Elkview Health, LLC

New Patient Information

Welcome to our practice! Please complete these forms to the best of your knowledge.

Patient's Name_____

Patient's Home Phone Number: _____ Alternate Phone Number (0 cell or 0 work): _____

E-Mail Address: _____

Address: _____ Apt. #_____

City: _____State: _____Zip:_____

Date of Birth: _____ Age: _____ Sex: M F Social Security Number:_____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Preferred Pharmacy: _____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed
[ ] Retired [ ] Student [ ] Other: _____

Emergency Contact: _____ Relationship to Patient:_____

Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder:_____Relationship to Patient:_____

Address:

Social Security Number:_____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number:

How did you hear about us?_____

Can we contact you by mail?	Yes	No
Can we contact you by phone?	Yes	No
Can we leave a detailed message?	Yes	No

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above-named patient.

Name(s): _____Relationship to Patient: _____

Elkview Health, LLC, reserves the right to charge a fee for any scheduled visits that are:

1. Cancelled with less than 24 hours' notice
2. Are missed without calling to cancel (no show)

Cancellation Fee schedule: New Patient $25.00; Established Patient: $25.00

Patient / Parent or Guardian Signature:_____Date:

Release of information, benefits assignment, payment authorizations, full disclosure statement, and payment agreement:

I hereby authorize Elkview Health, LLC, to release my information necessary to process my Insurance/Medicare claim, acquired in the course of my examination treatment, to allow a photocopy of my signature to be used to process my Insurance/Medicare claim for the period for a lifetime. I claim any insurance benefits due to me for services rendered at Elkview Health, LLC, and authorize and direct any carrier to issue payment check(s) directly to Elkview Health, LLC, regardless of my insurance benefits, if any. I understand that lam fully financially responsible for any and all fees incurred, and I agree to pay such fee in full. The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which lam entitled. I understand that failure to disclose pre-certification/second opinion requirements for any all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

Patient/ Responsible Party Signature Date

Please list any/all physicians we can share medical information with: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical Information

Concerns you would like to discuss with your Nurse Practitioner today?

Please list any MEDICATIONS you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Allergies:
Foods? _____
Environmental? _____
Medications? _____
_____

Please list any SURGERIES you have had and indicate month/year?

Date of last completed physical exam?

Date of last blood work?

Date of last Tetanus shot?

Date of last Flu shot?

If **YOU** or a **FAMILY MEMBER** has had any of the following, please circle and indicate which family member or self:

Heart disease:	Genetic disorder:
Diabetes:	Cancer:
Thyroid Disease:	Alcoholism:
Mental Illness:	Arthritis:
Glaucoma:	Asthma:
Tuberculosis:	Stomach Issues:
Hypertension:	Hyperlipidemia:

List any diseases that run in your family and specify your relationship to each family member listed:

For Females Only

Age of first period? _____

Date of last menstrual period? _____ Abnormal Pap? _____

Date of last Mammogram? _____ DEXA? _____

Number of pregnancies: _____ Living Children: _____ Miscarriages: _____

Terminations: _____

Method/s of Contraception: _____

Menopause? _____ (has it been more than 1 year since your last period? _____)

Do you have (circle):

Irregular periods	Bad menstrual cramps	Heavy Periods
Female trouble	Hot flashes	Vaginal dryness
Vaginal Itching	PMS	Breast Problems
Pelvic Pain	Infertility	Abnormal Mammogram
Abnormal Pap	Vaginal discharge	Vaginal Odor

Social History

Tobacco use: Do you smoke? _____ if so, how many cigarettes/cigars per day? _____

# of years smoking: _____

Do you chew tobacco? _____ Have you thought about quitting? _____

Have you quit before? _____ How long?

Alcohol use: Do you drink alcohol? _____ if so, what type? _____

How many in 1 week? _____

Drug use: Any history of illegal drug use? _____ if so, what type? _____

Do you exercise? _____

What activities do you do, and how often in 1 week?

Are you on a special diet? _____ if so, what? _____

Do you consume any caffeinated products? _____ if so, what and how much per day?

Have you recently noticed an increase in sadness or gloominess? _____

Have you lost interest in enjoyable activities? _____

Do you have a living will? _____ if yes, please provide us a copy.

Describe any skin problems.

Describe any lung and breathing problems.

Describe any problems with your stomach, intestines, colon, digestion, or bowel movements.

Describe any urinary trouble.

Describe any sexual concerns.

Describe any bone, muscle, or joint problems.

Describe any hormone problems.

Describe any problems with your thinking, concentration, moods, energy level, interest in life, etc.

Describe any problems with strength, sensation, coordination, or neurologic function.

Patient signature Date

Payment Policy:

- **Insurance**

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we care verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. _____(initial)

- **Co-Payments & Deductibles**

All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. _____(initial)

- **Non-Covered Services**

Please be aware that some- and perhaps all- of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. _____(initial)

- **Proof of Insurance**

All patients must complete our patient information form before seeing the provider. We must obtain a copy of your drivers license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. _____(initial)

- **Claims Submission**

We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. _____(initial)

- **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. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. _____(initial)

- **Nonpayment**

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from the 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 days period, our provider will only be able to treat you on an emergency basis. _____(initial)

- **Patient Portal**

I am aware that providing Elkview Health, LLC, with my current email, I will have access to my secure medical chart via the patient portal. I will be able to access my appointment request or reminders, prescription refills, non-urgent medical questions, lab results, and more. _____(initial)

- **Electronic Prescribing**

Elkview Health, LLC is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to provide the best possible treatment. I give Elkview Health, LLC, permission to request and use prescribing medication history from other healthcare providers. _____(initial)

- **Fee for Service**

Services are rendered to the patient, not the insurance company. Our office will file your insurance claim. All CO-PAYS and DEDUCTIBLES are due in dull at the time of service. For unpaid claims in over 45 days, it is the patient's responsibility to follow up with their insurance carrier and the balance due is considered the patients responsibility. Payment will be due in full. _____(initial)

Patient Consent for Use and Disclosure of Protected Health Information (PHI)

With my consent, Elkview Health, LLC, may use and disclose protected health information (PHI) about me in order to carry out treatment, payment and healthcare operations (TPO). A more complete description of such uses and disclosures can be found in Notice of Privacy Practices for Elkview Health, LLC.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Elkview Health, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Elkview Health, LLC, 105 Credes Landing, Elkview, WV 25071.

With my consent, a representative of Elkview Health, LLC may call my home or other designated location and leave a message on an answering machine, voicemail, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results.

With my consent, Elkview Health, LLC may mail to my home or other designated location any item that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

I have the right to request that Elkview Health, LLC, restrict how it uses or discloses by PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, such uses and disclosures are bounded by this agreement. I have such requested restrictions listed below:

_____

_____

By signing this form, I am consenting to Elkview Health, LLC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing expect to the extent that the practice has already made disclosures in reliance to my prior consent. If I do not sign this consent, Elkview Health, LLC may decline to provide treatment to me. By signing this form, I also acknowledge that I have received and reviewed the Notice of Privacy Practices (NPP).

Patient Consent for Release of Protected Health Information (PHI):

I give permission for Elkview Health, LLC to release any information regarding my medical history, including but not limited to any test results, appointments, and medications to ONLY the following persons listed below:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Patient/Responsible Party Signature:	Date:	