Miller Heights Medical Associates

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Patient Information Sheet

Patient Name: _____ **Social Security #:** _____
Date of Birth: _____ **Sex:** *(circle one)* Male/Female
Street Address: _____ **City, State, Zip:** _____
Mailing/Billing Address: _____ **City, State, Zip:** _____
Marital Status: *(circle one)* Single Married Divorced Widowed
Home Phone: _____ **Cell Phone:** _____
Work Phone: _____
Preferred # to reach you: *(circle one)* Home Cell Work
Email Address: _____
How did you hear about Miller Heights Medical? _____

Emergency Contact:

Name: _____ **Relationship:** _____
Home Phone: _____ **Cell Phone:** _____

I authorize my medical information may be shared with the following individuals:

Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

Primary Insurance		Secondary Insurance	
Policyholder:		**Policyholder:**	
Policyholder's SS#:		**Policyholder's SS#:**	
Policyholder's DOB:		**Policyholder's DOB:**	
Employer:		**Employer:**	
Insurance Company:		**Insurance Company:**	
Policy #:		**Policy #:**	
Group #:		**Group #:**	
Sex: *circle one*	Male/Female	**Sex:** *circle one*	Male/Female
Policyholder's Relationship to Patient:		**Policyholder's Relationship to Patient:**	

Assignment and Release of Information Statement

I acknowledge that the information that I have provided is true and correct. I hereby authorize my insurance carrier to make payment directly to **Miller Heights Medical Associates** for services rendered to me or my dependents. I understand that I am fully responsible for any charges incurred for services rendered as well as any costs or fees incurred for collection of this account. I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents.

Patient Name (print): _____ **Signature:** _____
Parent/Guardian Name (print): _____ **Signature:** _____
Relationship to Patient _____ **Date:** _____

Miller Heights Medical Associates
Medical History

Patient Name: _____ **Date of Birth:** _____

Allergies to Medications, X-rays, or Other Substances: Yes/No
(if yes, please list name of medicine and type of reaction)

_____

_____

Medications:
(prescriptions, over-the-counter, vitamins, supplements, herbs, etc)

Name	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Gynecologic and Obstetric History

Age of onset of periods: _____ Frequency: _____ Length: _____

Number of Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged and abnormal bleeding:	Yes/No	If yes explain: _____
Leakage of Urine:	Yes/No	_____
Pelvic Pain:	Yes/No	_____
Abnormal Discharge:	Yes/No	_____
History of abnormal pap smear:	Yes/No	_____

Please List and Supply the Dates of:

Operations: _____ _____

_____ _____

Hospitalizations other than surgery:

_____ _____

Immunization history:

Pneumovax	Yes/No	Date received: _____
Flu	Yes/No	Date received: _____
Tetanus	Yes/No	Date received: _____
Hepatitis B	Yes/No	Date received: _____

Past Medical History:

(please list doctor diagnosed medical problems):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Has any member of your family (siblings, parents, grandparents) ever have the following:

Illness	Family Member	Age diagnosed	Circle one
Bleeding Diseases	_____	_____	Alive/Deceased
Cancer (describe type)	_____	_____	Alive/Deceased
Diabetes	_____	_____	Alive/Deceased
Heart Disease	_____	_____	Alive/Deceased
Hypertension (high blood pressure)	_____	_____	Alive/Deceased
(anxiety, depression)	_____	_____	Alive/Deceased
Stroke	_____	_____	Alive/Deceased

Prevention:

Do you wear seat belts?	Yes/No	
Do you smoke?	Yes/No	How many packs/day? _____
Do you drink alcholic beverages?	Yes/No	How much a week? _____
Do you drink caffeinated beverages?	Yes/No	How much a week? _____
Have you ever worked with chemicals, asbestos, or other hazardous materials?	Yes/No	Explain: _____
Do you use drugs? (marijuana, cocaine, crack, etc)	Yes/No	Explain: _____
Do you engage in any sexual activities that would put you at risk for venereal diseases or AIDS/HIV?	Yes/No	

FINANCIAL POLICY

The purpose of this Financial Policy is to help understand our billing and payment policies for our professional services. We ask that you read and acknowledge the following with your signature.

- All patients should provide accurate and complete personal demographics and insurance information prior to being seen by the provider. All insurance cards **should be** shown at each and every visit.
- All applicable co-payments and balances, both current and prior, are due at the time of service.
- We accept cash, check, Visa, MasterCard, American Express and Discover credit cards.

Regarding Insurance

Our practice participates with many health insurance companies. It is your responsibility to comply with any predetermination of benefits or referral requirements. Please be aware that some or all of the services provided may be non-covered by your insurance company. Our billing department will submit a claim to the insurance company on your behalf. If you are a member of an insurance company that we do not participate in, we will request payment in full at the time of service.

If your plan assigns a PCP (primary care physician) to you and we are **not** your PCP, we will not file a claim with the insurance company (i.e. HMO).

You are responsible for contacting our office to request a referral or authorization required by your insurance company. This request should be submitted within 72 hours prior to the date of the office visit or procedure because of the processing time needed to obtain a referral or authorization. We must participate with your insurance company to obtain a referral or an authorization.

In the event of personal financial hardship, Medical Associates of the Lehigh Valley, PC can offer special financial arrangements, including payment plans. Financial documents could be requested for any financial hardship.

Billing Statements

A billing statement for any balance due for services rendered will be sent to you on a monthly basis. If you cannot pay the balance in full, please contact our billing department to make payment arrangements (610-973-1410).

Returned Checks

If a personal check is returned from your bank for any reason, your account will be charged a **$20.00** return check fee.

Past Due Accounts
Accounts that are past due **could be referred** to our Collection Agency.

Children Accounts
For a child under 18, the accompanying parent or guardian of a child is responsible for payment according to terms described above. We will not get involved in any custody arrangements for payment.

Completion of Forms
Please be aware that your physician reserves the right to charge a fee when requesting the completion of forms at a time other than your office visit.

Copying Medical Records
We reserve the right to charge a medical records copying fee in accordance with Act 26. We do not seek to make a profit on providing medical records, rather to recover our costs for copying them.

I authorize and assign insurance benefit payments directly to LVPG MATLV for any medical services I receive. I understand and agree that I am ultimately responsible for the charges on my account for any professional services rendered that is not covered by my insurance company.

I have read the Financial Policy. I understand and agree to the Financial Policy.

_____
Print Name

_____
Signature

_____
Date

Miller Heights Medical Associates
Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Miller Heights Medical Associates to use and disclose health information about your treatment, payments, and healthcare operations purposes.

Notice of Privacy Practices

Miller Heights Medical Associates has a Notice of Privacy Practices which describes how we may use and disclose your protected health information andhow you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments

We serve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Mail: Miller Heights Medical Associates
Attn: Privacy Officer
3833 Linden Street
Bethlehem, PA 18020

Telephone: (610) 691-0404

I have received the Notice of Privacy Practices for Miller Heights Medical Associates and authorize them to use and disclose health information about (print patient's name)_____ for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of Patient (or Patient's guardian if a minor) Date

_____ _____
Parent/Guardian Name (print) Relationship to Patient

Miller Heights Medical Associates

3833 Linden Street

Bethlehem Pa 18020

Phone # 610-691-0404

Fax # 610-419-9159

Medical Records Release Form

By signing this form, I authorize you to release my confidential health information. Please release my entire file to the entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release is as follows:

____ Complete Records	____ History & Physical	___ Progress Notes
____ Care Plan	____ Lab Reports	___ Radiology Reports
____ Pathology Reports	____ Treatment Record	___ Operative Reports
____ Hospital Reports	____ Medication Record	___ Other (Please specify)

Please list previous physician to retrieve records from:

Name: _____

Address: _____

City: State: Zip Code: _____

Signature: _____