

NEW PATIENT APPLICATION



Current date: _____

Requested Provider:
(Circle One)

Dr. David Oliver, D.O.
Dr. Rafael Rosa-Algarin, M.D.
Dr. Charles Overturf IV, D.O.
Dr. Aya Olejeme
Dr. Molly McCoy, M.D.

PATIENT INFORMATION

By what name do you like to be
called: _____

Patient's Last Name: _____ First Name: _____ MI _____
Mr. __ Miss __ Mrs. __
Ms. __ Dr. __

Sex: Male __ Female __ Other __

Patient's Date of Birth: _____ Marital Status _____
Single __ Married __ Lives with Significant
Patient's Social Security #: _____ Widowed __ Divorced __ other __

Phone #: _____ Email: _____

Patient's Primary address: _____
Street _____ City _____ State _____ Zip Code _____

Patient's Secondary address: _____
Street _____ City _____ State _____ Zip Code _____

Do you want to receive text messages: Yes No

Occupation: _____

Employer: _____ Work Status: Full-time Part-time Retired Disabled
Occupation: _____

Name of spouse: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's SS#: _____

Spouse's Occupation: _____

INSURANCE INFORMATION**(Please provide your insurance card to our receptionist)****Primary Insurance Company Name:** _____**Subscriber's Name:** _____**Social Security #:** _____**Relationship to Patient:** _____**Date of birth:** _____**Policy #:** _____**Copayment:** _____**Group#:** _____**Secondary Insurance Name:** _____**Subscriber's Name:** _____**Social Security #:** _____**Relationship to Patient:** _____**Date of birth:** _____**Policy #:** _____**Copayment:** _____**Group#:** _____**Person responsible for the bill:** _____**Address:** _____**Phone #:** _____

Whom may we thank for referring you? Advertisement Friend Internet Family Other: _____
Billboard or Internet

I herby give consent for treatment and herby authorize any physician, hospital, or medical facility to release any information concerning my medical history and treatment.

I hereby authorize release of medical information including positive exposure to HIV infection, ARC, AIDS, alcohol or drug dependency, mental and nervous disorders to other physicians, hospital, or medical facilities that may be included in my care.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize American Family Medical, LLC or my insurance company to release any information required to process claims.

Parent/Guardian Signature_____
Date**IN CASE OF EMERGENCY:****Name of a friend or relative (not living at the same address):** _____**Phone #:** _____ **Relation to patient:** _____



Dear Patient:

In an effort to make our office as efficient as possible, and to reduce waiting time for you the patient, please review the following suggestions. We have found that when patients' follow these simple steps we are able to provide better care in a more timely and efficient manner.

KNOW YOUR MEDICATIONS: The name of the medication, what the medication is being taken for, and also the strength and dose. Keep an updated list of your medications with you for quick reference. This includes any supplements that you may be taking. Please bring all of your prescription medications to every visit.

REFILLS: Advise the medical assistant of any refills you need and whether your insurance prefers 30 or 90 day refills. Also, provide a name and phone number of your pharmacy, as we send all prescriptions electronically. When calling in for a prescription refills, please check your prescription bottle first to avoid any confusion or delay in refill. Allow 3 business day for all refill request to be completed. If your prescription requires prior authorization for refill, it is your responsibility to notify the practice. Authorization of a medication can take up to two weeks for approval or denial by insurance company.

INSURANCE FORMULARY: Become familiar with your insurance formulary plan for prescriptions. If we prescribe a medication for you that is not on your formulary and you don't inform us, there will be need for you to schedule an appointment with the provider to select another medication that is best suited for your medical condition.

OFFICE VISITS: Our office tries, if possible, to evaluate only one-two medical problems per patient, per visit. This allows our appointment schedule to run at a manageable rate and has proven to be the fairest to all concerned. Emergencies and exceptions do arise some problems take longer to evaluate than others. We make every effort to minimize our patients waiting time.

SCHEDULING APPOINTMENTS: Allow yourself sufficient time when scheduling office appointments; realizing that due to the nature of our office we do handle medical emergencies when they arise, this may cause our schedule to run behind.

American Family Medical, LLC is committed to providing a safe, respectful, and professional environment for our patients, providers, and staff.

Patients and visitors are expected to treat all physicians, clinical staff, and administrative staff with courtesy and respect at all times. **Verbal abuse, harassment, threats, intimidation, or inappropriate behavior of any kind will not be tolerated.**

Any patient who engages in **verbal abuse or disruptive behavior toward staff or providers** may result in the **immediate withdrawal of care** and dismissal from the practice, at the sole discretion of American Family Medical, LLC. This includes abusive language in person, by phone, through electronic communication, or via patient portals.

YOUR INSURANCE: We have made prior arrangements with many insurers and health plans. We will bill those plans whom we have an agreement, and will collect any required copayment, coinsurance, or deductible **AT THE TIME OF SERVICE**. Copayment, coinsurance, and/or deductible will collected upon sign in for your appointment time without exceptions. Payment may be made via cash, check, or debit. In the event your health plan determines a service "not covered", you will be responsible for the complete charge. **PLEASE INFORM US WHEN YOUR INSURANCE PLAN CHANGES.**

MINOR PATIENTS:

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment in full at the time of service, regardless of who is legally responsible. All minors must be accompanied by a parent or legal guardian unless prior arrangement for another party to be present of children under 12 years old to be seen alone has been made in writing by a parent or legal guardian.

MISSED APPOINTMENTS:

In order to provide the best possible service and availability to all our patients, it is our policy to charge a \$50.00 fee for missed lab appointments, \$80.00 fee for any missed appointments that re NOT Annual Wellness Exams and are NOT cancelled 24 hours in advance, and \$180.00 for wellness visit. Please call us as early as possible if you know you will need to reschedule your appointment.

MEDICAL RECORDS:

Medical records may be released with a signed consent from the patient only, and maybe charged \$1.00 per copy. There is also a \$50.00 charge for completion of medical forms(i.e. FMLA, Medication Authorization, Supply Forms)

Prisma Health Information Exchange Authorization:

Patient may approve or decline access to medical records via Prisma for continuity of care with other healthcare providers.

Circle ONE: APPROVE / DO NOT APPROVE**Physician Medical Research Authorization:**

Patient may approve or decline the use of your medical records to be reviewed by a physician, APRN, PA, MA or other clinical staff for medical research and quality improvement.

Circle ONE: APPROVE / DO NOT APPROVE**COMPLIANCE:**

In an effort to maintain optimal health, each patient is expected to comply with the physicians advice regarding their health care needs. Failure to do so may result in our inability to continue providing your health care. In order to maintain continuity of care, we request that you scheduled an annual physical exam.

FINANCIAL AGREEMENT:

We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that will not be covered(e.g. yearly physicals, pap smears, mammograms, urinalysis, hemoccult, blood work). It is YOUR responsibility to be familiar with your health insurance plan.

Credit Card Processing Fee:

A 3% processing surcharge will be applied to all balances paid using a credit card. This fee does not apply to cash, check, or debit card payments.

We must emphasize that as your medical care providers, our relationship and concern with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE OF SERVICE RENDERED. For your convenience we accept VISA, MASTERCARD, PERSONAL CHECKS, and DEBIT CARDS. There will be a \$100.00 charge on all returned checks. On any balance on your account over 90 days, including those that insurance has not paid, collection action will be taken. If it becomes necessary to collect any sum due through an attorney, then the patient/guarantor agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not. If you have any questions about the above information or uncertainty regarding insurance coverage, please do not hesitate to ask us, as we are here to assist you.

I have read and understand the policies of American Family Medical, LLC. I understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient/Parent

Date

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Spouse: _____

Children: 1. _____ 2. _____ 3. _____ 4. _____

Ages: _____

Medical Problems/Diagnosis:

Specialist Involved in your care: _____

Current Medications/Supplements Presently Taking:

Name	Dose	How Often

Medication Allergies:

Type of Reaction:

Food Allergies:

Type of Reaction:

Other Allergies:

Type of Reaction:

Do you utilize concierge or direct primary care services? **YES NO**

Do you take prescription medication for weight loss? **YES NO**

Do you have a Medical Marijuana Card? **YES NO**

Do you utilize online/internet based healthcare providers for prescription medication(s)? **YES NO**

Surgeries**Date****Reason****Hospitalizations (Other than for surgery)****Reason****Place and Date****Serious Accidents/Fractures****Date****Lasting complications(if any)****Family Medical History**

<u>Relative</u>	<u>Living/Deceased</u>	<u>Medical Problems</u>	<u>Age</u>
Mother	_____	_____	_____
Father	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
Sister	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

List Anyone in The Family With:

High Blood Pressure: _____	Diabetes: _____
Heart Disease: _____	Cancer: _____
Kidney Disease: _____	Lung Disease: _____
Tuberculosis: _____	Neurological/Musculoskeletal: _____
Premature Death(before 60): _____	Mental Illness/Addiction: _____
	<u>Suicide Prevention Phone Number: Call 988</u>

Review of Systems

Would you describe your general health as: Excellent Good Fair Poor (circle one)

Have you experienced any unexpected weight loss or weight gain: ___Yes ___No If YES, how much_____

Alcohol Use: Yes/No **Current Illicit Drug Use:** Yes/No Type: _____
How many: _____ How often: _____

Tobacco Use: SMOKER NONSMOKER NEVER SMOKED

Last EKG: _____ Last Chest X-ray _____ Last Tetanus _____ RSV Vaccine _____
Pneumonia Vaccine _____ Shingles Vaccine _____ Flu Vaccine _____

FEMALES ONLY:

Total number of: Pregnancies: _____ Births: _____ Miscarriages: _____

Complications of pregnancy and labor, if any: _____

Menstrual Cycle: How often: _____ Durations: _____, Heavy___ Moderate___ Light___

When was you last pap smear: _____ Type of Birth Control Used: _____

Post Menopausal: Yes/No Year _____

Do you take medication for hormone replacement therapy: YES NO

Do you have any concern for being a victim of domestic violence? YES NO

Domestic Violence Hotline: 800-799-7233