WELCOME TO THE PRACTICE!

Name: ______________________________ **Middle Initial(s):** __________
(first) (last)

DOB: ____/____/____ **Sex:** ☐ Male ☐ Female

Mailing Address: ______________________________ **Apt #:** __________

City/State/Zip: ______________________________

Home Phone: ____________________ **Cell Phone:** ____________________

Email: ______________________________

Preferred Method of Contact: ☐ Voice ☐ Text ☐ Email

Check the box if you would like to opt in for automatic appointment reminders ☐

Emergency Contact:

Name: ____________________ **Phone:** ____________________

Relationship: ____________________

Next of Kin:

Name: ____________________ **Phone:** ____________________

Relationship: ____________________

INSURANCE

Primary Medical Ins.	Secondary Medical Ins.
Ins. Co. Name:	Ins. Co. Name:
ID/Group #	ID/Group #
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Relationship to Policyholder:	Relationship to Policyholder:

Preferred Pharmacy:

Name: ________________________________

Address: ____

Phone: ______________________________ **Fax:** ________________________________

Mail Order Pharmacy (if applicable): ____

MEDICATIONS:

NAME	DOSE	TIMES TAKEN PER DAY

Allergies:

Drug: ____ **N/A** ☐

Food: ____ **N/A** ☐

PATIENT MEDICAL HISTORY (please circle all that apply):

ADHD ☐

Alcoholism ☐

Allergies, Seasonal ☐

Anemia ☐

Anxiety ☐

Arrhythmia ☐

Arthritis ☐

Asthma

Bipolar ☐

Bladder Problems ☐

Incontinence ☐

Bleeding Problems ☐

Cancer ☐

- ________________

Headaches ☐

Crohn's Disease ☐

COPD/Emphysema ☐

Dementia ☐

Depression ☐

Rheumatoid Arthritis ☐

Seizure Disorder ☐

Sleep Apnea ☐

Stroke ☐

Thyroid Disorder ☐

Ulcerative Colitis ☐

Diabetes: 1 or 2 ☐

Diverticulitis ☐

DVT (blood clot) ☐

GERD (acid reflux) ☐

Peptic Ulcer ☐

Psoriasis ☐

Pulmonary Embolism ☐

Glaucoma ☐

Heart Disease ☐

Heart Attack (MI) ☐

Hiatal Hernia ☐

High Blood Pressure ☐

Kidney Stones ☐

Kidney Disease ☐

High Cholesterol ☐

HIV ☐

Hepatitis ☐

IBS (irritable bowel syndrome) ☐

Lupus ☐

Liver Disease ☐

Macular Degeneration ☐

Neuropathy ☐

Osteopenia ☐

Osteoporosis ☐

Parkinson's Disease ☐

Peripheral Vas. Disease ☐

Colonoscopy? Yes/No
Date:____________(year) Normal? Y/N

Mammogram? Yes/No
Date:_________(year) Normal? Y/N

Cont.

Other Medical Problems Not Listed Above:

1. ____
2. ____
3. ____
4. ____
5. ____

Surgical History: please list all surgeries and the approximate date performed

1. ____
2. ____
3. ____
4. ____
5. ____

Social History:

- Are there any vision problems that affect your communication? YES / NO
- Are there any hearing problems that affect your communication? YES / NO
- Are there any limitations to understanding or following written/verbal instructions? YES /NO
- Smoking/Tobacco Use: Current Past Never Type:______________
  Amount________ Number of Years: _________
- Alcohol: Current Past Never Drinks/week:______________
- Recreational Drugs Current Past Never Type______________________________
- How often do you get the social/emotional support you need?
  - Always
  - Usually
  - Sometimes
  - Rarely
  - Never

Family History:

FATHER: Living? Y / N Age:________ Deceased? Y / N Age:________

- ☐ Alcoholism
- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Bipolar Disorder
- ☐ __________Cancer
- ☐ COPD/Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: type I or type II
- ☐ DVT (blood clot)
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid Disorder

MOTHER: Living? Y / N Age:________ Deceased? Y / N Age:________

- ☐ Alcoholism
- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Bipolar Disorder
- ☐ __________Cancer
- ☐ COPD/Emphysema
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes: type I or type II
- ☐ DVT (blood clot)
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid Disorder

Other:

____

____

____

MY CARE TEAM

For continuity and efficiency of care, please list any and all specialist below (cardiologist, mental health provider, nephrologist etc.)

Physician Name	Specialty	Phone/Fax	Address

Listing my care team above and signing below, gives consent for MBMA/1stDocs to discuss matters and receive information concerning my health.

X ______________________________ Date: ______________

PATIENT AGREEMENT ON CONTROLLED SUBSTANCES & THERAPY FOR CHRONIC PAIN TREATMENT

A treatment agreement is a document signed by a healthcare provider and a patient who is prescribed an opioid medication. The purpose of the treatment agreement is to help you and your healthcare provider work together toward safe and effective pain management and to avoid potential adverse issues.

Our office will review this agreement with you and educate you so that you can get the best pain relief and know how to lower the chances of possible harm to yourself and others while you are taking your medication(s).

The topics and education covered in the treatment agreement include:

1. Your responsibilities as a patient, your healthcare provider's responsibilities, and shared responsibilities of you and your treatment team. Your treatment team includes you, your healthcare provider, and medical office.
2. The goals of treatment and how to take your opioid medication as prescribed
3. How to safely dispose of unused, unwanted, or expired medication(s).
4. The prescribing policies of the medical office and your healthcare provider.
    a. Timeframe in which you must be seen for refills; contingent upon medication classification.
5. The risks of addiction and overdose associated with taking an opioid medication.
6. Health conditions that increase the risk of addiction overdose
7. Other substances/drugs to avoid taking while on opioid medication.
8. Alternative treatment options, available for pain management that do not involve opioids.

The Goal of Opioid Therapy

The goal of opioid medication therapy is to reduce your pain and help you complete every day activities.

You should know that opioid medication will not cure your pain. They also have major risks and side effects. That is why it is important for you and your healthcare provider to carefully monitor your use of opioids to see if they are the right medicine for you.

You should understand that opioid medications work best when you also use self-care skills and follow your chronic pain care plan.

Patient Initials:	***Shared Responsibilities***
	Discussed a controlled substance is a drug or other substance that the U.S Drug Enforcement (DEA) has identified as having potential for abuse. An opioid medication is a controlled substance.
	Discussed possible side effects of opioid medications and the risk of overdose. We also talked about what to do if this happens.
	Discussed how everyone's body reacts to opioid medication differently. People with mental health conditions may be more likely to become addicted. Risk

PATIENT FINANCIAL & PAYMENT POLICY

This financial payment policy is an agreement between Mercer Bucks Medical Associates/FirstDocs (MBMA/1stDocs) and you, the patient, or responsible party. By signing the patient registration form you are acknowledging that you understand and agree to our financial payment policy.

Patient Responsibility:

- **You must provide us with the current insurance card and billing information. Your insurance policy is a contract between you and the insurance company. It is your responsibility to know your insurance benefits and pay any remaining portion due after insurance processes your claim.**

- **Copays are due at the time of service.**

- **No Show Fees (NS): You must cancel your appointments 24hrs before your set appointment time by calling our office and speaking to a staff member or leaving a message. If you fail to do so you will be charged a $25.00 no show fee.**

- **Auto Accident Claims: We will bill your auto policy in the event of a motor vehicle accident (mva). If someone else is responsible for the accident, we will not bill his or her insurance. You will be responsible for our bill and you will need to seek reimbursement from the other party.**

I understand that I am financially responsible for all charges regardless of the third-party involvement. I agree to pay any deductible, co-insurance, co-pay, or ant service(s) deemed a "non covered benefit" by my insurance company. I understand that failure to pay outstanding balances within 90 days of receiving my first statement will result in submission of my account to an outside collection agency. If the debt remains after transfer to our outside collection agency, the debt may be reported to the credit bureaus and your credit rating may be affected. In addition, failure to pay delinquent account balances may result in termination of care from MBMA/1stDocs.

I certify that I have read and agree to the Mercer Bucks Medical/FirstDocs (MBMA/1stDocs) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to MBMA/1stDocs all money to which I am entitled for medical expenses related to services performed from time to time by MBMA/1stDocs, but not to exceed my indebtedness to MBMA/1stDocs. I authorize MBMA/1stDocs to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand failure to pay outstanding balance within 90 days of notification of the amount due will result in submission to an outside collection agency. I choose to receive communications from MBMA/1stDocs by mail, phone, text, or email at the information provided above,including but not limited to communications about appointments, feedback, treatment, and payment. I understand that

such emails, text etc. may not always be secured and there is low risk that it may be read by a third party.

Medicare Beneficiaries: **I request that payment of authorized Medicare benefits be made to MBMA/1stDocs. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or benefits payable for related services.**

I have reviewed a copy of Mercer Bucks Medical Assoc./FirstDocs Privacy Policy ________ (initials)

Signature of Responsible Party: X____

Printed Name of Responsible Party: X____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. **Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
2. **Obtain payment from third-party payers**
3. **Conduct normal healthcare operations such as quality assessments and physician certifcations.**

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ________________________________ DOB: ____________________

Patient Signature: ______________________________ Date: ____________________

I give permission for Mercer Bucks Medical Associates/FirstDocs (MBMA/1stDocs) and its employees to speak with the following on my behalf. Understanding that no other individual/persons will be able to receive any information as it pertains to my health, treatment, etc.

Name: ______________________________________ Relationship: ______________________

Name: ______________________________________ Relationship: ______________________

OFFICE USE ONLY

We (MBMA/1stDocs) attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Name: ______________________ **Initials:** ________ **Reason:** ______________________