Dear Patient,

Welcome to Hermitage Primary Care, LLC! We look forward to providing you with excellent patient care.

Please take a few minutes to complete the enclosed forms before you arrive at our office for your scheduled appointment. Also, remember to bring your insurance cards and driver's license with you.

By having these forms completely filled out prior to your appointment, it will enable us to serve you in a timely fashion.

On the day of your appointment, please arrive 30 minutes prior to your scheduled time in order for us to process your chart and copy your insurance card.

Please bring any medication, in the bottles, that you are taking with you.

Thank you for your cooperation in helping us to be more efficient.

Please remember to bring these completed forms along with your driver's license and insurance card to your appointment.

Sincerely,

Staff of Hermitage Primary Care, LLC
Ashley Guild, MD
Chad Kurzynske, MD
Rachel McHenry, FNP
Sara McClellan, PA-C

Narcotics Policy

This letter is to inform that the providers at Hermitage Primary Care do not prescribe any controlled medications. Should you require controlled medications you will be referred to a specialist who prescribes the medication.

Patients requiring prescriptions for pain medication will be referred to a pain management facility and patients requiring psychiatric medication will be referred to a psychiatrist. Listed below are the medications we do not prescribe.

Xanax	**Oxycodone**	**Vyvanse**	**Codeine**
Lorazepam	**OxyContin**	**Adderall**	**Morphine**
Valium	**Lortab**	**Roxicet**	**Clonazepam**
Diazepam	**Vicodin**	**Norco**	**Vyvanse**
Ativan	**Hydrocodone**	**Ritalin**	**Soma**
Alprazolam	**Dilaudid**	**Percocet**	**Klonopin**
Librium	**Suboxone**	**Benzodiazepines**	**Opiates**
Naltrexone	**Ultram/Tramadol**		

Print Name:____

Signature:____ Date:_____________

Sincerely,
Staff of Hermitage Primary Care, LLC
Ashley Guild, MD
Chad Kurzynske, MD
Rachel McHenry, FNR
Sara McClellan, PA-C

Please <u>check</u> the appropriate box for today's visit:

- ☐ A preventative (physical) examination or well women's exam **<u>(With no other issues or concerns & at least 1 year)</u>**
- ☐ A problem focus visit only (headache, cold, backache, etc.)

I understand that my insurance will only cover a preventative examination (physical) with <u>NO OTHER issues at this visit.</u> If I have other issues present, <u>I may need to change my visit to address my immediate need.</u> Please understand that this is not a rule of Hermitage Primary Care's, but of your insurance company. We do not know what your insurance covers because each company policy is different. Every insurance company has a set contractual rate of fee for service; depending on your policy you are obligated to pay the amount that is not covered. If you are not sure what is covered under your policy, please call the member services number on your insurance card.

I acknowledge that if there is a balance for my visit due to combining my annual physical or well woman visit with another issue during visit, I will be responsible for it.

____
Signature

____________________________ ____________________
Print Name | Date of Birth

NEW PATIENT QUESTIONNAIRE		Medical Staff Only
NAME:		
DOB:		
PATIENTS - Please complete the following questions by answering Yes or No!		
EXERCISE- If yes, how often? Type of Exercise?		**HT**
LIVES WITH?		**WT**
PERSONAL SAFETY:		**BP**
HAS ANYONE CLOSE TO YOU EVER THREATENED TO HURT YOU?		**P**
HAS ANYONE EVER HIT, KICKED, CHOKED OR HURT YOU PHYSICALLY?		**T**
HAS ANYONE EVER FORCED YOU TO HAVE SEX?		**O2**
ARE YOU AFRAID OF YOUR PARTNER?		**Drug Allergies?**
COMMUNICATION:		
DO YOU NEED GLASSES OR CONTACTS TO READ BROCHURES?		
DO PEOPLE FREQUENTLY TELL YOU THAT YOU ARE NOT HEARING AND/OR UNDERSTANDING THEM?		
HEALTH LITERACY:		**Medications Taking:**
ARE MEDICATION LABELS OFTEN WRITTEN IN A WAY THAT IS EASY TO READ AND UNDERSTAND?		
DO YOU HAVE PROBLEMS COMPLETING MEDICAL FORMS BECAUSE OF DIFFICULTY UNDERSTANDING THE INSTRUCTION?		
HIGH RISK SEXUALLY ACQUIRED DISEASE INCLUDING HIV?		
DO YOU HAVE ANY SOCIAL CONCERNS?		
DO YOU HAVE ANY FINANCIAL CONCERNS?		
HOUSE/CONDO/APARTMENT, ASSISTED LIVING		

Patient Name:_________________________________ Date of Birth:_______________________

PAST MEDICAL PROBLEMS	
1.	2.
3.	4.

PAST SURGERIES	
1.	2.
3.	4.
5.	6.

MEDICATIONS: List medications you are currently taking.		**ALLERGIES:** To medication or substances.
1.	8.	
2.	9.	
3.	10.	
4.	11.	
5.	12.	
6.	13.	
7.	14.	
Pharmacy Name:		Phone:

Fill in health information about your family			
	Age	Medical Problems	Age & Cause of Death
Mother			
Father			
Sister			
Brother			
MGF			
MGM			
PGM			
PGF			

Check (✓) the substance you use and describe how much you use.		Social History
Caffeine	Coffee ❑ Yes ❑ No Cups per day: _____ Tea ❑ Yes ❑ No Cups per day: _____ Cokes ❑ Yes ❑ No Cups per day: _____	Marital Status Single Married Divorced Widowed
Tobacco	Cigarette/Packs _______ day for ______ years Date Quit ___________	Children Male _______ Female _______
Alcohol	❑ Yes ❑ No Drinks per day: ___________	I have sex with ❑ Men ❑ Women ❑ Both ❑ Neither
Illicet Drugs	❑ Yes ❑ No	Occupation

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Signature

______________________________ Date

______________________________ Physician Signature

______________________________ Date Reviewed

PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)______________________(First)______________________(MI) ____________

Preferred Full Name (if different from above): ______________________

Address: ____

City, State, Zip: ____

Home Phone Number (landline):______ ______________Cell:______________________Work: ______________

E-Mail Address:____Date of Birth: ______________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose ☐ Additional Gender category not listed ______________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Chose not to disclose ☐ Other not listed ______________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc ☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian ☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_______

Patient Social Security Number:___-______-________

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐

Responsible party name: (Last)______________________(First)______________________(MI) ____________

Date of birth: MM_______/DD_______/YYYY_______ Sex: ☐ Female ☐ Male

Responsible Party Social Security Number:_-_________-______Phone number: ______________

Address:____

City, State:______________________ZIP: ______________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)______________________ (First) ______________________

Phone number:______________________________ Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:______________________ ☐ Guardian

Address____

City, State:______________________ZIP: ______________

Home phone:______________________Work hone:______________Ext. ________

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:______________________Date: ______________

Printed name of patient or personal representative:______________________Relationship to patient: ______________

Patient name: ______________________________
Date of birth: _______________________________

Patient Consent for Financial Communications

Financial Agreement

- I acknowledge, that as a courtesy, HERMITAGE PRIMARY CARE may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand there is a fee for returned checks.

Third Party Collection. I acknowledge HERMITAGE PRIMARY CARE may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits. I hereby assign to HERMITAGE PRIMARY CARE any insurance or other third-party benefits available for health care services provided to me. I understand HERMITAGE PRIMARY CARE has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to HERMITAGE PRIMARY CARE I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to HERMITAGE PRIMARY CARE by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications. I agree that, in order for HERMITAGE PRIMARY CARE or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that HERMITAGE PRIMARY CARE or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or HERMITAGE PRIMARY CARE or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Patient/patient representative signature: ______________________________ **Date:** ________________

If you are not the patient, please identify your relationship to the patient. Circle or mark relationship(s) from list below:

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) ______________________________

NO SHOW AND LATE POLICY

These policies assure that patients have access to care when needed by maximizing the utilization of available appointments. They are also used to provide a mechanism for appropriately managing the patient that fails to utilize assigned appointment times without sufficient notice.

NO SHOW POLICY - If a patient is unable to keep their appointment, they are required to cancel their appointment within 24 hours of their scheduled appointment. Barring any unusual circumstance, if you have more than (2) no shows with in a twelve (12) month period, you may be dismissed from the practice for failure to follow a physician's recommendation.
Thank you for understanding our No Show Policy. Please let us know if you have any questions or concerns.

LATE POLICY - Barring any unusual circumstance, if a patient is greater than 15 minutes late for their appointment, they will be asked to reschedule. Late patients will be handled on a case by case basis. Thank you for understanding our Late Policy. Please let us know if you have any questions or concerns.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____

Signature of Patient or Personal Representative Date:________________

____ ______________________

Printed Name of Patient or Personal Representative Relationship to Patient

Patient Name: ______________________ Date: ____________

We are very excited to have you as a new patient in our office! Please take a moment to tell us how you heard about our office.

_______ Family/Friend/Word of Mouth

_______ Another Physician, if so, the Physician's name: ____________

_______ Walk - In

_______ Tristar Website

_______ Retail Medicine Please Circle

CVS Minute Clinic Care Spot Kroger Walgreens

_______ Community Event

_______ Newspaper Advertisement

_______ Yellow Pages

_______ Insurance Company

_______ HCA Website

_______ Flyer in the mail

_______ Social Media

_______ Internet Search (Google, Yahoo, Health Grades, Yelp, Four Square)

_______ Another healthcare facility, if so, please list: ____________

_______ Other, if so, please list: ______________________

Thank you!!!!