout
☐ Asthma	☐ Hepatitis	☐ Difficulty holding urine	☐ Sleep Problems

Gynecologic and Obstetric History: Women only

Age at onset of periods: ____________ Frequency: ____________ Length of Period: ____________

Pregnancies: ____________ Births: ____________ Miscarriages: ____________

Prolonged or abnormal bleeding? ☐ No ☐ Yes (Please describe) ____________

Leakage of urine? ☐ No ☐ Yes (Please describe) ____________

Pelvic Pain? ☐ No ☐ Yes (Please describe) ____________

Abnormal Discharge? ☐ No ☐ Yes (Please describe) ____________

History of abnormal Pap smear? ☐ No ☐ Yes (Please describe) ____________

Past Medical History and Review of Symptoms

☐ High Blood Pressure	☐ Bronchitis	☐ Change in bowel habits	☐ Arthritis
☐ Diabetes	☐ Pneumonia	☐ Unexplained weight loss/gain	☐ Osteoporosis
☐ Cancer	☐ Persistent cough	☐ Hemorrhoids	☐ Low back problems
☐ Anemia	☐ T.B.	☐ Gall bladder disease	☐ Numbness of arms or legs
☐ Heart Disease	☐ Hay fever	☐ Colitis	☐ Skin diseases
☐ Chest Pain or tightness	☐ Abdominal discomfort	☐ Bruise easily	☐ Blood disorders
☐ Shortness of Breath	☐ Indigestion	☐ Thyroid Disease	☐ Sexually Transmitted Disease
☐ Swollen ankles	☐ Nausea / Vomiting	☐ Head or neck radiation	☐ Anxiety
☐ Palpitations	☐ Diarrhea	☐ Headache	☐ Depression
☐ Lightheadness	☐ Constipation	☐ Kidney disease	☐ Alcohol abuse
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☐ Rheumatic Fever	☐ Ulcers	☐ Difficulty passing urine	☐ Gout
☐ Asthma	☐ Hepatitis	☐ Difficulty holding urine	☐ Sleep Problems
______	______	______	______

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Leakage of urine? ☐ No ☐ Yes (Please describe) ______

Pelvic Pain? ☐ No ☐ Yes (Please describe) ______

Abnormal Discharge? ☐ No ☐ Yes (Please describe) ______

History of abnormal Pap smear? ☐ No ☐ Yes (Please describe) ______

Operations & Hospitalizations (List Year and type of operation or diagnoses after hospitalization)

____	______	____	______	____	______
____	______	____	______	____	______
____	______	____	______	____	______

Immunization History	Year	Other Vaccines	Year
Last Tetanus Shot?	______	Lyme Vaccine?	______
Pneumovax Shot?	______	Hepatitis A Vaccine?	______
Flu Shot?	______	______	______
Hepatitis B Vaccine?	______	______	______

Screening Tests (Last One)	Year
Mammogram?	______
Breast Exam?	______
Pap Smear?	______
Cholesterol Check?	______
Stool Check for blood?	______
Prostate Exam?	______

Family History

Illness	GF	GM	F	M	Br	Sis	Child		Age(s) when Diagnosed
Cancer (type):									
Hypertension									
Diabetes									
Strokes									
Mental Disease (anxiety, depression)									
Drug or Alcohol addiction									
Glaucoma									
Bleeding Diseases									
Other:									

Prevention:

Do you wear seat belts? ☐ Yes ☐ No

Do you wear a bike helmet? ☐ Yes ☐ No

Do you smoke? Amount: ☐ Yes ☐ No

Do you drink alcohol beverages? ☐ Yes ☐ No

Do you drink coffee? Amount: ☐ Yes ☐ No

Do you drink tea? ☐ Yes ☐ No

Is there a gun in your home? ☐ Yes ☐ No

Do you use drugs? Type: ☐ Yes ☐ No

Have you ever engaged in any activity which would put you at risk of AIDS? ☐ Yes ☐ No

Women: Do you perform self breast exams? ☐ Yes ☐ No

Men: Do you perform self testicular exams? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Are you following a specific diet? ☐ Yes ☐ No

If so, type of diet:

Do you ever feel afraid of your partner? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

Do you have a donor card? ☐ Yes ☐ No

Have you ever worked with chemicals, paints, asbestos or other hazardous material? ☐ Yes ☐ No

Voice-Mail Authorization

I recognize that timely delivery of results of tests or other communications of health care information is important to the delivery of quality health care. I understand that there may be times when it is more efficient and/or effective to receive information telephonically. In order to allow for the free-flow of such information, the following acknowledgement is executed.

My signature below acknowledges that it is permissible for members of this practice to communicate medical information to me by calling me at the following number: ___________________________. If I do not answer and a voice mail system or answering machine is initiated, the practice is authorized to leave information related to my medical condition on that voice mail system or answering machine. I recognize that this may mean that others that are in the vicinity of the system or machine or that have access to it may have access to an audio transmission of my private health care information. However, the risk of any such incidental disclosure is so small and/or I do not have such privacy concerns in my household, that the benefits of efficient delivery of my healthcare information significantly outweighs any risks involve.

This authorization does not apply to the release of records related to psychotherapy, HIV or drug and alcohol testing, which are subject to more specific protections afforded by state law.

I recognize that I have the right to revoke this authorization at any time by calling the practice. Also, this authorization only allows for such communication that is related to past, present or on-going treatment of me. Any authorizations required by the privacy rule issued as a result of the Health Insurance Portability Act of 1996 (“HIPAA”) that are for the release of information to someone other than myself will require a separate authorization form and is not incorporated into this document.

I acknowledge and understand the above:

____ ________________

Signature of Patient/Legal Guardian/Legal Representative Date

____ ________________

Name of Personal Representative Relationship to Patient

PATIENT NOTICE OF PRIVACY PRACTICES

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.

WHO WILL FOLLOW THE PRACTICES OUTLINED IN THIS NOTICE?

We recognize that information about your health and the care you receive is very sensitive and personal, and we will use every effort to protect that information in accordance with our privacy practices. This Notice describes the privacy practices of Family Practice Associates of Upper Dublin (FPUD), employees, physicians employed by FPUD, medical staff members of FPUD and other volunteers and students training at FPUD. These persons and programs may share your medical information with each other for purposes of your treatment, payment for your care, or general health care operations as described in this Notice.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your health information and to provide you with this Notice of our legal duties and privacy practices and your rights with respect to the health information we collect, create and maintain about you. Family Practice Associates of Upper Dublin (FPUD) will abide by the terms of this Notice currently in effect. We are required to notify you if your information has been affected by a breach of unsecured protected health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We are either permitted or required by law to use and/or disclose your health information for various purposes. We cannot describe every possible use or disclosure of your health information in this Notice. However, uses or disclosures that we are permitted or required to make will generally fall within one of the following categories:

We will use your health information for your treatment – We are permitted to use and/or disclose your information for treatment: the provision, coordination, or management of your health care and related services among the providers of such care. For example: we may share your health information with other providers involved in your care, such as specialists or other health providers you see, to recommend your course of treatment, and to remind you about appointments at Family Practice Associates of Upper Dublin (FPUD).

We will use your health information for payment purposes – We will use and disclose information about your care to obtain payment for such care. For example, we may send a bill to you, your insurance company and/or a third party payer for the services we provide to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We will use your health information for our health care operations – We may use or disclose your information for our administrative activities necessary to run Family Practice Associates of Upper Dublin (FPUD). For example, we may use health information to review the quality of our treatment and services, evaluate the performance of our staff in caring for you, and to physicians, nurses, technicians, students and other staff for review and learning purposes.

Facility Directories – We may include your name, location in the facility, and general condition in the hospital's facility directory. The directory information may be released to anyone who asks for you by name. Your religious affiliation may also be given to a member of the clergy, such as a pastor, priest or rabbi, even if they don't ask for you by name. You have the opportunity to tell us that you do not wish to be included in the facility directory and/or you do not want us to release any information to the clergy.

Personal Representatives – We may disclose your health information to your guardian, or someone you have named as your Power of Attorney for healthcare decisions, or to someone you have authorized to make decisions on your behalf in a Living Will or other health care directive, and in the event of your death, to your executor or administrator.

Family Members – Unless you communicate your objection to us, we may disclose to individuals such as family members or close friends, information relevant to their involvement in your care or for payment for your care. We may use and disclose information to identify and locate family members or other persons to inform them about your location and general condition. This includes emergency circumstances when you are not able to object to the disclosure and in disaster circumstances, where we may disclose information to an entity assisting in the relief effort, so that your family can be notified about your location and/or condition.

Fundraising – We may contact you in an effort to raise money for Family Practice Associates of Upper Dublin (FPUD) and its programs, facilities and operations. You have the right to opt out of these communications if you do not wish to receive them.

Business Associates – In certain circumstances, we may disclose your information to outside entities with whom we have contracted to perform certain services for Family Practice Associates of Upper Dublin (FPUD). These include transcription services, software systems, billing services, collection services and consultants to assist in improving our operations. These entities, or business associates, are required to appropriately safeguard and protect the privacy and confidentiality of your health information.

As Required By Law – We will disclose your health information when required to do so by federal, state, or local law. For example, we may disclose your health information to the representatives of the Office for Civil Rights of the U.S. Department of Health and Human Services so that they may ensure that we are appropriately protecting the privacy of your health information.

To Prevent a Serious Threat to Health or Safety – We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others. Any disclosure, however, would be to someone able to help prevent the threat.

Organ and Tissue Donation – If you are an organ or tissue donor, we will release health information to organizations involved with organ donation banking, organ and tissue procurement and transplantation, as necessary to facilitate organ, tissue, or eye donation and transplantation.

Specialized Government Functions – We may disclose health information for certain specific government functions. For example, if you are a member of the armed forces, we will release your information as required by military command authorities, or to the Department of Veterans Affairs to determine your eligibility for certain benefits. We may also release health information to authorized federal officials for intelligence, counter-intelligence, or other national security activities as authorized by law.

Correctional Institutions – We may disclose health information about an inmate or individual in lawful custody to the correctional institution or law enforcement individual, if the information is needed for the provision of care to the individual or for the health and safety of others at the correctional institution.

Victims of Abuse, Neglect, or Domestic Violence – If we believe you are a victim of abuse, neglect, or domestic violence, we may, consistent with law, disclose your health information to a governmental authority, including a social service or protective services agency, authorized by law to receive such reports.

Workers' Compensation – We may release your health information for workers' compensation or similar programs that provide benefits for work-related injuries or illnesses.

Public Health – Consistent with law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability, to report vital

statistics such as deaths, to report child abuse, or to notify appropriate persons of adverse reactions to products or drugs of a product recall.

Health Oversight Activities - We may disclose health information to a health oversight agency for activities such as audits, investigations, inspections, licensure, and other activities that are necessary for the government to monitor the healthcare system, government programs and compliance with civil rights.

Lawsuits and Disputes – We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process, if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement – In certain situations, consistent with law, we may release limited health information for law enforcement purposes. This includes reporting certain types of wounds or physical injuries, or information we believe is the result of criminal conduct, and instances where information is requested from law enforcement officials for identifying or locating a suspect, fugitive or missing person.

Coroners, Medical Examiners and Funeral Directors – We may release health information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to allow them to carry out their duties.

Research – In limited situations, we may use your health information in connection with research activities or activities in preparation for research. In these situations, the use has been approved by a committee who will ensure the privacy of the information is protected.

Incidental Uses and Disclosures – We may use or disclose your medical information if it is a by-product of any of the uses or disclosures described above and it could not be reasonably prevented.

Participation in an HIO – We participate with one or more secure health information organization networks (each, an "HIO"), including an HIO called "HealthShare Exchange of Southeastern Pennsylvania, Inc., ("HSX"), which makes it possible for us to share your health information electronically through a secure connected network. We may share or disclose your health information to HSX and other secure HIOs, including HIOs contracted with the Commonwealth of Pennsylvania, and even HIOs in other states. Other health care providers, including physicians, hospitals and other health care facilities, that are also connected to the same HIO network as us can access your health information for treatment, payment and other authorized purposes, to the extent permitted by law.

You have the right to "opt-out" or decline to participate in HSX and other HIOs. To opt out of HSX, go to http://www.hsxsepa.org/patient- options-opt-out-back

YOUR AUTHORIZATION

Uses and disclosures of health information that do not fall within the categories listed above will be made only with your written authorization. For example, your authorization is needed for Family Practice Associates of Upper Dublin (FPUD) to use your health information for marketing purposes, or the sale of the protected health information. Additionally, your authorization and additional informed consent is needed for research outside of the limited situations described above.

There are certain types of health information subject to more stringent privacy protections, and the disclosure of this information requires your authorization, except for certain limited circumstances.

Psychotherapy notes, recorded by a mental health care professional documenting or analyzing the contents of a conversation during a private, group, joint, or family counseling session, are afforded additional protections, such as being kept separately from the medical record, and require the patient's authorization before they are disclosed. Other mental health records, drug and alcohol treatment information, and HIV-related information may be released only with your authorization, except in limited circumstances under state law.

If you provide us with authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your health information for the reasons covered by your written authorization. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care that we provided to you.

YOUR PRIVACY RIGHTS

You have rights regarding your health information. However, there are limited circumstances where we may deny these requests. You may make these requests by contacting either the Patient Advocacy Department or the Compliance Department. We may ask that your request be made in writing.

Right to view and receive your health information – You have the right to inspect and obtain a copy of your health information, with certain exceptions. We may charge a reasonable fee for any copying and mailing costs we incur.

Right to request an amendment of your health information – You have the right to request an amendment of your health information that you feel is incorrect or incomplete.

Right to request information on how your health information was disclosed – You have the right to receive an accounting of the disclosures we have made of your health information.

Right to request restrictions of your health information – You have the right to request restrictions and limitations on how we use and disclose your health information, either for treatment, payment, or operations functions as described above, or restrictions on disclosing information to certain individuals. However, we are not required to agree with your restriction, unless it is to restrict the disclosure of health information for payment and/or operations functions, where the item or service has been paid in full, out of pocket, by the patient.

Right to receive confidential communications – You have the right to request that your health information is received by an alternative means of communication, or at alternative locations. We will accommodate reasonable requests, such as requesting an alternative mailing address or phone number to receive your test results, or to not leave any information on an answering machine or with another member of your household.

Right to a paper copy of this Notice – You have the right to request a paper copy of this Notice.

Changes to our privacy practices – We are required to abide by the terms of this Notice. However, we reserve the right to change this Notice in the future. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. Updated Notices will be available upon request.

For more information or to report a complaint – If you have questions and/or would like additional information, you may contact our office at 215-646-1686. If you believe your privacy rights have been violated, you may file a complaint with Family Practice Associates of Upper Dublin (FPUD).
If you wish to send a written privacy complaint, you may send it to the address below.

Family Practice Associates of Upper Dublin (FPUD)
1244 Fort Washington Ave # E
Fort Washington, PA 19034

Patient Signature: ______________________________
Date: ______________________________

Revised Effective: 12/6/2018