

IMPORTANT PRACTICE INFORMATION

GENERAL PRACTICE INFO:

- If you require a same day appointment, please call by 10 AM. We cannot guarantee a same day appointment, if you call after 10 AM.
- Please always leave a message. Your call will be returned promptly, as you are our priority.
- We have a pager for after hours; if you've never used a pager, please ask Nakia.

PROVIDERS' SCHEDULES:

- They are not in the office every day:
 - Brien schedules patients on Wednesday and Thursday - ****Closed to New Patients****
 - Michelle sees patients on Monday, Tuesday and Thursday - ****Closed to New Patients****
 - MaryAlice sees patients Monday, Tuesday and Wednesday
 - Kristie sees patients on Monday, Tuesday, Wednesday and Thursday
- Monday, Tuesday and Thursday we are open 8 AM to 4 PM. Wednesday from 7:30 AM to 5 PM; Friday 8AM to noon.
- We close daily for lunch from noon to 1 PM.

MISSED APPOINTMENTS:

- We expect 24-hours' notice for appointment cancellation.
- **New Patient appointments are 45-minutes in duration. 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 ADVANTAGE PLANS:

- We have a contract with Medicare.
- We do NOT have a contract with all the Medicare Advantage plans or the Medicare secondary insurers. Please call the office if you think you will be changing plans.
- If we don't take your insurance, you will be asked to find a provider that does.

YOUR VISITS:

- Please be prepared to show your insurance card(s) at each visit. This will ensure proper billing and you won't be unnecessarily charged.
- Please bring your medications with you for each office visit.
- If you are on regular medication(s), 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.
- The State of Maine has strict guidelines for those patients on controlled substances. You will be required to have more frequent visits.

MEDICATION REFILLS:

- When calling in for a refill, press option "2" for the refill line.
- Allow 24-48 hours for medication refills.
- **Check with the pharmacy 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 / out of network referrals. These types of referrals are at the discretion of the provider and will only be done if all in network options have been exhausted.

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
- Dribbling/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
- 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
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Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Spouse: _____

Children: _____

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

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

Other: _____
