PATIENT INFORMATION

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Last Name: _____ First: _____ Middle Initial: _____

Preferred Name: _____

DOB: ____/____/_____ SSN: _____

Home Address: _____ Sex: ▫ Male ▫ Female

_____

Marital Status: ▫ Married ▫ Divorced ▫ Widowed ▫ Separated

Occupation: _____

Telephone:_____ Cellphone:_____

Email:_____

May we send you emails? (i.e., appointment reminders, service offerings) ▫ Yes ▫ No

May we leave voicemails at the above telephone numbers? ▫ Yes ▫ No

Nearest friend/relative not living with you: _____ Relationship to patient: _____

Telephone:_____

WHERE DID YOU HEAR ABOUT US?

Referring physician: _____ Telephone: _____

▫ Physician ▫ ER ▫ Friend/Patient ▫ Advertisement ▫ Website ▫ Other (please list:_____)

INSURANCE INFORMATION

Primary Insurance Co.: _____ Address: _____

Subscriber Name: _____ SSN: _____

DOB: ____/____/_____ Policy Identification Number: _____

Group Identification Number: _____ Subscriber Relation to Patient:_____

Employer: _____ Phone:_____

Deductible:_____ Copay:_____

Secondary Insurance Co.: _____ Address: _____

Subscriber Name: _____ SSN: _____

DOB: ____/____/_____ Policy Identification Number: _____

Group Identification Number: _____ Subscriber Relation to Patient:_____

Employer: _____ Phone:_____

Deductible:_____ Copay:_____

Medical History

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Full Name:_____ Age: _____ Birthdate: ____/____/____

Address: _____ Sex: ▫ Male ▫ Female

_____ Home phone:_____

Occupation:_____ Work phone:_____

Phone:_____ Emergency Contact: _____

Marital Status: ▫ Married ▫ Divorced ▫ Widowed ▫ Separated

If married, spouse's name: _____

Children's names and ages: _____

Allergies

Are you allergic to any medications, x-ray dyes, or other substances? ▫Yes ▫No
If yes, please list (name and type of reaction): _____
_____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

▫Heart disease / Murmur / Angina ▫High cholesterol
▫High blood pressure
▫Low blood pressure
▫Heartburn (reflux)
▫Anemia or blood problems ▫Swollen ankles
▫Shortness of breathe
▫Asthma
▫Lung problems / cough
▫Sinus problems
▫Seasonal allergies
▫Tonsillitis
▫Ear problems
▫Eye disorder / Glaucoma ▫Seizures
▫Stroke
▫Headaches / Migraines ▫Neurological problems
▫Depression / Anxiety
▫Psychiatric care
▫Diabetes
▫Kidney / Bladder problems
▫Liver problems / Hepatitis
▫Arthritis
▫Cancer
▫Ulcers/colitis
▫Thyroid problems
▫Please describe any current or past medical treatment not listed above

_____
_____
_____

Please list your past surgeries:

_____
_____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name: _____ _____ _____ _____

Dose: _____ _____ _____ _____

Females: Gynecological History

How many times have you been pregnant? _____

Have you had an abnormal Pap Smear? ▫Yes ▫No
Diagnosis: _____Follow up: _____

Have you had a sexually transmitted disease? ▫Yes ▫No
Diagnosis: _____

Date of last mammogram: _____
Mammogram results: _____

Have you ever had a breast biopsy? ▫Yes ▫No
Diagnosis: _____

Date of last Pap Smear:_____

Family History

Has any member of your family (including children and parents) had any of the following illnesses:

Illness:	**Which family member?**
Anemia or Blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
HIV disease / AIDS	_____
Mental Illness / Depression / Stroke	_____
Other serious illness	_____

Social and Preventive History

Do you currently smoke or chew tobacco? ▫Yes ▫No
If no, have you in the past? ▫Yes ▫No
How many packs per day? _____

Do you drink alcohol, beer, or wine? ▫Yes ▫No
If no, have you in the past? ▫Yes ▫No
How many drinks per week? _____

Do you currently drink coffee and/or tea? □Yes □No
If yes, how many cups per day? _____

Do you exercise daily/weekly? □Yes □No

Do you use a seatbelt while driving? □Yes □No

Do you wear a helmet while riding a bike? □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/Legal Guardian Signature_____

Date _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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PLEASE COMPLETE TO HAVE YOUR RECORDS COPIED

PATIENT NAME: _____
LAST FIRST MI MAIDEN

DATE OF BIRTH: _____ SS#: _____

ADDRESS: _____
CITY STATE ZIP CODE

I AUTHORIZE _____ TO RELEASE MY PROTECTED HEALTH INFORMATION TO ARBOR PLACE FAMILY MEDICINE P.C.

PURPOSE OF DISCLOSURE: _____
(EXAMPLE: CONTINUUM OF CARE, RELOCATION, ETC.)

INFORMATION TO BE RELEASED:

- ***MEDICATION LIST, PROBLEM LIST, IMMUNIZATION FORM, DIABETIC/ HYPERTENSION FLOWSHEET**
- ***OFFICE NOTES FOR ONE LAST YEAR**
- ***MOST RECENT EKG, ECHO, EXCERCISE/NUCLEAR STRESS TEST**
- ***X-RAY REPORTS FOR THE ONE LAST YEAR**
- ***MOST RECENT SPIROGRAM/PFT/OXIMETRY**
- ***ANY DRUG/ALCOHOL, AIDS/HIV, STD, MENTAL HEALTH INFORMATION**
- ***OTHER**

I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS FROM THIS DATE.

I UNDERSTAND THAT MY HEALTHCARE AND PAYMENT FOR MY HEALTHCARE WILL NOT BE AFFECTED IF I DO NOT SIGN THIS FORM AND THAT I MAY REFUSE TO SIGN IT.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITTEN NOTICE. THIS AUTHORIZATION WILL CEASE TO BE IN EFFECT ON THE SATE OF THIS NOTCIE EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ACTER IN TRUST UPON THIS AUTHORIZATION

I UNDERSTAND A CHARGE MAY BE INCURRED FOR ARBOR PLACE FAMILY MEDICINE P.C. TO COPY MY RECORDS

_____
SIGNATURE DATE

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Patient Name: _____

DOB: _____

Consent to Medical Treatment

In consideration of medical services to be rendered to me (herein referred to as Patient) at Arbor Place Family Medicine P.C. (herein referred to as "Medical Practice"), Patient does hereby consent as follows:

1. Consent and Treatment Authorization

Patient (or the undersigned asking on behalf of Patient), who is requiring medical treatment, does hereby consent to the rendering of such care and treatment, which may include diagnostic procedures and such medical treatment and care as the Attending Physician or other physicians of the Medical Practice staff consider to be necessary and appropriate. In the event that the Medical Practice should decide that blood specimens should be provided by the Patient for testing purposes in the interest of the safety of those with whom Patient may come in contact, Patient does hereby consent to such blood withdrawal and for the testing thereof, as well as to the release of test information where this is deemed medically appropriate or required by law.

2. Disclaimer of Guarantee

Patient hereby acknowledges that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury and of adverse results. Patient hereby acknowledges that no guarantees have been made to Patient or those acting for Patient as the results of procedures which Patient may undergo while a patient of Medical Practice.

3. Acknowledgments of Patient

Patient understands that:

- It is customary, absent emergency or extraordinary circumstances, that no substantial or invasive medical procedures be performed upon a patient unless and until the patient has had the opportunity to discuss these procedures with the physician or other health professional so that the patient may be informed of the contemplated procedures.
- Each patient has the right to consent, or refuse to consent to any specific procedure or therapeutic course of treatment.

4. Patient Understanding of Consent

This Consent Form has been adequately and fully explained to Patient, and Patient, by his or her signature, indicates satisfaction as to an adequate understanding of this Consent and of its significance and that Patient is voluntarily executing the same.

5. Validity of Consent

This consent is valid during the entire term of my association with Arbor Place Family Medicine P.C. and may be relied upon by Arbor Place Family Medicine P.C. unless, and until, revoked by Patient, in writing.

PERSON GIVING CONSENT (SIGNATURE): _____

PERSON GIVING CONSENT (PRINT NAME): _____

RELATIONSHIP TO PATIENT IF NOT THE PATIENT: _____ DATE: _____

PATIENT UNABLE TO SIGN BECAUSE: _____

WITNESS: _____ DATE: _____

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

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Controlled substance medications (narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and abuse and are, therefore, clearly controlled by the local, state, and federal governments. They are intended to relieve pain or to improve function and/or ability to work and not simply to feel good. Because my doctor is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. **I AM RESPONSIBLE FOR MY CONTROLLED SUBSTANCE MEDICATIONS.** If the prescription or medication is lost, misplaced, or stolen or if I use the medication other than prescribed and run out of the medication, I understand that **IT WILL NOT BE REPLACED.**
2. **I WILL NOT REQUEST OR ACCEPT** controlled substance medication from another physician or individual while I am receiving such medication from Dr. Varughese or other provider. It is illegal to do so (NRS 453.391) and may endanger my health. The only exception is if it is prescribed while I am admitted to the hospital.
3. **REFILLS OF CONTROLLED SUBSTANCE MEDICATIONS:**
    1. Will be taken only on Monday, Tuesday, and Wednesday from 8:30 AM until 4:30 PM. I understand I must allow **5 working days for refills to be authorized by my doctor. All refills will be written. Refills will not be made at night, holidays or weekends.**
    2. In the event of excessive refill requests, I may be required to come in for reassessment before the refill is authorized.
    3. Refills will not be made “if I run out early”. I am responsible for taking my medication in the dose prescribed and for keeping track of the amount on hand.
    4. Refills will not be made on an “emergency basis” such as Friday afternoon because I realize that I will “run out over the weekend”. I must keep track of the medication and plan ahead.
    5. I will call in at least 24 hours ahead if I need assistance with a controlled substance medication prescription.
4. I understand that **IF I VIOLATE ANY OF THE ABOVE CONDITIONS, MY CONTROLLED SUBSTANCE PRESCRIPTIONS AND/OR TREATMENT MAY BE ENDED IMMEDIATELY.** If there is a violation involved in obtaining controlled substances from another individual as described above, I may also be reported to my other physician, local, and medical facilities, and other authorities.

I understand **THE MAIN TREATMENT GOAL IS TO IMPROVE MY ABILITY TO FUNCTION AND/OR WORK. IN CONSIDERATION OF THAT GOAL, I AGREE TO HELP MYSELF BY FOLLOWING BETTER HEALTH HABITS;** specifically involving exercise, weight control, and the use of tobacco or alcohol. I understand that only through following a healthy lifestyle can I hope to have the most successful outcome to my treatment.

PATIENT PRINTED NAME:_____

PATIENT SIGNATURE: _____ DATE:_____

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Patient Name: _____

DOB: _____

PATIENT ACKNOWLEDGEMENT OF PRACTICE POLICIES

Prescription Refills: It is our policy that you should be aware of your medications and when they will run out. Refill requests should be made through your pharmacy or at your visit, including mail order prescriptions. Weekend, walk-in or after hours refill requests cannot be honored. All refill requests may require up to 48-72 hours to address. All requests after 3:30 are considered the following business day. A follow up visit is often required prior to additional refills. Refills requested outside of routine appointments may incur a $10 refill charge that may conveniently be paid by phone. This fee helps cover administrative fees associated with chart review per your refill request outside of an office visit. ALL controlled medication refills outside of an office visit WILL incur a $10 charge.
Prior Authorizations: Many prescribed medications require prior authorization (PA). If your medication is denied, our staff may attempt this approval process for a $25 fee. Otherwise you may find an alternative medication then contact this office for review.
Pharmacy: By signing this document, you agree to disclose all medications and pharmacies that you currently use. Also, you give permission to Arbor Place Family Medicine to obtain medication history and to conduct pharmacy searches.

Appointments: There may be times your treatment will be provided by a Nurse Practitioner rather than Dr. Varughese without prior notification. Your appointment time has been set especially for you. A minimum 24 hour notice is required for appointment cancellation as a courtesy to other patient's seeking services. The first failure to comply with the cancellation/rescheduling policy will incur a $25 fee. The second failure to comply will result in a $50 fee. Additional no show occurrences will also incur a $50 fee and may result in "same day" scheduled appointments or possible dismissal from the practice.

FINANCIAL RESPONSIBILITY

Insurance co-payments, deductibles, and coinsurance: We will file in-network insurance claims as a courtesy. All insurance policies are different and many have separate fees or exclude certain services. It is your responsibility to contact your insurance company and determine coverage for services. You have the right to decline any service before it is performed. All co-pays must be paid at the time of service. If your deductible has not been satisfied for the year, you must pay the estimated OV allowed amount for your plan. Accounts with a history of slow payments, may be required to pay for the visit in full if the deductible has not been met at the time of service. All claims to your insurance should be paid in a timely fashion. If insurance does not pay promptly, charges will be transferred to patient responsibility. If requested and as a condition of service, you agree to sign an "advance beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance is billed. You agree to allow Arbor Place Family Medicine to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment of a claim to you directly, you agree to endorse the payment to the practice within 10 days of the post mark. By signing this form, you accept all financial responsibility for charges for services rendered.
Slow Insurance Response: You agree that if your insurance takes more than 60 days to respond to the claim that we shall consider your services your financial responsibility, and it will be your responsibility to seek reimbursement from your insurance company. Late fee charges may be applied.
Accident & Worker's Compensation: If the diagnosis for which you seek treatment is related to an auto or work related accident, we are willing to treat your medical conditions. However, you are required to pay in full at the time of service.
Patient Balances: Payment is expected immediately upon request. For your convenience, we accept cash, check, and several major credit cards. Payments may be made directly by phone. Any balance due

must be paid in full before additional appointments will be scheduled. Prior arrangements must be made with the billing department if a payment plan is requested. Appointments and medication requests may be delayed for failure to pay an outstanding balance. Interest charges will accrue to balances not satisfied within 30 days from the time of service. If we have filed a claim to your insurance company on your behalf, your statement may be delayed until your insurance responds. Such a delay can take months. The delay does not alter our policy of patient financial responsibility, and you will be liable for all fees and interest incurred for late payments.

Form Fees & Protocol: Our practice charges for additional paperwork outside of the completion of the medical record. This includes but is not limited to forms such as FMLA paperwork, disability forms, work release, adoption paperwork, and patient assistance forms. Paperwork may not be dropped off. An office visit is necessary and required for all documents to be completed, and it is the responsibility of the patient to have the paperwork in hand at the time of the visit. The provider may require additional time for completion, and a call will be placed to the patient when the paperwork is ready to be picked up. A standard work or school excuse may be issued at no charge if requested at the time of the visit.

Referrals: Referrals may be necessary by your insurance company for various reasons. If you need to seek treatment from a specialist, be aware that insurance referrals require 3-4 business days from the day of your request. Same day referral requests will not be honored to be fair to all patients. Complete information is required to include the name and location of the provider, the reason for seeking treatment, and any pertinent information required by your insurance company. It is the responsibility of the patient to keep up with their referral details and number of authorized visits.

Medical Records: The medical record is the property of the practice. Copies of your medical records are available with proper authorization upon request. The practice utilizes an outside vendor to handle all medical record requests, and may require up to 30 days to complete requests. Medical records may not be released for patient's with an outstanding account balance.

Release of Information: By signing this document, you give Arbor Place Family Medicine permission to release relevant medical information to your insurance carrier and/or outside laboratory services in addition to any referrals.

Patient Discharge: The practice reserves the right to discharge a patient for any reason. Please note that discharges may incur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plans as outlined by your provider.

By signing below, I understand and agree to Arbor Place Family Medicine practice policies.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

RELATIONSHIP TO PATIENT IF NOT THE PATIENT: _____

PATIENT UNABLE TO SIGN BECAUSE: _____

WITNESS: _____ DATE: _____

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ACKNOWLEDGEMENT and ACCEPTANCE of NO SHOW POLICY and COPAY POLICY
Effective January 1, 2007

NO SHOW POLICY

When a scheduled appointment cannot be kept, you must call at least 24 hours prior to the time of the appointment.

NO SHOW SERVICE CHARGE:
A $25.00 service charge for any missed appointment will be billed to the guarantor of the patient(s).

Arbor Place Family Medicine schedules appointments to assure that you as a patient are allowed a space of time to be given the care you need. If you do not notify us that you are not coming, then we continue to keep that time for you when in fact we could probably give the appointment time to another person in need.

WITHDRAWAL FROM CARE:
Arbor Place Family Medicine will withdraw from care to ALL patients whose guarantor accumulatively has three(3) NO SHOW visits on their record. NO EXCEPTIONS.

COPAYMENT POLICY

Per your insurance policy, you are required to pay your office visit copayment at the time of service.

These charges are not billable to your insurance plan and you accept full responsibility for payment.

Patient's Name:_____ Date of Birth: _____
(Please Print)

Guarantor's Name:_____

Guarantor's Signature:_____ Date:

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When you visit our office, it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs.

RELEASE OF INFORMATION
(PLEASE MARK YOUR PREFERENCES WITH A CHECK MARK)

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.

THIS *RELEASE OF INFORMATION* WILL REMAIN IN EFECT UNTIL TERMINATED BY ME IN WRITING.

MESSAGES

Please call (select all that apply):

[ ] My home _____

[ ] My work _____

[ ] My cell number _____

If unable to reach me [ ] you may leave a detailed message [ ] please leave a message asking me to return your call

I ACKNOWLEDGE THAT I HAVE BEEN MADE AWARE OF THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES AND HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS.

PATIENT NAME (PRINT): _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:

_____ DATE: _____

IF PERSONAL REPRESENTATIVE, GIVE RELATIONSHIP TO PATIENT: _____