PRACTICE RULES

BRIEN, MICHELLE AND HEATHER'S WORK SCHEDULES:

- They are not in the office every day:
  - Brien's schedule is: Monday, Wednesday and Thursday.
  - Michelle's schedule is: Monday, Tuesday and Thursday
  - Heather's schedule is: Tuesday, Wednesday, Thursday and Friday AM
- Monday, Tuesday & Thursday we are open from 8am to 4pm; Wednesday from 7:30am to 5pm; Friday 8am to noon.
- We close daily for lunch from Noon – 1 PM.

MISSED APPOINTMENTS:

- We expect 24-hours notice for appointment cancellations. If you "late-cancel" and we are unable to fill your appointment time, there will be a charge for this missed appointment (minimum $25).
- **If you miss your very 1st appointment, you will not be allowed to join the practice**
- If you no-show (miss your appointment without notifying us), and you do this **three** times, we will discharge you from the practice.

MEDICARE AND MEDICARE HMO PLANS:

- We have a contract with Medicare.
- We do NOT have a contract with all the Medicare HMO plans or the Medicare Secondary insurers. Please call the office if you think you will be changing plans.
- We are moving away from Medicare Advantage plans. We will not be accepting new Martin's Point, AARP-HMO/POS and other similar plans.

YOUR VISITS:

- Please **bring** your medications with you for each office visit.
- If you are on regular medication, you will be required to have an annual visit, at a minimum.
- If you have not been seen in a year and have a health care need, you will need a visit.

MEDICATION REFILLS:

- Allow 24-48 hours notice for medication refills.
- Check with the pharmacy first to verify that your refill has been completed. We are unable to call patients and tell them we've done their refills.

INSURANCE REFERRALS:

- Insurance referrals can be time consuming and many insurance companies will not allow a referral to be done after the date of service.
- Please allow one week for the office to complete your "in state" insurance referral.
- ***Most insurance plans do not approve out of state referrals. For this reason, we are no longer doing out of state referrals. It has proven to be a wasted use of our time.***

FRONT DESK

Hope Health
77 Elm Street, Suite 4
Camden, Maine 04843
Ph: 207-236-2201 Fax: 207-236-2203

(PLEASE PRINT LEGIBLY)

Date _____ Name _____Gender M__F__
First Last Middle

Mailing Address_____
Street City State Zip

Home Phone _____ Work Phone _____ Ext ____ (if applicable)

Cell Phone_____E-mail address _____

IF SUMMER/PART-TIME RESIDENT:

Local Address _____
Street City State Zip
Phone Number _____

Birth Date _____AGE _____ Social Security Number _____

Domestic Status (circle one) Single Married Divorced Partnered Separated Widowed

How did you hear about us? _____

EMERGENCY INFORMATION

Person to contact (spouse, parent or friend) and the home and work phone numbers for that person NAME _____Phone (h) _____ (w)_____

Name of the nearest relative, not living with you, that you would like contacted if the person named above is unreachable _____ Phone # _____

HEALTH INSURANCE INFORMATION

Primary Insurance Company _____ Policy or ID# _____
Group # _____ Subscriber's Name _____ DOB_____
Address (if different) _____
Co-Pay $_____
Secondary insurance (if applicable)_____Policy or ID# _____
Group# _____ Subscriber's Name _____ DOB_____
Address (if different) _____
Co-Pay $_____

Continued

PAGE 2
INSURANCE AUTHORIZATION AND ASSIGNMENT

I request payment of authorized Medicare or **other** commercial insurance company benefits to me or on my behalf for any services furnished me by Hope Health. I authorize any holder of medical and other information about me to release to Medicare or other commercial insurance company agents any information needed to determine these benefits or benefits for related services.

I understand that if I do not obtain an insurance referral *(if required) prior to services rendered by Hope Health, I will be responsible for any charges not covered by my insurance company.

If I am uninsured/under-insured, I understand that I am financially responsible to Hope Health for any non-covered charges.

***PLEASE NOTE:** If you are concerned about your ability to pay for healthcare services at Hope Health, please feel free to discuss payment options with the office manager.

CONSENT FOR TREATMENT

Permission is hereby given to Hope Health staff to render treatment to me/my ward and to order any necessary tests for evaluating my condition.

I permit a copy of this authorization to be used in place of the original.

I give the staff of Hope Health permission to leave messages on my home answering machine.
YES ___NO ___

I give the staff of Hope Health permission to leave messages with anyone at my residence.
YES ___NO ___

X Signed: _____Date:_____
(Patient)

Signed: _____ Date: _____
(Parent must sign if patient is under 18)

Witnessed: _____ Date: _____
(Staff signature)

*If you are covered by an HMO policy through your insurance company, written permission for you to be treated by another provider other than your PCP (primary care provider) is required and should be obtained prior to services being rendered.

CLINICAL INFORMATION

HOPE HEALTH

Date _____ Name _____Date of birth_____

List all medications (including dosage) you are currently taking: (Please include vitamins, supplements and herbs, etc.)

_____ _____

_____ _____

_____ _____

Allergies or Drug reactions: _____

Food intolerance or dietary restrictions: _____

_____

Operations:	Year	Procedure
	_____	_____
	_____	_____
	_____	_____

Hospitalizations:	When	Reason
	_____	_____
	_____	_____
	_____	_____

Major Accidents: _____

_____

Ongoing Health Issues (ie: hypertension, diabetes, thyroid disorder,etc…): _____

_____

Reason for Today's Visit: _____ _____

_____ _____

_____ _____

General: Marital/Domestic Status_____ Employer/Occupation_____

Do you have children? How many_____ Number of times you exercise weekly_____

Are you a smoker? Y N How many per day? ____ Ready to quit? Y N

Do you use street drugs? Y N Number of alcoholic drinks per week _____

Have you ever had a sexual encounter you did not want? Y N

Other specialists/Health Care Providers or Alternative Therapist and/or Therapies:

_____

_____

Most Recent Immunizations (Please note year received)/Examinations:

Tetanus _____ Flu shot_____ Last physical exam (mo/yr) ___/_____

Colonoscopy (mo/yr) ___/_____ Chest x-ray_____ EKG_____ Bone Density___/_____

If over 60: Pneumovax _____ Tetanus _____

Women only: Date of last Pap smear (mo/yr) ____/_____ Mammogram (mo/yr) ____/_____

Do you have a Living Will (a document that tells us what medical care/life support you want or do not want if you become irreversibly ill)? YES ___NO ___

Do you wish to be an organ donor? YES ___NO ___

Continued

Initial History/Review of Systems -Page 2
Please check if you have any ongoing problems with any of the following:

Constitutional

- ☐ None
- ☐ Weight Change
- ☐ Fever
- ☐ Weakness
- ☐ Fatigue
- ☐ Other

Gastrointestinal

- ☐ None
- ☐ Change in appetite
- ☐ Nausea/vomiting
- ☐ Rectal bleeding/black stool
- ☐ Diarrhea or constipation
- ☐ Change in bowel habits
- ☐ Hemorrhoids
- ☐ Excess gas
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Other _____

Neurological

- ☐ None
- ☐ Seizure
- ☐ Weakness
- ☐ Fainting/blackouts
- ☐ Paralysis
- ☐ Tingling
- ☐ Memory loss
- ☐ Tremors
- ☐ Loss of coordination
- ☐ Headache
- ☐ Other _____

Eyes

- ☐ None
- ☐ Last eye exam_____
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Blurring vision
- ☐ Other _____

Hematological

- ☐ None
- ☐ Anemia
- ☐ Bruising
- ☐ Blood transfusion
- ☐ Tender lymph nodes
- ☐ Other _____

ENT

- ☐ None
- ☐ Deafness
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Frequent colds
- ☐ Postnasal drip
- ☐ Last dental exam ____
- ☐ Chew tobacco
- ☐ Other _____

Genitourinary

- ☐ None
- ☐ Penile/vaginal discharge
- ☐ Sexually transmitted disease
- ☐ Frequent urination
- ☐ Burning/pain with urination
- ☐ Dibbling/trouble starting
- ☐ Getting up to urinate at night (If so, how many times ____)
- ☐ Incontinence
- ☐ Sexual problems
- ☐ Menstrual problems
- ☐ Other _____

Psychiatric

- ☐ None
- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Mood changes
- ☐ Difficulty concentrating
- ☐ Nervousness
- ☐ Irritability
- ☐ Sleep disturbance
- ☐ Other _____

Cardiovascular

- ☐ None
- ☐ Chest pain
- ☐ Palpitations
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Swelling in feet
- ☐ Varicose veins
- ☐ Other _____

Musculoskeletal

- ☐ None
- ☐ Back/neck pain
- ☐ Joint swelling
- ☐ Muscle tenderness
- ☐ Leg cramps/pain
- ☐ Other _____

Endocrine

- ☐ None
- ☐ Diabetes
- ☐ Thyroid problems/goiter
- ☐ Excessive sweating
- ☐ Heat or cold intolerance
- ☐ Excess thirst/hunger
- ☐ Other _____

Respiratory

- ☐ None
- ☐ Cough
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Shortness of breath
- ☐ Exposed to smoking
- ☐ Other _____

Skin & Breast

- ☐ None
- ☐ Hair/nail change
- ☐ Rashes
- ☐ Itching
- ☐ Change in skin color
- ☐ Moles-new or changing
- ☐ How often do you wear Sunscreen 100% 50% 0%
- ☐ Breast lumps or pain
- ☐ Other _____

Continued

Initial History – Page 3

FAMILY HISTORY:

☐ Anemia	☐ Diabetes	☐ Liver disease
☐ Arthritis	☐ Drug Use	☐ Osteoporosis
☐ Asthma	☐ Epilepsy / seizures	☐ Mental illness
☐ Alcoholism	☐ Glaucoma	☐ Pancreatitis
☐ Allergies	☐ Heart Disease	☐ Rheumatic fever
☐ Cancer	☐ High blood pressure	☐ Stroke
☐ Depression	☐ High cholesterol	☐ Tuberculosis

Other: _____

	Birthdate	State of Health (or cause of death)	Medical Problems
Father:			
Mother:			
Brothers:			
Sisters:			
Spouse:			
Children:			

Grandparents (specify maternal/paternal and grandmother/grandfather): _____
_____
_____

Aunts and Uncles related by blood (specify maternal/paternal): _____
_____
_____

Other: _____
_____