M. C. Sneider, DO - Lara M. Kauffman, MD - Ryan C. Crim, MD

Carlisle Family Care

1533 Commerce Avenue, Suite 1, Carlisle, PA 17015 Phone (717)240-1322 Fax (717)240-0382

Date_____

PATIENT INFORMATION SHEET

Patient Name_____SS#_____

Mailing Address_____City_____State_____Zip_____

Phone (home)_____ (work)_____ (cell)_____

DOB _____ Age _____ Gender: ☐ Male ☐ Female

May we leave a message at the above numbers? ☐Yes ☐No Comments: _____

What is the best phone number to be able to reach you? _____

What pharmacy do you prefer to use? _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated--If married, spouse's name:_____

Patient's Employer_____Address_____Phone_____

List doctors whom you see on a regular basis and the reason:

1.)_____ 2.)_____3.)_____

INSURANCE/BILLING INFORMATION

PRIMARY INSURANCE

Insurance Company Name_____ID#_____Group#_____Subscriber_____

Relationship to Subscriber_____Subscriber's DOB_____Subscriber's SS#_____

SECONDARY INSURANCE

Insurance Company Name_____ID#_____Group#_____Subscriber_____

Relationship to Subscriber_____Subscriber's DOB_____Subscriber's SS#_____

THIRD INSURANCE

Insurance Company Name_____ID#_____Group#_____Subscriber_____

Relationship to subscriber_____Subscriber's DOB_____Subscriber's SS#_____

GUARANTOR (Person responsible for copays and for charges which are **NOT** covered by insurance)

Guarantor Name_____Guarantor SS#_____

Address (required for accurate billing) _____

AUTHORIZATION: I HEREBY AUTHORIZE THE PHYSICIANS INDICATED ABOVE TO FURNISH INFORMATION TO ANY INSURANCE CARRIERS CONCERNING MY MEDICAL CONDITION, AND I HEREBY IRREVOCABLY ASSIGN THE DOCTOR ANY PAYMENT FOR SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

I authorize the following person(s) to have access to my private health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient's Signature Date

For Medicare Patients Only:

Name of Beneficiary _____ Health Insurance Claim Number _____

"I request payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service."

Beneficiary Signature _____ Date _____

"I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to _____
(Name of Medigap Insurer)
any information needed to determine these benefits payable for related services."

Beneficiary Signature _____ Date _____

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Name: _____ Date: _____

Age: _____ DOB: _____ Occupation: _____

Height: feet _____ inches _____ Weight: _____

Do you have an Advanced Directive or Living Will? Yes _____ No _____ *If yes, please provide a copy

EMERGENCY CONTACTS:

1). Name: _____ Relationship: _____
Phone (home) _____ (other) _____
If necessary may I discuss your medical care wit this person? Yes ____ No ____

2). Name: _____ Relationship: _____
Phone (home) _____ (other) _____
If necessary may I discuss your medical care wit this person? Yes ____ No ____

Allergies to Medication: _____
_____

Current Medications and Dosages: (list all prescription and non-prescription medications, including herbal supplements)

Medication	Dosage	Directions

All patients 12 years and older:

If female, are you now pregnant? Yes _____ No _____ If yes, what is your due date? _____

Do you smoke? Yes ____ No _____ If yes, how many packs per day? ____ Chewing Tobacco? Yes____ No_____

Do you drink alcohol? Yes ____ No ____ If yes, how much and how often? _____

Do you use street drugs? Yes ____ No ____ If yes, how much and how often? _____

Reviewed by _____ Date _____
(Office Staff Only)

Carlisle Family Care 1533 Commerce Ave, Ste. 1 Carlisle, PA 17015
Phone: 717-240-1322 Fax: 717-240-0382

Please complete this form if you would like us to request records from a previous office / facility

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _(____)_____

☐ **Access Request to Copy/Inspect**

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

_____
Name of Facility / Office

_____
Address

_____(_____)_____ _(_____)_____
Phone Number Fax number

2. The type of information to be used or disclosed is as follows (please include dates of service)

Date(s) of Service: _____

☐ Complete Medical Record

☐ Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)

☐ History & Physical (H&P)
☐ Discharge Summary
☐ Operative Report
☐ Consultation Reports
☐ X-ray and imaging reports
☐ Progress Notes
☐ Laboratory Test Results
☐ Immunization Record

☐ Other- list specific Items:_____

Behavioral Health Reports:

☐ Social History
☐ Client Data Form
☐ Referral/Treatment Form
☐ Admission Evaluation
☐ Notification of Admission
☐ Treatment Plan
☐ Academic History
☐ Aftercare Instructions
☐ Psychological Evaluation

☐ Other – list specific items: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol / drug abuse.

   This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with State law.

5. This information may be disclosed to and used by the following individual/organization:

Name: Carlisle Family Care

Address: 1533 Commerce Avenue, Suite 1, Carlisle, PA 17015

For the purpose of:

☐ Further Medical Care ☐ Insurance Eligibility/Benefits ☐ Inspection/Copying of my records
☐ Legal Investigation or Action ☐ Personal
☐ Changing Physicians ☐ Other (please specify):_____

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #7 above.

8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

_____ _____
Signature of Patient Date
(If signed by person other than the patient, state relationship and authority to do so.)

_____
Name of Patient (Please Print)

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased
☐ Power of Attorney for Health Care ☐Authorized Legal Personal Representative

_____ _____
Signature of Witness Date

Revised 10/22/2009

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-COLLECTION BALANCES-

If you had a previous collection balance or are presently in collection, the physician may use her discretion as to seeing you and your dependant again. It may be required that you pay your previous balance prior to being seen. If seen by the physician, we must verify current insurance coverage. You will be responsible for payment of the office visit, co-pay, deductibles, etc., on the day of the visit.

-ADMINISTRATION/CLINICAL MANAGEMENT FEES-

There may be fees for the following services:

-Physician care without an appointment (via phone)
-Prescription Management (refills/pharmacy)
-Completion of forms:
(disability, medical leave, FMLA, etc.)
-Request for lab results (via phone)
-Appeals for denied services/claims
- Medical Records (copy and/or fax)

(PAYMENT WILL BE REQUIRED WHEN PICKING UP FORMS OR PRIOR TO MAILING RECORDS)

-PATIENT CANCELLATIONS-

Carlisle Family Care requires a call 4 hours prior to scheduled appointments. There will be a $25.00 fee if we are not notified 4 hours prior to your appointment time. We do understand that there are emergencies and we will consider waiving the fee at our discretion.

- PATIENT NO SHOWS-

1st & 2nd Infraction: A $25.00 fee will be charged to your account and cannot be billed to your insurance.

3rd Infraction: You will receive a letter of dismissal and a $25.00 fee will be charged to your account and again cannot be billed to your insurance.

(The dismissal will be determined after the 3rd infraction within the same calendar year.)

-MEDICAL INFORMATION, INSURANCE PAYMENT AND PRESCRIPTION RELEASE-

I GIVE PERMISSION TO Central Penn Management Group, and its authorized employees, agents, and medical providers to release my medical information to insurance carriers, health maintenance organizations, governmental agencies, and other entities or individuals charged with the fiscal responsibility for the payment of medical services rendered to me. I hereby authorize payments of the medical benefits otherwise payable to me to be paid directly to Central Penn Management Group and/or the appropriate provider. I consent to having any monies received by the provider of services on my behalf to be applied to my outstanding accounts. I assume full responsibility for payment of any charges for the medical services provided. I acknowledge and understand that in order to facilitate billing and related activities, my medical information will be maintained by CPMG on its computer network, and that all such information will be subject to appropriate measure to protect confidentiality. I also give consent to phone/fax prescriptions to my pharmacist.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY OF CARLISLE FAMILY CARE.

_____ _____

Signature of Patient or Responsible Party Date

If you have any questions about our financial policy, please contact our office at 717-240-1322. Thank You!

Carlisle Family Care

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Medical Record Number: N/A

Social Security Number _____

Date of Admission: N/A

Notice Version (Date): N/A

Acknowledgement of receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Privacy Practices Notice from:

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

☐ Notice has previously been distributed by another location in our OHCA (except for physicians):

List location that distributed the Joint Notice: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

(OFFIC STAFF ONLY) Signature:

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement form in the individual's records.