Gahanna Family Practice, Inc.
4550 N. Hamilton Rd., Gahanna, Ohio 43230
(614) 428-8200 ~ fax (614) 428-9700
drlake@gahannafp.com ~ www.GahannaFP.com

Welcome to Gahanna Family Practice!

Dear New Patient,

Welcome to Gahanna Family Practice! Thank you for considering our practice for your healthcare. We are committed to providing supportive, high-quality medical care to our patients.

We encourage you to use our website at www.GahannaFP.com for information on our practice and the providers.

Please complete the enclosed paperwork. Bring it, along with your insurance card and a list of current medications, to your first appointment. Please confirm with your insurance carrier whether we are listed on your plan within network. If your insurance requires you to designate a primary care physician (PCP), you must contact them in advance of your appointment to name one of our physicians.

If for some reason you need to cancel an appointment, please call at least 24 hours in advance to reschedule, as a fee will be charged for “no-show” appointments.

We look forward to meeting you!

The Staff of Gahanna Family Practice

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Patient Information Form

Date: ___/___/______ Doctor: ______________ Acct. No: ________
If new patient, referred by: ____________________________________

Patient's Legal Name: ____ Date of Birth: ____/____/______ Age: ___
(Last) (First) (M.I.)

Address: ____ City: ______________ State: __________ Zip: ________

Home #: ________________________ Work #: ________________________ Ext: ______

Cell #: ________________________ Social Security Number: ______-_____-________ Work Hours: ________________

☐ Male ☐ Female Employer/School: ________________________________ Occupation: ____________________

Marital Status: ☐ Single ☐ Married Spouse's Name: ____________________________ Spouse's DOB: ____/____/______

Name(s) and DOB(s) of family members who live with you that are patients here: ____________________________________,
______________________________, ______________________________, ______________________________

Primary Insurance Company: __________________________ SSN of Policy Holder: _____-____-_______ Co-payment: $____

The following will be in effect until any written changes are provided by patient/responsible party:

May we leave detailed information on your answering machine or voicemail concerning referrals or appointments? ☐ Yes ☐ No

May we leave detailed information with other residents at your home concerning referrals or appointments? ☐ Yes ☐ No

If you are unavailable, is it okay for our automated "Housecalls" system to leave appointment reminders at your home? ☐ Yes ☐ No

To whom may we give laboratory or test results? Name: ____________________________ Relationship: ________________

Whom do you give authorization to pick up medical information for you, such as prescriptions, samples, X-rays, and other paperwork, from our office? ____ and ____

****More extensive authorization for us to discuss or release your medical information requires a separate authorization form.****

In case of an emergency and if unable to communicate with the office due to illness, list a family member whom we may contact:

____________________________________ Relationship: ______________________ Phone: (_____)______________

Person not living with you that we may contact for non-emergency issues:

____ Phone: (_____)______________

Email address for communication of non-emergency issues (optional): ____

____

I hereby give my consent for Gahanna Family Practice to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care options (TPO). (The Notice of Privacy Practices provided by Gahanna Family Practice describes such uses and disclosures more completely) I have the right to review the Notice of Privacy Practices prior to signing the consent. Gahanna Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Gahanna Family Practice, Attention Privacy Officer. With this consent, Gahanna Family Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. I have the right to request that Gahanna Family Practice restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions.

By signing below I am giving Consent for Treatment and Acknowledgement and Receipt of Privacy Notice:

Patient (Responsible Party) Signature: ____________________________________ **Date:** ____________________

For office use only: **Amicore** ______ **Med Mgr** ______

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History and Physical

Name: ____________________ SS#: ____________ Date: ____________
Address: ____________________ Occupation: ____________
Phone (home): ____________ (work): ____________ Date of Birth: ____________ Age: ______
Chief Complaint: ____________________

Drug Allergies:

Current Medications:

Surgeries/Hospitalizations (Date/Reason):

Past History			Family History		Who has disease?
☐ Yes	☐ No	**Heart Disease**	☐ Yes	☐ No	______
☐ Yes	☐ No	**High Blood Pressure**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Cancer:** ______	☐ Yes	☐ No	______
☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Thyroid Disease**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Stroke**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Asthma/emphysema**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Osteoporosis**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Depression**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Seizures/epilepsy**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Glaucoma**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Ulcers/abdominal pain**	☐ Yes	☐ No	______
☐ Yes	☐ No	**Other:** ______	☐ Yes	☐ No	______
☐ Yes	☐ No	**Allergies:** ______	☐ Yes	☐ No	______

Habits

Smoke Cigarettes? ☐ Yes ☐ No #packs/day: ______
How long? ______
Interested in quitting? ☐ Yes ☐ No
Exercise routine: ____________________

Caffeine: coffee: ______ cups/day
colas: ______ cans/day
Alcohol: type: ______
amount: ______
Diet: low salt? ☐ Yes ☐ No
low fat? ☐ Yes ☐ No

Sleep:
insomnia? ☐ Yes ☐ No
snoring? ☐ Yes ☐ No
daytime drowsiness?
☐ Yes ☐ No

Women Only

Pregnant? ☐ Yes ☐ No
Age at onset of periods: ______
Date of last PAP smear: ______
History of abnormal PAPs? ☐ Yes ☐ No

Total number of pregnancies: ______
Date of last menstrual period: ______
Last mammogram: ______

Vital Signs: Temp.: ______ Pulse: ______ Bp: ______ Height: ______ Weight: ______ Resp.: ______

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Payment Policy

Patient Name (please print): ______________________________ Date of Birth: ________________

Thank you for choosing us as your primary cary provider. We are committed to providing you with quality and affordable health care. This payment policy explains your financial responsibilities. Please read it, let us know if you have any questions, and sign below.

1 **Insurance.** We participate in most insurance plans. If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance does not pay your claim within 45 days, the balance will be your responsibility. Knowing your insurance benefits is your responsibility; please contact your insurance company with any questions you may have regarding your coverage.

*** I request that payment of authorized Medicare and/or other insurance company benefits be made to** Gahanna Family Practice, **Inc. on my benalf for any services furnished me by** Gahanna Family Practice**. I authorize any holder of medical information about me to release any information needed to determine those benefits or to pay for related services.**

2 **Co-payments and 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. Please help us by paying your co-payment at each visit.

3 **Non-covered services.** Please be aware that some—and perhaps all—of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You would be responsible to pay balance in full.

4 **Claim 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 between you and your insurance company; we are not party to that contract.

5 **Self Pay.** Self pay patients are required to pay 100% fee for service at time of visit.

6 **Nonpayment.** If your account is over 60 days past due, you will receive a letter stating you have 30 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 collections agency and you and your immediate family will be discharged from the practice. We would notify you by certified mail and provide emergency care during the next 30 days while you find alternative medical care.

7 **Missed appointments.** It is important to notify us if you are unable to keep an appointment. Our policy is to charge for missed appointments that are not cancelled the day before the appointment time. These charges will be your responsibility and billed directly to you. Help us serve you better by keeping your scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges in our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Patient (Responsible Party) Signature: ________________________________ Date: ___/___/_____

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Notice of Privacy Policy

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information. This is also a consent for treatment, consent for release of information by payment and healthcare operations, and consent for contacting you by mail or by the telephone. Please review this notice carefully!

I **This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice.** It is important that all patients and staff understand the importance of guarding patient information. This practice has a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard patient information. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results, and other information that may be of a confidential nature, such as having someone on your behalf come to our office to pick up prescriptions, samples, x-rays, and other paperwork. Patient information about health care is identified as "PHI" or protected health information.

This change in policy requires that you, the patient, identify and clarify at the time of registration or re-registration with this practice, who we can talk to, how we can leave information on your behalf, who can pick up material that contains your PHI and the process for ongoing continuity of your medical care. **You can change this information at any time by written notification.** Changes can only impact the care or information from that point in time forward.

II I, with my signature, authorize **Gahanna Family Practice, Inc.**, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) blood draws, allergy shots, preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with are prescription. This consent includes and discussion with other health care professional for care and treatment, such as but not limited to outside X-Ray interpretations, photographed evidence of illness if necessary. I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities.

III Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:

- For your treatment in this practice and other locations under the physicians immediate care. This may include any referral for services and treatment related to your condition or medical care needs such as blood draws, x-rays, mailings, faxing, or e-mailing of your PHI. This may also include conversations with other physicians or their staff, and physicians in training.
- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes or operative notes. This would include eligibility verification, prior authorization, and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders, confirmations, re-scheduling needs and health related services.
- Disclosure to your family and friends concerning any health care information with your consent on the registration form which can be modified at any time **in writing**.
- **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician or medical entity requiring immediate and full information for care on your behalf.**

These items can be disclosed without your consent:

- Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds, domestic violence, and victims of abuse or neglect.
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking such as immunization records and communicable diseases.
- Information used for health care oversight, such as site review by an insurance program
- Information related to organ donation
- Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Information provided to **avoid harm** if there is a threat to patient or other person.
- Specific governmental functions
- Workers compensation review

Your rights with respect to your protected health information:

- The right to request limits on the uses and disclosure at registration or any time during your care
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of this information within a reasonable time frame set by the physician, but there may be a copy and postage fee.
- The right to get a listing of who we have made disclosures to about your PHI that is not treatment, payment, or operations related.
- The right to correct and update your file through an amendment process if appropriate.

IV This practice reserves the right to modify or change this Privacy statement and Consent process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice and Consent. An updated Privacy Notice and Consent will be posted in the office within 90 days of the revision.

V If you have any concern or complaint about how your protected health information is being used, from this time forward you should first contact our office to see if we can resolve your concerns.

- Contact our office and complete a complaint form for review and discussion:

  Dr. Susan Lake
  4550 North Hamilton Road, Gahanna, Ohio 43230
  (614) 428-8200

- If you are not satisfied with this response, you may report the practice to:

  Office of Civil Rights
  Regional Manager
  Department of Health and Human Services
  233 N. Michigan Ave. Suite 240
  Chicago, Illinois 60601

  Or the local Medicare Part B Intermediary

  GBA Palmetto
  Part B Operations – HIPAA Compliance Concern
  P.O Box 182957
  Columbus, Ohio 43218