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

CONSENT AND UNDERSTANDING

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

Consent for Care:

I with my signature, authorize (this practice) and any employee working under the direction of the provider to provide medical care for me, or to this patient 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) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review or 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 a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for Release of Information and Assignment of Benefits:

I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I consent to assign all payments for services directly to this practice. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Financial Policy:

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services provided.

- I understand that I am responsible for all copayments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance copayment, I am expected to make payment on the day of service.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. They vary by employer group. We cannot be responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. Not all services are covered by all health plans. If I seek care outside of the contract terms, I am aware that I may be responsible for all charges that are incurred.
- We have limited time to file with the insurance companies. If we have an issue, you will get a statement. If you respond to our statement, we can often rectify the issue. If you ignore our statement and the filing time limit is reached. The charges will be your responsibility.

Thank you for your understanding and cooperation with this policy. It is our privilege to provide your medical care.

I have read and understand the Consents and Financial Policy stated above and agree to accept full responsibility as described above.

____ ________________________

Patient/Responsible Party Date

Patient Name if different from Responsible Party: ____________________________

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

FAMILY HISTORY:

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