New Patient Information

Welcome to our practice! Please complete these forms to the best of your knowledge.

First Name: *Middle Initial:* *Last:*

Address: *City:* *State:* *Zip:*

DOB: *SS#:* *Home Phone:* *Cell:*

Email: *Referred By:*

Employer: *Occupation:*

Work Address: *Work Phone:*

Emergency Contact/Relationship: *Phone:*

Medical Insurance: *ID:* *Group:*

Insurance Claims Address:

Insured First Name: *Middle Initial:* *Last:*

Insured DOB: *Relationship to Patient:*

Insured SS#: *Insured Employer:*

Insured Home Address: *Phone:*

Living Will/Advance Directives: ☐ Yes ☐ No

Release of information, benefit assignments, payment authorizations, full disclosure statement, and payment agreement:

I hereby authorize Family Health Associates of the Kanawha Valley to release my information necessary to process my insurance/Medicare claim, aquired in the course of my examination or treatment; to allow a photocopy of my signature to be used to process my insurance/Medicare claim for the period of a lifetime. I claim any insurance benefits due to me for services rendered by Family Health Associates of the Kanawha Valley, and authorize and direct any carrier to issue payment check(s) directly to Family Health Associates of the Kanawha Valley, regardless of my insurance benefits, if any. I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fee in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

Patient/Responsible Party Signature: *Date:*

New Patient Information

Full Name: *DOB:*

Previous Physicians:

Current Specialist Providers:

Concerns for today:

Hospitalizations (including reasons & dates):

Current Medications:

Medication Allergies (including reaction type):

Gender: ☐ Male ☐ Female *Number of Children:*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

Occupation: *How Many Years:*

Do you use tobacco products?: ☐ Yes ☐ No *If no, have you ever?:* ☐ Yes ☐ No *Date Quit:*

Which tobacco products?: ☐ Cigarettes ☐ Cigars ☐ Smokeless Tobacco ☐ E-Cigarettes *How much per day?:*

Do you drink wine, beer or liquor?: ☐ Yes ☐ No *How much?:* *How often?:*

Do you drink coffee?: ☐ Yes ☐ No *How much per day?:*

Do you drink other caffeinated beverages?: ☐ Yes ☐ No *How much per day?:*

Are you willing to participate with preventative measures? I.e: Colonoscopy, DEXA, Mammogram, etc. ☐ Yes ☐ No

New Patient Information

Full Name: _____ *DOB:* _____

Current Medical Problems:

- ☐ Hypertension/High Blood Pressure
- ☐ Hypothyroidism/ Underactive Thyroid
- ☐ GERD/Reflux
- ☐ Chronic Constipation
- ☐ Prior Heart Attack
- ☐ Seizure Disorder
- ☐ Diabetes
- ☐ Depression
- ☐ Migraines
- ☐ Asthma
- ☐ Osteoarthritis
- ☐ Irritable Bowel
- ☐ Prior Stents or Surgery
- ☐ Hyperlipidemia/High Cholesterol
- ☐ Anxiety
- ☐ Emphysema/COPD
- ☐ Fibromyalgia
- ☐ Seasonal Allergies
- ☐ Coronary Artery Disease
- ☐ Atrial Fibrillation

☐ Cancer _____ Other _____ ☐ Other _____

Prior Surgeries/Procedures:

- ☐ Dexa Scan
- ☐ Colonoscopy
- ☐ Tonsillectomy/Tonsils Removed
- ☐ Thyroid Removal
- ☐ Tubal Ligation/Tubes Tied
- ☐ Hysterectomy
  - ☐ Complete ☐ Partial
- ☐ Pap
- ☐ Upper Endoscopy/EGD
- ☐ Heart Stents
- ☐ Cholecystectomy/Gall Bladder Removed
- ☐ Mammogram
- ☐ Appendectomy
- ☐ Heart Bypass
- ☐ Hernia Surgery
- ☐ Vasectomy

☐ Other _____ ☐ Other _____ ☐ Other _____

New Patient Information

Full Name: *DOB:*

Family History:	*Mother*	*Father*	*Children*	*Siblings*	*Mother's Parents*	*Father's Parents*
Alcoholism	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer -*Type?:*	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Epilepsy/Seizure	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Suicide Attempt	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

New Patient Information

Date: _____/_____/_____

Full Name: *DOB:*

Payment Policy: *Please Initial*

•Insurance

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

•Co-payments & Deductibles

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

•Non-Covered Services

Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

•Proof of Insurance

All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

•Claims Submission

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract your insurance company; we are not party to that contract.

•Coverage Changes

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

•Nonpayment

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

•No-show

Please be aware - should you no-show an appointment with one of our providers, you will be charged a $40 no-show fee that must be paid in full prior to being seen.

New Patient Information

Date: _____/_____/_____

Full Name: *DOB:*

Patient Consent for Use and Disclosure of Protected Health Information (PHI):

With my consent, Family Health Associates of the Kanawha Valley may use and disclose protected health information (PHI) about me in order to carry out treatment, payment and healthcare operations (TPO). A more complete description of such uses and disclosures can be found in the Notice of Privacy Practices for Family Health Associates of the Kanawha Valley at www.familyhealthwv.com.

I have the right to review the aforementioned Notice of Privacy Practices prior to signing this consent. Family Health Associates of the Kanawha Valley reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at Family Health Associates of the Kanawha Valley, 509 2nd Avenue, South Charleston, West Virginia, 25303.

With my consent, a representative of Family Health Associates of the Kanawha Valley may call my home or other designated location and leave a message on an answering machine, voice mail, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results.

With my consent, Family Health Associates of the Kanawha Valley may mail to my home or other designated location any item that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

I have the right to request that Family Health Associates of the Kanawha Valley restrict how it uses or discloses by PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, such uses and disclosures are bound by this agreement. I have such requested restrictions listed below:

By signing this form, I am consenting to Family Health Associates of the Kanawha Valley's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance to my prior consent. If I do not sign this consent, Family Health Associates of the Kanawha Valley may decline to provide treatment to me. By signing this form, I also acknowledge that I have received and reviewed the Notice of Privacy Practices (NPP).

Patient Consent for Release of Protected Health Information (PHI):

I give permission for Family Health Associates of the Kanawha Valley to release any information regarding my medical history, inlcuding but not limited to any test results, appointments, and medications to ***only*** the following persons listed below:

Name: *Relationship:* *Phone #:*

Name: *Relationship:* *Phone #:*

Name: *Relationship:* *Phone #:*

Patient/Responsible Party Signature: *Date:*