PARTNERS in Family Practice Ltd.

Tammy Eisentrout, D.O.
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

I, _____, authorize _____
to release my medical records to: (Physician's name with old records)
(Please include a phone # or address)

Partners in Family Practice, Ltd.
Phone: 478-4132
Fax: 330-478-3341

4048 Dressler Rd. N.W. Suite 203
Canton, Ohio 44718

As you may know, the HIPAA Privacy Rule permits a provider who is a covered entity to disclose a complete medical record including portions that were created by another provider, assuming that the disclosure is for a purpose permitted by the Privacy Rule, such as treatment!

The following information is authorized for release (check all appropriate items):

☐ Emergency Room Report(s)	☐ Radiology Reports	☐ Lab Reports
☐ History & Physical	☐ Discharge Summary	☐ Pathology Reports
☐ **Complete Medical History**	☐ Operative Reports	☐ EKG Reports

☐ Other _____

I understand and acknowledge that my medical records may contain alcohol/drug abuse and/or HIV/AIDS and/or mental health information, and I expressly consent to the release of any such information contained in the records designated above. **This release expires 1 year from the date of signature unless otherwise, indicated by patient.**

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian (Relationship) Date

_____ _____
Signature of Witness Date

PARTNERS IN FAMILY PRACTICE, LTD., 4048 Dressler Rd., N.W., Suite 203, Canton, Ohio 44718

Legal Authorizations

MINOR CONSENT

I/We, the undersigned parent(s) or legal guardian of _____ a minor, do hereby authorize and consent to any medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff at Partners in Family Practice, Ltd. under the provisions of the Medicine Practice Act. It is understood that this authorization is given in advance of any specific diagnosis and/or treatment being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his or her best judgment may deem advisable. I also authorize the following people to bring my minor child to the office for treatment: _____

Parent/Guardian Signature: _____ Date: _____

HIPAA ACKNOWLEDGEMENT

I, _____, the undersigned Patient or the parent and/or legal guardian of the patient acknowledge that I have received a copy of Partners in Family Practice's Notice of Privacy Practices. **Our practice leaves ALL normal results on your answering machine. If you would prefer not to receive normal results on your answering machine please notify us.** We will honor all requests within reason but please know that legally we do have the right to contact you with any means available in an emergency.

I wish to be contacted in the following manner (PLEASE CHECK ALL THAT APPLY)

- ☐ Home Telephone: _____
  - ☐ OK to leave a message with detailed Information
  - ☐ Leave message with call back number Only
- ☐ Cell Phone Number: _____
  - ☐ OK to leave a message with detailed Information
  - ☐ Leave message with call back number Only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed Information
  - ☐ Leave message with call back number Only
- ☐ Written Communication (CHECK ALL THAT APPLY)
  - ☐ OK to mail to my home address
  - ☐ OK to fax to this number: _____

CANCELLATION / MISSED APPOINTMENTS POLICY

Due to the very busy schedule of our providers, we have found the need to develop a policy for cancellations and missed appointments. **All appointments must be cancelled or rescheduled 24 hours in advance**. If you fail to give appropriate notice on 3+ occasions, treatment at this office will be terminated. It will be your responsibility to find another private physician or contact your insurance carrier for further treatment. There could be a $10.00 fee to call in medications if it is due to a missed appointment or cancellation that was not done within the 24 hour period (at the discretion of the provider). This will have to be paid prior to your next appointment time.

FINANCIAL POLICY / AUTHORIZATIONS

We ask for co-payments, co-insurances and deductibles at the time of service. A copy of your insurance card is required at the time of the initial service and yearly as well as any time your insurance coverage changes. All self-pay patients are asked for $100 down for a new patient and $50 down payment for established patients. Balances paid on the same day will receive an additional 20% discount; balances paid within 30 days will receive a 10% discount. All balances held after 30 days will NOT receive a discount and will be due and payable prior to next appointment.

With the proper information, we will prepare and file your insurance claims as a service to you free of charge. In some cases, you may need to file your own claims. We will assist you by providing you with an itemized statement that you can attach to your form and submit. Your insurance policy is a contract between you and your insurance company. It is important that you understand its provisions. We CANNOT guarantee payment of your claims, and our office will NOT accept responsibility of negotiating claims with your insurance companies or other persons. The Patient is responsible for payment of his/her medical care, regardless of the status of the claim. If your insurance company pays only a portion of your bill or rejects the claim, any contact or explanation should be made to you, the policy holder. Reduction or Rejection of your claim by your insurance company does not relieve your financial obligation that you have incurred with our office. If necessary we will lend assistance when needed to help process your rejected claims. **It is ultimately your responsibility to make sure we have your correct insurance card on file at the time of service and if the claim is denied for "no authorization," you will be responsible for payment. It is also your responsibility to verify coverage for your particular plan and if your insurance company denies claim payment for a plan provision, you will be responsible for the balances.**

*There is a $20 charge to fill out disability forms with a 48 hour notice.
*There is a $35 charge for a written NSF check.
*We reserve the right to charge for transfer of medical records
*We have the authorization to verify employment if needed

By signing below I agree that all of the above is true to the best of my knowledge. I agree to give Partners in Family Practice, Ltd. Permission to bill my insurance company on my behalf. I agree that ultimately I am responsible for all incurred costs not covered by my insurance company and it is my responsibility to know the terms of coverage for my insurance plan.

A SPECIAL NOTE: In situations of divorce, separation, court orders, etc., the party initiating treatment will be financially responsible for the account (including no-shows and late cancels).

_____

Patient Signature and/or Parent(s) or Legal Guardian of Patient **Date**

Partners in Family Practice , Ltd.
Authorization to Name a Personal Representative

Patient's Full Name: _____

Date of Birth: _____

I hereby authorize that following people to be my Personal Representative:

_____
_____
_____

I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

I understand that Partners in Family Practice, Ltd. will not condition treatment, payment of (if applicable) enrollment in the health plan, or eligibility for benefits on my providing authorization for the requested use of disclosure and that I may refuse to sign this authorization.

I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Partners in Family Practice, Ltd.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Expiration date or event: This authorization will expire at the end of the year.

Partners in Family Practice, Ltd. provides authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

Ohio State law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions.

_____
Date

_____
Signature of Patient

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E-PRESCRIBING PBM CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions--** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions--** Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent for you are agreeing that ***Partners In Family Practice*** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed) _____ Date of Birth ___/___/___

Signature of Patient (or representative) _____

Date ___/___/____ Relationship if other than patient_____

Consent Denied_____ Date ___/___/_____

If consent is denied, we CANNOT send your prescriptions to the pharmacy

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Name: _____ **Race:** White / Black/African American / American Indian
Last Name First Name Middle Name Asian / Hawaiian / Other / Unknown / Declined

Prefix: □ Miss □ Mr. □ Mrs. □ Ms. **Suffix:** □ I □ II □ III □ IV □ Jr. □ Sr. **Ethnicity: Hispanic/Latino? YES / NO**

Nickname/Preferred Name: _____ **Maiden Name:** (if applicable) _____

Date of Birth: ____/____/____ **Sex:** □ Female □ Male **Social Security #** ____/____/____

Marital Status: □ Divorced □ Married □ Single □ Separated □ Widowed □ Other

Address: _____
Street City State ZipCode

Preferred Method of Contact for Appointment Reminder? Home Phone Call , Cell Phone Call , Text Message
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Email Address: _____ **Employer Name:** _____

Emergency Contacts (if patient is a minor, mothers AND father's information MUST be completed):
1.) Mother / Spouse: ↓ ***IF YOUR PARENT HOLDS INSURANCE ON YOU WE NEED ADDRESS/PHONE#**

_____
Name Address (if different from above) City State Zip Phone

2.) Father / Spouse: ↓

_____
Name Address (if different from above) City State Zip Phone

3.) Emergency Contact: ↓

_____
Name Address City State Zip Phone

4.) Legal Guardian: ↓

_____
Name Address City State Zip Phone

5.) Family Member NOT Living in Home/ Closest Relative: ↓

_____
Name Address City State Zip Phone

Family Member Names Who Are Patients Here: _____

Insurance Coverage: (*IF INSURANCE IS THROUGH PARENT WE NEED ALL THEIR INFORMATION)
Primary Insurance: _____ **Policy #: *** _____ **Group #** _____
Insured Name: * _____ **Insured Date of Birth:*** _____ **Copay $** _____
Insured Social Security #: * _____ **Effective Date:** ____/____/____
Insured Employer: * _____ **Phone:*** _____
Insurance Address: _____

Insurance Coverage: (IF YOU HAVE A THIRD INSURANCE COMPANY PLEASE WRITE INFO ON BACK)
Secondary Insurance: _____ **Policy** _____ **Group #** _____
Insured Name: _____ **Insured Date Birth** _____ **Copay $** _____
Insured Social Security #: _____ **Effective Date:** ____/____
Insured Employer: _____ **Phone** _____
Insurance Address: _____

****

Preferred Pharmacy: _____ ***Phone*** _____

MEDICAL INFORMATION

Name: _____ **DOB:** _____

Reason for today's visit: _____

Past Medical History: Have you ever had any of the following? Check box if "Yes."

Heart
- _____ Hypertension
- _____ Hyperlipidemia
- _____ Heart Attack
- _____ Congestive Heart Failure
- _____ Heart Murmur
- _____ Heart Valve Disorder
- _____ Atrial Fibrillation
- _____ Peripheral Vascular Disease
- _____ Deep Venous Thrombosis
- _____ Aortic Aneurysm
- _____ Carotid Stenosis
- _____ IHSS/ Subaortic Stenosis
- _____ Marfan Syndrome
- _____ Ehlers- Danlos Syndrome

Lungs
- _____ COPD
- _____ Asthma
- _____ Emphysema
- _____ Sleep Apnea
- _____ Pulmonary Embolism
- _____ Asbestos Exposure
- _____ Positive PPD
- _____ Tuberculosis
- _____ Lung Nodules
- _____ Sacoidosis
- _____ Cystic Fibrosis
- _____ Polio

Gastrointestinal
- _____ GERD/Reflux
- _____ Hiatal Hernia
- _____ Diverticulosis
- _____ Colon Polyps
- _____ Gastric/Peptic Ulcer
- _____ Hepatitis
- _____ Ulcerative Colitis
- _____ Crohns Disease
- _____ Irritable Bowel Syndrome
- _____ Fatty Liver Disease
- _____ C. Diff Diarrhea
- _____ Pancreatitis

Nervous System
- _____ Seizure/ Epilepsy
- _____ Stroke
- _____ Head Injury
- _____ Parkinsons
- _____ Migraines
- _____ Alzheimers/Dementia
- _____ Mental Retardation
- _____ Aneurysm
- _____ Hydrocephalus/Shunt
- _____ Peripheral Neuropathy
- _____ Multiple Sclerosis

Psychiatry
- _____ Anxiety
- _____ Depression
- _____ Bipolar Disorder
- _____ ADHD
- _____ ADD
- _____ Learning Disability
- _____ Speech Delay
- _____ Obsessive Compulsive
- _____ Schizophrenia

Endocrine
- _____ Diabetes
- _____ Hypothyroidism
- _____ Goiter
- _____ Osteoporosis
- _____ Osteopenia

Kidney/Bladder
- _____ Polycystic Kidney
- _____ Kidney Stones
- _____ Kidney Failure
- _____ Dialysis
- _____ Recurrent UTI
- _____ Incontinence/Overactive Bladder

Musculoskeletal
- _____ Rheumatoid Arthritis
- _____ Osteoarthritis
- _____ Degenerative /Herniated Disc
- _____ Systemic Lupus Erythmatosis
- _____ Fibromyalgia
- _____ Gout

Congenital
- _____ Congenital Heart defect
- _____ Down Syndrome
- _____ Turners Syndrome
- _____ Cleft lip/Cleft palate
- _____ Prematurity
- _____ Congenital Hearing Loss

Skin
- _____ Psoriasis
- _____ Eczema
- _____ Rosacea

Blood
- _____ Anemia
- _____ Blood Transfusion
- _____ Bleeding Disorder
- _____ Clotting Disorder
- _____ Thalassemia
- _____ Sickle Cell

Infections
- _____ HIV
- _____ Herpes Simplex Virus
- _____ Chlamydia
- _____ Gonorrhea
- _____ Syphillis
- _____ Genital Warts
- _____ HPV

Eyes
- _____ Cataracts
- _____ Glaucoma
- _____ Macular Degeneration
- _____ Retinal Detachment
- _____ Diabetic Retinopathy

Ears/Nose/Throat
- _____ TMJ
- _____ Menieres Disease
- _____ Allergic Rhinitis

Cancer

Please name type of CANCER you have had : _____

_____

Female problems
- _____ Ovarian Cyst
- _____ Endometriosis
- _____ Uterine Fibroids
- _____ Abnormal PAP smear
- _____ Polycystic Ovarian Syndrome
- _____ Breast Mass
- _____ Miscarriage/Abortion
- _____ HPV

Male problems
- _____ BPH- Prostate Problems
- _____ PSA elevation
- _____ Erectile Dysfunction
- _____ Testicular Mass
- _____ Low Testosterone

Childhood Diseases? _____ **Chicken Pox**

_____ **Other?** _____

Name: _____ DOB: _____

Surgeries: Have you had any surgeries ? Check box if "yes" and write date of surgery .

_____ Hernia/ what type?
_____ Appendix
_____ Gall bladder
_____ Gastric Bypass
_____ Ear Tubes
_____ Tonsils
_____ Adenoids
_____ Sinus Surgery
_____ Splenectomy
_____ Cataracts
_____ Laser eye Surgery
_____ LASIK

_____ Colonoscopy
_____ EGD
_____ Joint Replacement?/ what joint?_____
_____ Coronary Artery Bypass/ Open Heart Surgery
_____ Heart Valve Replacement/ what valve?_____
_____ Heart Catheterization
_____ Heart Stent Placement
_____ Heart Angioplasty
_____ Carotid Surgery
_____ Aneurysm repair
_____ Greenfield filter

Female
_____ Tubal Ligation
_____ Hysterectomy/ovaries removed?
_____ Colposcopy
_____ LEEP/cervical surgery
_____ D&C
_____ Endometrial Ablation
_____ Breast

Male
_____ Vasectomy
_____ TURP

Other surgery _____

Medications:

Medication Name	Dosage (mg)	# Pills taken	How many times per day

Allergies:

Medication/Other	Reaction

Social History:

Alcohol Use: __Never __Former __Current, Amount _____
Tobacco Use: __Never __Former __Current, Amount _____
Illegal Drug Use: __Never __Former __Current, Amount _____
Type of Drugs used _____
Caffeine Use: __Never __Former __Current, Amount _____

Exposed to Second Hand Smoke? Yes or No
If so, by Whom? _____

Marital Status ? _____
What is your highest level of education? _____
What is your occupation? _____

Have you ever been exposed to any hazardous materials? (Lead, Asbestos, etc) YES or NO
If YES, what material were you exposed to and when? _____

Are you at increased risk of infection? (TB, Hepatitis, Sexually Transmitted Diseases, etc)
YES or NO If YES, why? _____

Do you wear your seat belt riding or driving a car? YES or NO

Do you have a routine exercise plan? YES or NO
How many times per week do you exercise? _____

Have you ever or do you currently serve in the military? YES or NO
If YES, what branch of military? _____

Is there any history of domestic violence (physical or verbal)? YES or NO
If YES, by whom? _____

Do you have a Living Will/POA for Health Care ? YES or NO. Please provide a copy for your chart or you may request one from our office.

Hand Dominance? Are you right handed ___ , left handed ___ , both ___

Name: _____ DOB:_____

Family History : ** Maternal = Mother's Family , **Paternal = Father's Family

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Children
Heart Disease									
High Blood pressure									
Diabetes									
Thyroid									
Cancer(type)									
Kidney									
Stroke									
Osteoporosis									
Mental Illness									

Please indicate by circling if you are experiencing any of the following symptoms at this time:

Fever / chills
Eye pain / vision changes
Headache / head injury
Chest pain
Irregular heart beats
Shortness of breath
Wheezing
Nausea/ vomiting/ diarrhea/ constipation
Abdominal pain
Blood in stool
Blood in urine
Burning with urination
Seizures / tremors
Anxiety / depression
Seasonal allergies
Rash
Change to skin lesion

Please indicate the last time you have had a:

Dental Ex _____
Vision Ex _____
Flu vaccin_____
Pneumoni_____
Tetanus va_____
Heapatitis_____
TB test _____

For WOMEN ONLY :

Is there any chance of pregnancy today ? YES or NO

Age at onset of menstrual period? _____ Date of last menstrual period? _____

Do you do regular self breat exams ? YES or NO

Do you use birth control ? YES or NO What type ?_____

Number of pregnancies _____ Number of live births_____
Number of abortions _____ Number of miscarriages_____

Please indicate the year of your last:

Breast Exam _____
Mammogram _____
PAP smear _____
HPV test _____

For MEN ONLY:

Please indicate the year of your last :

Rectal/ Prostate exam _____
PSA _____

PLEASE PROVIDE OUR OFFICE WITH A COPY OF YOUR IMMUNIZATIONS