PATIENT INFORMATION FORM

To allow us to improve our service to you, we are asking all patients to complete an updated patient form. Please complete the **entire** form and return to the front desk before your visit.

Name: ______________________ __________ ____________________________

First *M.I.* *Last*

Street Address: ________________________________ *Unit #:* ______________

City: ____________________________ *State:* ________ *Zip:* ______________

Date of Birth ___________ *Sex* ___________ *S.S #* ______________________

Home Phone Number: ___________ *Cell Phone Number:* ___________ *(reminders sent electronically)*

Email Address: (reminders sent electronically) ______________________________

Ethnicity (Circle One): Hispanic / Non-Hispanic

Preferred Language: English / Other (Please specify): ______________________

Race (Circle one): African American / Asian / Caucasion / Native American / Other

Emergency Contact: ________________________________ ***Phone:*** ______________

Past Medical History:

__*Alcoholism*	__*Bleeding Disorder*	__*Epilepsy*	__*Kidney Disorder*	__*Rheumatic Fever*
__*Allergies*	__*Blood Disease*	__*Glaucoma*	__*Liver Disorder*	__*Skin Disorder*
__*Anemia*	__*Blood Transfusion*	__*Gout*	__*Lung Disease*	__*Stomach Ulcer*
__*Anxiety Disorder*	__*Cancer*	__*Heart Disease*	__*Measles*	__*Substance Abuse*
__*Arthritis*	__*Diabetes*	__*Hepatitis A, B or C*	__*Migraines*	__*Stroke*
__*Asthma*	__*Depression*	__*High Blood Pressure*	__*Osteoporosis*	__*Thyroid Disorder*
__*AIDS/HIV*	__*Ear Problems*	__*High Cholesterol*	__*Pneumonia*	__*Tuberculosis*
__*Back Problems*	__*Eating Disorder*	__*Joint Disorder*	__*Polio*	__*Venereal Disease*

Hospitalizations & Surgeries:

Reason: ________________________________ *Date:* ______________

Reason: ________________________________ *Date:* ______________

Reason: ________________________________ *Date:* ______________

Family History: *Has anyone in your family ever had any of the following conditions:*

__*Alcoholism*	__*Asthma*	__*Diabetes*	__*High Cholesterol*	__*Migraines*
__*Allergies*	__*AID/HIV*	__*Epilepsy*	__*High Blood Pressure*	__*Psychiatric Dis*
__*Alzheimer's*	__*Bleeding Disorder*	__*Genetic Disorder*	__*Joint Disorder*	__*Osteoporosis*
__*Anemia*	__*Blood Disorder*	__*Glaucoma*	__*Kidney Disease*	__*Stroke*
__*Anxiety*	__*Cancer*	__*Heart Disease*	__*Liver Disorder*	__*Substance Abuse*
__*Arthritis*	__*Depression*	__*Hepatitis*	__*Lung Disease*	__*Thyroid Disorder*

*Details:*____

____

Smoker? *[ ]no* *[ ]yes* *How much?*____

Alcohol use? *[ ]social* *[ ] moderate* *[ ] heavy*

Current Medications*:* *What medications are you currently taking?*

*Name*______________________________ *Dosage*_____________ *Frequency*_______________

*Name*______________________________ *Dosage*_____________ *Frequency*_______________

*Name*______________________________ *Dosage*_____________ *Frequency*_______________

*Name*______________________________ *Dosage*_____________ *Frequency*_______________

*Name*______________________________ *Dosage*_____________ *Frequency*_______________

Allergies*:* *Are you allergic to any of the following?*

__*Adhesive Tape*	__*Antibiotics*	__*Aspirin*	__*Barbiturates (sleeping pills)*	
__*Codeine*	__*Iodine*	__*Latex*	__*Local Anesthetics*	__*Sulpha*

Do you have any other allergies?

*Name*____________________________________ *Reaction*________________________________

*Name*____________________________________ *Reaction*________________________________

*Name*____________________________________ *Reaction*________________________________

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Who else do you allow to have access to your health information? What is their relationship to you?

Name______________________________ Relationship______________________Phone #_________________

Name______________________________ Relationship______________________Phone #_________________

Today's Date: ____

Print Patient Name: ____

Patient Signature: ____

Or

Parent/Guardian (for patients under 18)____

Print Name: ____

Signature: ____

Comprehensive Care Medical Associates, P.C.
1205 Langhorne Newtown Road, Suite 309
Langhorne, PA 19047
Phone Number: 215-741-1963
Fax Number: 215-741-1914

Financial Policy

We would like to thank you for choosing Comprehensive Care Medical Associates as your healthcare provider. Comprehensive Care Medical Associates is committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For Our Patients With Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please bring your insurance card with you at the time of your appointment.

Coverage Changes:

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Co-Payments:

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash or the following credit cards: Visa, MasterCard and Discover. If you do not have your co-payment your appointment may be rescheduled. Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you.

Payment Plan:

Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship, call (800) 263-9054 for assistance.

Delinquent Balance Appointment:

Patients with a delinquent balance are required to make payment in full for future services. A delinquent account is defined as a patient balance in excess of 120 days if the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused.

Nonpayment:

All patient responsible balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to a collection agency. Please be aware that if a balance remains unpaid, you and/or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Patient Signature: ______________________________ Date: ______________

Print Patient Name: ______________________________

New Office Policy

Recurrent No Shows for Appointments

Starting May 1st 2014, our office has implemented a new policy for patients who are No Show to their appointments. A warning will be given for the first no show and any no shows after that a $15 charge will be applied to the patients account. Unfortunately, some people's recurrent actions have caused our office to develop this new policy. We would like patients to call in advance and cancel their appointment if they know they cannot make it. This allows us to use that time slot for other patients who also need to be seen. We appreciate all the patients that come into our office and look forward to continue treating everyone for years to come.

If you have any questions or concerns about this new policy, please feel free to speak to any of our staff members or our office manager.

Thank you very much for your cooperation and support!

Print Patient's Name: ______________________________

Date of Birth: ______________________________

Patient's Signature: ______________________________

Date: ______________________________