INFORMATION FOR NEW PATIENTS

Welcome to Mountain Laurel Medical Clinic! We appreciate your confidence in us by choosing our Clinic for your healthcare needs. We always welcome feedback from our new patients, as well as our established patients, so that we can continue to provide every patient with quality care.

We are sending you several forms that we would ask you to complete and bring to your first visit with us. This will expedite the check-in time and get you seen in an efficient manner. The list below includes information we would like you to be aware of and also includes items we ask you to bring to each visit.

1) We ask our patients to BRING THEIR INSURANCE CARD(S) TO EVERY VISIT. This may seem redundant but it is our practice to scan your insurance cards into our system at EVERY visit to ensure that we are billing the appropriate insurance.
2) Co-pays, co-insurance and payment on prior balances are collected at EVERY visit. (If you are in for only a lab draw or a nursing visit only, co-pays are not collected).
3) PLEASE BRING YOUR MEDICATION BOTTLES TO EVERY VISIT. This is done to also ensure that we have an accurate listing of your medications; this is done for patient SAFETY.
4) We also like to take a patient photo to incorporate into the patient's chart. This is done for ID purposes. It is the patient's choice as to whether they would allow the picture to be taken. We will also ask to scan a driver's license into your chart for ID purposes as well.
5) Providers at Mountain Laurel Medical Clinic do not write for ***narcotic medications*** on a chronic or continued basis. If at the point a patient requires long-term use of this type of medication, they will be referred to a pain management clinic.

Again, WELCOME!

119 Main Street W., Suite A • Oak Hill, WV 25901

MOUNTAIN LAUREL MEDICAL CLINIC NEW PATIENT INFORMATION SHEET
(PLEASE PRINT TO ENSURE ACCURACY!)

PATIENT INFORMATION

Patient Name (LAST)____________________(FIRST)________________(M)________ Home Phone #__________

Address____Work Phone #__________

____Email Address__________

Social Security #________________________

Gender ( ) Male ( ) Female Date of Birth__________ Age _____ Marital Status: M S W D

Race __________________ Language ____________________ Ethnicity______________________

Employed: YES NO Name of Employer____
Employer address____

Spouse's Name (if applicable)____ Spouse's date of birth__________

If patient is child, Parents' Names: Mother_____________________________ Phone Number____________________
Father_____________________________ Phone Number____________________

Next of Kin (Someone not living in your household)_______________________ Phone Number ____________________

Was patient referred to our clinic by another physician YES NO NAME__________________________________
Phone #__________________________________

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYING ACCOUNT)

If same as patient, check here ______

Name(LAST)__________________(FIRST)______________(M)______ Home Phone#_______

Address____ Work Phone #_______

____

Date of Birth_____________________________ Social Security #_________________________

Relationship to Patient: Spouse Parent Guardian

Employed: YES NO Name of Employer____

Employer Address____

DO you have a living will or medical power of attorney on file? YES NO

WE APPRECIATE FEEDBACK FROM OUR PATIENTS ABOUT THEIR CARE WHILE A PATIENT IN OUR CLINIC. WOULD YOU LIKE A FOLLOW-UP CALL FROM ONE OF OUR STAFF? YES NO

PLEASE SEE REVERSE SIDE

INSURANCE INFORMATION

Primary Insurance ______________________________

Address ______________________________

Insured's Name ______________________________ Insured's Social Security # ____________

Policy # ______________________________ Insured's Date of birth ____________

Group Name and Number ______________________________

Secondary Insurance (if applicable) ______________________________

Address ______________________________

Insured's Name ______________________________ Insured's Social Security # ____________

Policy # ______________________________ Insured's Date of birth ____________

Group Name and Number ______________________________

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered to my insurance company and any of my treating physicians. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the physician of insurance benefits under which I am entitled. I also authorize the faxed transmission of medical records on my behalf to my insurance company or any of my treating physicians.

Patient Signature (or representative) ______________________________

Date ______________________________

MOUNTAIN LAUREL MEDICAL CLINIC
PATIENT QUESTIONNAIRE

PATIENT NAME:_________________________________**DOB:**_________________________

I. List the family members or other persons, if any, whom we may inform about your medical condition and your diagnosis.

____

____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGECY.

Name___________________________________Phone #____________________

Name___________________________________Phone #____________________

Name___________________________________Phone #____________________

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL".

YES___________ NO__________

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results (only if they are abnormal), or other health care information if other than your home phone number ____________________.

VI. Can confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail? YES___________ NO_________

By signing this form, I am consenting to Petersen Clinic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Petersen Clinic may decline to provide treatment to me.

____ _______________

Signature of Patient or Legal Guardian Date

____

Print Name of Patient or Legal Guardian

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

3. **NOTICE OF PRIVACY PRACTICES:**

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

I hereby consent to engaging in virtual health/telemedicine services, where available, as part of my treatment. I understand that "virtual health" or telemedicine services includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications.

5. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**

Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.

Please check one:

- ☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
- ☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
- ☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).

Patient Label

- ☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.
- ☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

6. **RESEARCH STUDIES:**

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)* ______________________________

Who can the Physician Clinic contact with questions about the Study? ____________________.

7. **CONSENT TO PHOTO/VIDEO:**

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

8. **CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

9. **E-MAIL:**

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

10. **CELL PHONES:**

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

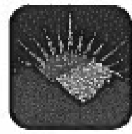
11. **VIDEOTAPING/RECORDING:**

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, If Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label



NEW PATIENT – HEALTH HISTORY

NAME________________________________DATE OF BIRTH________________________

REASON FOR VISIT____

MEDICATIONS (NAME, STRENGTH, FREQUENCY)

____
____
____
____
____
____
____
____
____
____

ALLERGIES____

____

SURGICAL HISTORY____

____

SOCIAL HISOTRY

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. DO YOU SMOKE?__________IF YES, HOW MUCH PER DAY?________________________
2. DO YOU USE CHEWING TOBACCO?__________IF YES, HOW MUCH PER DAY?__________
3. HOW MANY YEARS HAVE YOU USED TOBACCO PRODUCTS?________________________
4. DO YOU DRINK ALCOHOLIC BEVERAGES?______IF YES, HOW MUCH/OFTEN?__________
5. DO YOU DRINK CAFFEINE (COFFEE, TEA, SODA)?_____IF YES, HOW MUCH?________
6. DO YOU NOW OR HAVE YOU EVER TAKEN ILLEGAL DRUGS?_______________________
7. ARE YOU SINGLE,MARRIED,SEPARATED,DIVORCED,WIDOWED?_____________________
8. DO YOU HAVE CHILDREN?____________IF YES, HOW MANY?_____________________
9. WHAT IS YOUR HIGHEST LEVEL OF EDUCTION?___________________________________
10. ARE YOU EMPLOYED?___________WHAT IS YOUR OCCUPATION?____________________
11. DO YOU GET REGULAR EXERCISE?____

PAST MEDICAL HISTORY

PLEASE ANSWER YES OR NO FOR THE FOLLOWING:

ADHD		HEART MURMUR/VALVULAR DISEASE	
ABNORMAL WEIGHT LOSS		HEPATITIS (ACUTE/CHRONIC)	
ALCOHOLISM		HERNIA	
ALLERGIES		HIGH CHOLESTEROL	
ANEMIA		HIGH BLOOD PRESSURE	
ANXIETY DISORDER		HYPERTHYROIDISM	
ARTHRITIS		KIDNEY DISEASE	
ASTHMA/ BREATHING PROBLEMS		LIVER DISEASE	
BLADDER/KIDNEY PROBLEMS		LUMBAR DISC DISEASE	
BLEEDING DISORDER		MEASLES	
BLOOD DISEASES		MIGRAINE HEADACHES	
BREAST LUMP		MISCARRIAGE	
BROKEN BONES		MONONUCLEOSIS	
BRONCHITIS		MULTIPLE SCLEROSIS	
CANCER		MUMPS	
CAROTID DISEASE		PACEMAKER	
CHEMICAL/DRUG DEPENDENCY		PNEUMONIA	
COPD		POLIO	
CONSTIPATION		PROSTATE PROBLEMS	
DEEP VEIN THROMBOPHLEBITIS		PSYCHIATRIC CARE	
DEPRESSION		RHEMATIC FEVER	
DIABETES		SCARLET FEVER	
DIARRHEA		SEXUALLY TRANSMITTED DISEASE	
EAR/HEARING PROBLEMS		STROKE	
EPILEPSY		SUICIDE ATTEMPT	
GERD/REFLUX		THYROID PROBLEMS	
GLAUCOMA		TONSILLITIS	
GOITER		TUBERCULOSIS	
GOUT		TYPHOID FEVER	
HIV POSITIVE		ULCERS	
HEADACHES/DIZZINESS		URINARY PROBLEMS	
HEART ATTACK/CHEST PAIN		VAGINAL INFECTIONS	
HEART DISEASE			

Mountain Laurel Medical Clinic

FAMILY HISTORY

CIRCLE YES OR NO. PLEASE INDICATE RELATIONSHIP TO YOU

BREAST CANCER	YES	NO	RELATIONSHIP____________________
COLON CANCER	YES	NO	RELATIONSHIP____________________
OTHER CANCER	YES	NO	RELATIONSHIP/TYPE____________________
DIABETES	YES	NO	RELATIONSHIP____________________
HEART DISEASE	YES	NO	RELATIONSHIP____________________
HEART ATTACK	YES	NO	RELATIONSHIP____________________
STROKE	YES	NO	RELATIONSHIP____________________
KIDNEY DISEASE	YES	NO	RELATIONSHIP____________________
ASTHMA	YES	NO	RELATIONSHIP____________________
HIGH BLOOD PRESURE	YES	NO	RELATIONSHIP____________________
HIGH CHOLESTEROL	YES	NO	RELATIONSHIP____________________
THYROID DISORDERS	YES	NO	RELATIONSHIP____________________

OTHER (PLEASE SPECIFY)____________________RELATIONSHIP____________________

HAVE YOU HAD ANY RECENT LAB WORK?____________________

IF YES, WHERE WAS IT DONE?____________________

HAVE YOU HAD ANY RECENT IMAGING (CT, MRI, X-RAY, ULTRASOUND, ECT.)____________________

IF YES, WHERE WAS IT DONE?____________________

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD THE DOCTOR/STAFF MEMBERS RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

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SIGNATURE DATE

119 Main Street W., Suite A • Oak Hill, WV 25901