Dunbar Medical Associates, PLLC

Patient Information Sheet

Full Name: _____
Last First MI

Address: _____

Sex: M F DOB: _____ Marital Status: _____ SS#:_____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____

Employer Address: _____

Email Address: _____

Spouse's Name: _____ DOB: _____

SS#: _____ Phone #: _____

Employer: _____ Work#: _____

Who is responsible for this account?

Name: _____ Relationship to Pt: _____ DOB: _____

SS#:_____Phone#: _____

Address: _____

Employer: _____

Employer Address: _____

Primary Insurance Company: _____

Insured: _____ Relationship to Patient: _____

Policy #: _____ Group#: _____

Address: _____

Date Insurance Became Effective: _____

Secondary Insurance Company: _____

Insured: _____ Relationship to Patient: _____

Policy #: _____ Group#: _____

Address: _____

Date Insurance Became Effective: _____

Does your insurance require pre-authorization for hospital admission/outpatient testing?

Yes_____ No_____ Phone # to call: _____

******IF payment is not received within 90 days, balances will become patient responsibility******

Local Pharmacy you use regularly: _____ Phone: _____

I hereby authorize the release of any medical information necessary to process any insurance claim and adding any and all insurance benefits to Dunbar Medical Associates. I authorize the treatment of the above named patient and agree to pay for all services and treatment provided.

Patient (or Guarantor) Signature: _____ Date: _____

Employee Initial: _____

Patient Health Information

Personal Medical History

Please check all conditions you have experienced; give a brief explanation & approximate date.

- o Blood Clots _____
- o Diabetes_____
- o Lung Problems_____
- o Cancer_____
- o Anemia_____
- o Hernia_____
- o Abdominal Pain_____
- o Acid Reflux_____
- o Weight Gain_____
- o Breast Problems_____
- o Heart Disease_____
- o High Blood Pressure_____
- o Thyroid Problems_____
- o Asthma_____
- o Chest Pain_____
- o Recurring Diarrhea_____
- o Recurring Constipation_____
- o Weight Loss_____

Family Medical History

Has anyone in your family had the following conditions? (Circle NO or YES and specify relationship-parent, sibling, child, etc).

Breast Cancer?	No	Yes	Relationship:_____
Colon Cancer?	No	Yes	Relationship:_____
Diabetes?	No	Yes	Relationship:_____
Heart Disease, Stroke?	No	Yes	Relationship:_____
Arthritis, Gout?	No	Yes	Relationship:_____
Kidney Disease?	No	Yes	Relationship:_____
Asthma?	No	Yes	Relationship:_____
High Blood Pressure?	No	Yes	Relationship:_____
Other Cancer?	No	Yes	Relationship:_____

Please specify other cancer(s) and relationships:

_____

_____

Please provide the year, a description of the illness or surgery, and the hospital where you were treated:

Year	Illness or Surgery	Hospital

Year	Illness or Surgery	Hospital

Women's Health

If applicable, please provide dates for the following:

Last Menstrual Period: _____ Last Pap Smear: _____

Are you or could you be pregnant? Yes No If Yes, estimated due date: _____

Last Mammogram: _____

Last Diagnostic Testing

Provide the most recent date for the following tests:

Colonoscopy:	_____	Stress Test:	_____
Bone Density:	_____	Endoscopy:	_____
EKG:	_____	CT Scan:	_____
MRI:	_____	X-Ray:	_____

Allergies:

Please list all drug, food, & environmental allergies and reactions:

Allergy	Reaction

Prescription Medications:

Please list all prescription medications you are currently taking. (Use back of this sheet if needed)

Drug Name	Dosage	Prescribing Physician

OTC and Herbal Medications:

Are you currently using any of the following over-the-counter medications or herbal supplements? (Circle YES or NO)

Tylenol	NO	YES	Aspirin/Bayer/Goodies	NO	YES
Appetite Suppressants	NO	YES	Sleep Aids	NO	YES
Laxatives	NO	YES	Advil/Aleve/Ibuprofen/Motrin	NO	YES
Calcium	NO	YES	Decongestants/Nasal Sprays	NO	YES
Herbs/Vitamins/Supplements	NO	YES	Others:	NO	YES

If answered YES to others, please specify:

_____

_____

_____

Social History:

Please indicate exposure to the following. (Circle one and provide addition information as requested.)

Smoke	NO	YES	PAST	Packs Per Day?	____	How Many Years?	_____
Smokeless Tobacco	NO	YES	PAST	How Often?	____	How Many Years?	_____
Alcoholic Beverages	NO	YES	PAST	How Often?	____	How Many Years?	_____
Illegal Drugs	NO	YES	PAST	How Often?	____	How Many Years?	_____
Second-Hand Smoke	NO	YES	PAST				
Caffeinated Beverages	NO	YES	PAST				
Stress	NO	YES	PAST				
Hazardous Substances	NO	YES	PAST				
Heavy Lifting	NO	YES	PAST				

I certify the above information is correct top the best of my knowledge. I will not hold my doctor or any member of the staff responsible for errors or omissions I may have made as I completed this form.

Signature: _____ Date: _____

Dunbar Medical Associates, PLLC

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

PAYMENT IS DUE AT THE TIME OF SERVICE FOR OFFICE VISITS, UNLESS WE ACCEPT ASSIGNMENT WITH YOUR INSURANCE CARRIER. WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD/DISCOVER/AMEX. WE OFFER EXTENDED PAYMENT PLANS WITH PRIOR CREDIT APPROVAL.

Regarding Insurance:

ASSIGNMENT/PARTICIPATION-MANAGED CARE CONTRACTS:

We accept assignment of insurance benefits/managed care contracts with multiple insurance carriers. If you have any questions, our receptionist can assist you in determining if your insurance carrier is one Dunbar Medical Associates, PLLC is in contract with. You are responsible for coinsurance, deductibles, and copayments only which are due at the time of service.

COPAYS: Credit will not be extended for any copayments.

ALL OTHER INSURANCE CARRIERS:

Your insurance is a contract between you and your insurance company. Dunbar Medical Associates, PLLC is not a party to that contract. If your insurance company has not paid your account in full within 90 days, it becomes YOUR responsibility. Please be aware some, and perhaps all, of the services rendered may be "non-covered" services and not considered reasonable and/or necessary under the Medicare Program and/or other medical insurances.

UCR (Usual & Customary Rates):

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The parent(s) or guardian(s) is responsible for full payment.

By signing below, I understand and agree to the terms I have read in the above Financial Policy.

MEDICAID:

We **ARE NOT** Medicaid Providers and **CANNOT** bill Medicaid for services rendered. If you have Medicaid as a secondary insurance, you will be responsible for any charges incurred after your Primary Insurance pays their part (ie: deductibles, copays, etc).

******IF payment is not received within 90 days, balances will become patient responsibility******

Signature Patient or Responsible Party **Date**

Signature Co-Responsible Party **Date**

Revised 03/22/2019

Authorization to Use and/or Disclose Medical Records

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

Name of Patient: _____DOB: _____ SS# _____

Recipient of Records	***Who is releasing the records?***
Records To: Dunbar Medical Associates, PLLC	Records From:_____
Address: 1100 Grosscup Ave. Dunbar, WV 25064	Address: _____
Phone: 304-768-8811 Fax: 304-768-4072	Phone: _____

For the following purposes:

□Continued Medical Care	□Personal Information	□Legal Follow-Up
□Disability Insurance	□Other	

By checking the boxes below, I specifically authorize the use and/or disclosure of the flowing health information and/or medical records, if such information and/or records exist:

□Please send the entire Medical Record (all information) for the above named recipient.

-------OR-------

□Office Notes & Reports	□Most Recent One Year History	□Most Recent 3 Year History
□Rx History	□Transcribed Hospital Reports	□Laboratory Reports
□Billing Statements	□Diagnostic Reports	□Diagnostic Films

□Others (listed here): _____

The following items must be initialed to be included in the use and/or disclosure:

- — HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
- — Mental health information and/or records
- — Domestic Violence
- — Genetic testing information and/or records
- — Drug/alcohol diagnosis, treatment or referral information (federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

  _____

  _____

I understand if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPPA and other federal and/or state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I further understand I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand I may revoke this authorization at any time, provided I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire in six (6) months from the date of signing or until (insert date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patients or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to Patient: _____

Dunbar Medical Associates, PLLC

HIPAA Patient Questionnaire

1. Please list the family member(s) or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment and health care operations):

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

2. Please list the family member(s) or other(s), if any, with whom we may inform about your medical condition **IN CASE of an EMERGENCY ONLY:**

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

3. Please list the name(s) of anyone who is allowed to **PICK UP** prescription(s) &/or sample(s) on your behalf:

   Name: _____ Phone Number: _____

   Name: _____ Phone Number: _____

4. Can confidential messages (i.e. appointment reminders, normal labs) be left on your telephone answering machine or voicemail? □Yes □ No

5. Please print the telephone number or email address where you want to receive calls about your appointments, lab, and x-ray results or other health care information **IF OTHER THAN** what we have on file:

   Phone#: _____Email: _____

6. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

Patient Name: _____ (guardian if under 18 years of age)

Parent/Guardian Signature: _____ Date: _____

Dunbar Medical Associates, PLLC

Authorization for Retrieval of Prescription History

Dunbar Medical Associates, PLLC utilizes an Electronic Medical Record System which can retrieve information about prescriptions which have been paid for by insurance. Retrieving this history gives the physicians complete information which will assist them in providing they best care, as well as, preventing unwanted prescription interactions. Please select one of the following options:

☐ I authorize Dunbar Medical Associates, PLLC to retrieve my prescription history.

☐ I DO NOT authorize Dunbar Medical Associates, PLLC to retrieve my prescription history.

Patient/Parent/Guardian Signature

Patient Name Date

Account #