ShadysideCLINIC, LLC

Family Medicine & Walk-In Convenience Care

New Patient Information

Patient Name: _____ Social Security #:_____

Sex: Male / Female Marital Status: _____Age:_____ Birth date: _____

Mailing Address: _____City:_____

State: _____ Zip:_____Telephone:_____Cell:_____

If cell number is provided, may we text you regarding appointments, medications, etc?

YES **NO**

Patient's Employer: _____ Employer's Telephone: _____

Do you have advanced directives? _____

EMAIL

_____ @ _____

Primary Insurance Information

Primary Insurance Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Patient::_____

Home Number: _____ Cell Phone Number: _____

Pharmacy Information

Name: _____ City: _____

Mail Order Pharmacy Name: _____

I hereby authorize, **ShadysideCLINIC, LLC** to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed above or below.
I authorize payment for these services to be made directly to: **ShadysideCLINIC, LLC/ or Dr. Giannamore. I also understand that I am responsible for payment of services not covered by my insurance company and that payment for co-pays are required at the time of service.**

Signature of responsible party: _____ Date: _____

Printed Name (if not patient):_____

ShadysideCLINIC, LLC.
3948 Central Ave.
Shadyside, Ohio 43947
(740)325-1313 (Phone)
(740)325-1489 (Fax)

Patient Name: _____

DOB: _____/_____/_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize the use of the above named individuals health information described below:

Organization Making Disclosure:_____

I would like my information to be disclosed to: ShadysideCLINIC, LLC. 3948 Central Ave. Shadyside, Ohio 43947. For the Purpose of Primary Care/Family Practice Treatment. Please send the Complete Medical Record to the above address or fax.

I understand that I have the right to revoke this authorization at any time by sending a written revocation to ShadysideCLINIC at 3948 Central Ave. Shadyside, Ohio 43947. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked this authorization will expire in one year (365) days from the date of this authorization.

I understand that this authorization is voluntary and ShadysideCLINIC, LLC will NOT condition treatment, enrollment, payment, or eligibility for benefits on this authorization.

I understand that my Medical Records may contain information relating to mental health, alcohol or drug abuse, Human Immunodeficiency Virus, or Acquired Immune Deficiency Syndrome.

I understand that authorizing the disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Patients Representative Date

_____

Printed Name

ShadysideCLINIC, LLC
Family Medicine & Walk-In Convenience Care

Medical Information Release Form - HIPAA Release Form

Name: _____ Date: _____

RELEASE OF INFORMATION

I _____ authorize the release of verbal information including the diagnosis, care rendered to me during my visits and claims information. This information may be released to:

Spouse_____

Child (ren) _____

_____

Other_____

_____ Information is not to be released to anyone

Messages

Please call_____ my home _____my work _____cell Number_____

If unable to reach me:

_____you may leave a detailed message

_____please leave a message asking me to return your call

_____other instructions

The best time to reach me is (day)_____between (time)_____

Signed: _____ Date: _____

Witness: _____ Date: _____

ShadysideCLINIC, LLC

Family Medicine & Walk-In Convenience Care

I have reviewed this consent form and give my permission to ShadysideCLINIC, LLC to use and disclose my health information in accordance with:

_____

Name of Patient (Print)

_____

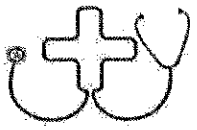
Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient



ShadysideCLINIC, LLC

Family Medicine & Walk-In Convenience Care

CURRENT MEDICATION	PURPOSE OF MEDICATION	Continued or D/C

Drug allergies: _____

ShadysideCLINIC, LLC – Policy Agreements

Authorization:

I hereby authorize the providers, including physicians, physician assistants, nurse practitioners, and medical students of ShadysideCLINIC, LLC, to provide medical treatment to myself/child.

- I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies, including Medicare and Medicaid, for the purpose of filing and payment of medical claims.
- I authorize payment of medical benefits to the provider of ShadysideCLINIC, LLC.
- I authorize the release of medical information to consultants if needed, and as necessary to process insurance claims and prescriptions.

Insurance:

- I understand that if my insurance coverage has expired or lapsed, I will be responsible for payment. If my insurance denies payment or does not pay, I am responsible to payment.
- I understand that my insurance is a contract between me and my insurance company, and that I am financially responsible for any service or deductible not covered for payment under my insurance plan.
- It is my responsibility to verify participation of the provider with the insurance company **FOR EACH VISIT.**
- I understand that it is my responsibility to inform the practice of any change of name, address, phone, insurance or employment.
- I understand that if my insurance changes, is left undisclosed, or inaccuracies are reported, this could lead to a reimbursement refusal from my insurance company, Medicaid, or Medicare, in which case, I will be held financially responsible for any unpaid balances.

Referrals:

- If referred by an insurance company, I have verified participation of the provider with the insurance company.
- I understand that if my insurance carrier lists the provider as participating physicians, I must follow the guidelines specified in my insurance policy, particularly regarding my referrals. If a referral is required by my health insurance plan, I understand that the referral must be valid and completed with the provider's name. I understand that I will be held responsible for the cost of the services provided if I do not present a valid referral.

Financial Responsibilities (we accept payment in the form of cash, check, Visa, MasterCard, Discover and American Express)

- All charges are due at the time of service – this includes co-pays, deductibles and any outstanding balances. If self-paying, payment is due at the time of visit.
- Some services may not be covered under your contract. Please check with your insurance company if you have any questions regarding which services are covered.
- If an over-payment is made by you on your account, a refund will be issued only if you have no other outstanding debts on other accounts you have provided for billing purposes. All balances are due within 30 days of the billing date.
- I understand that in the case of returned checks, the fee charged by the bank and the practice will be added to my account. In the case of non-payment of the services performed, 10% interest will be added to my account from the date of service. All collection charges incurred by ShadysideCLINIC, LLC for outstanding balances will be added to my account. Interest and/or collection fees may be charged on all balances owing to the provider that are past due.
- I understand that I am financially responsible for cosmetic, non-covered, or medically non-indicated services.
- A $25.00 fee will automatically be charged after a second no call/no show is recorded.

Diagnostics:

- I understand that I am responsible for all charges including any balance remaining after payment of insurance benefits (that is deemed my responsibility by my insurance) for any laboratory diagnostic services. If my insurance requires a designated diagnostics facility, it is my responsibility to request such a facility before the necessary tests are performed. If I neglect to inform the practice in a timely manner, I will be responsible for any testing expenses incurred on my behalf.

Informed Consent:

- I understand that during my course of treatment, unforeseen conditions may occur that necessitate procedures, injections, etc. that are deemed necessary for my care. In addition, I also give permission to have minor surgical procedures and any subsequent treatments as deemed necessary as long as the risks and complications are discussed with me prior to the said procedure. The risks include, but are not limited to, scarring bleeding, swelling, pain, deformity, infection, and/or ulceration. I will also inform the practitioner of any possible contraindications to the planned procedure, including medications, such as anticoagulant, aspirin, cardiac, infections, or psychotropic medications.
- I recognize that every procedure involves uncertainty and no result can be guaranteed. I also recognize that the practitioner is not responsible for natural complications that may occur. If any post-procedure complications occur, it is my responsibility to contact the practitioner as soon as possible.
- I consent to the disposal of any tissue that is removed in accordance with accustomed practice and procedure. I further give my permission to have any tissue that is removed during a procedure sent for histologic examination.
- I understand and consent that any controversy or claim arising out of medical care provided will be resolved through arbitration.
- I acknowledge having received the practices' Notice of Privacy Practices in relation to the Health Insurance Portability and Accountability Act of 1996.

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

My signature below certifies that I have read, understood, and agree with the terms set forth in this policy agreement.

Print Patient's Name: X_____

Signature of Patient/Responsible Party: X_____

Relationship to Patient: _____ **Date: X**_____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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