Lake Erie Medical Group, PC

Erie Family Medical Group **Niagara Internal Medicine**

2014 Physician_____ Account Number_____

Patient Information: This section refers to the PATIENT ONLY

Social Security Number_____
Last Name: _____ Jr., II, _____
First Name: _____ MI _____
Maiden Name: _____ Nickname: _____
Address: _____
City, State: _____ Zip Code: _____

If employed, Employer: _____
_____
Address: _____
_____
City, State: _____ Zip Code: _____

Home Phone: (___) _____	Health Related Msgs Allowed:	YES	NO
Work Phone: (___) _____ ext: _____	Health Related Msgs Allowed:	YES	NO
Cell Phone: (___) _____	Health Related Msgs Allowed:	YES	NO
	Text Msgs Allowed:	YES	NO
EMAIL: _____@_____	Health Related Msgs Allowed:	YES	NO

Birth Date (mm/dd/yy): _____ Sex: O Male O Female Marital Status: O Married O Single O Separated O Divorced Widowed
Race: O African American O American Indian O Asian O Caucasian O Hispanic O Pacific Islander
Preferred Language: O English O Other _____

EMERGENCY CONTACT: _____ Relationship: _____ Phone: ( ) _____
If Student: O Full Time O Part Time Name of School: _____

➢➢Complete Subscriber Information and Responsible Party if different from Patient≪≪

Subscriber Information: Primary card holder

Relationship to patient:
O Self O Parent O Spouse O Other

O If same as subscriber, skip this section.

Social Security Number: _____
Last Name: _____ Jr., II, _____
First Name: _____ MI _____
Address: _____
City, State: _____ Zip Code: _____
Home Phone: (___) _____
Birth Date: _____ Sex: O Male O Female
Employer: _____
- Address: _____
- Work Phone: (___) _____ Ext: _____

Responsible Party: (Who receives the bill)

Relationship to patient:
O Self O Parent O Spouse O Other

O If same as subscriber, skip this section.

Last Name: _____ Jr., II, _____
First Name: _____ MI _____
Address: _____
City, State: _____ Zip Code: _____
Home Phone: (___) _____
Work Phone: (___) _____ Ext: _____

Release of Information/HIPAA

I understand this release will be in effect unless changed by myself either in writing or by filling out a new release. I also understand that extraordinary confidential information is not included in this release, this includes: HIV, mental health, drug/alcohol, and sexually transmitted disease information.
I have been made aware of Lake Erie Medical Groups HIPAA compliance policy however, I authorize Lake Erie Medical Group or one of their associates employed by their practice to release medical test results or other medical information relating to my treatment to:
Check all that apply:
May leave a message to call the LEMG office: O on home answering machine/voice mail O at work
O Leave results/appointments on home answering machine/voice mail
O May only release test results to myself
O May give results/appointment information to person(s) listed below

Name: _____ _____ _____
Relationship: _____ _____ _____
Phone #: _____ _____ _____
Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY POLICY

Lake Erie Medical Group, PC

Consent to services:

Patient hereby requests registrations at Lake Erie Medical Group, PC office and voluntarily consents to any facility services deemed necessary or advisable as determined by, as appropriate, the attending physician or his or her assistants/designees, or employees or agents of Lake Erie Medical Group, PC with appropriate clinical privileges. Patient (responsible party) acknowledges that no guarantees have been made as to the results of treatment or examination at the Lake Erie Medical Group, PC office.

Payment Guarantee:

For and in consideration of services rendered by the Lake Erie Medical Group, PC office, patient (responsible party) hereby agrees to and guarantees payment of all charges incurred for the account of the patient. ***Payment is due in full when services are rendered. We accept cash or credit card.***

If the patient is eligible with Lake Erie Medical Group, PC participating insurance company and identification is provided, the insurance company will be billed for the services rendered in lieu of cash payment by the patient (responsible party); ***co-pays and deductible to be paid at the time of service.***

Consent to release information:

The undersigned hereby authorizes Lake Erie Medical Group, PC office to release to employer group, insurance companies, government agencies or other third party payers and their agents information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payments on the patient's behalf for the health care services rendered to the patient. Patient (responsible person) acknowledges that he or she will be financially responsible for charges incurred for the patient's treatment if revocation or refusal to authorize the disclosure of the medical records results in a payment denial of the insurance claim.

Medicare:

Patient certifies that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct Patient (responsible party) authorizes any holder of medical or other information about patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medical claim. Patient (responsible party) requests that payment of authorized benefits be made on his or her behalf to the name of provider of service for any services furnished to the patient by that provider of service.

Medigap:

Patient (responsible party) requests that payment of authorized Medigap benefits be made on patients behalf to the provider of service furnished to the patient by that provider of service. Patient (responsible party) authorizes any holder of Medicare information about patient to release to

(Medigap Name) _____ any information needed to determine these benefits payable for related services.

Assignments of Insurance Benefits and Agreement to Pay at the time of services:

Patient (responsible party) irrevocably assigns and transfers to Lake Erie Medical Group, PC all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering patient, for the payment of hospital and medical care being provided. Patient (responsible party) authorizes payment directly to Lake Erie Medical Group, PC of said medical reimbursement benefits. In the event that said medical insurance coverage is not sufficient to satisfy the charge in full, patient (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment if any balance is due. If the insurance is a non-contracted payer, or the patient does not have medical insurance, the balance will be deemed to be "patient responsible" and paid at the time of service. Patient (responsible party) acknowledges responsibility for any expenses incurred by Lake Erie Medical Group, PC for collecting any of the charges incurred on the account of the patient. Such shall specifically include any attorney's fee or any collection fees, or litigation and/or audit costs incurred by Lake Erie Medical Group on collecting said bill.

These agreements and authorizations shall be valid for one (1) year from the date of patient/parent/guardian signature.
PLEASE NOTE: Checks may be converted to electronic debits to your account. If returned, NSF fee may be electronically charged to your account.

Patient Name (Last, First, Mi) (print) Health Insurance Claim Number

Patient Signature (Parent/Guardian) Medigap Policy Number Date

Please check the appropriate description of your relationship to the patient:

_____self, _____Parent/Legal Guardian of Minor, _____Other

Lake Erie Medical Group, PC

11/01/2014

Lake Erie Medical Group, PC
Payment Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for the services rendered, we thought it would be in your best interest to develop a payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon your request.

Insurance- We participate with most major insurance companies, including Medicare, Highmark & Health America. If you are not insured by a company that we participate with, we will bill your insurance company for you, but the balance will remain your responsibility until payment is received. If you are insured by a company that we are participating with but do not have your current insurance card, the balance will remain yours until we receive the updated insurance card and can verify coverage.

Co-payments and 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.

Self-Pay - Cash Payment Only required- Payment is due at the time of service unless other arrangements are made in advance of the service.

Non-covered services- Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You may be asked to sign an acknowledgement or Medicare Waiver (ABN) that this was explained to you & you understood this before services are rendered and you may be responsible for the unpaid balance.

Proof of Insurance- All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's 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.

Claim submission- We will submit your claims and assist you in any way we reasonably 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 a party to that contract.

Coverage changes- If your insurance changes, please notify us before your next visit so that 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.

Nonpayment- If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payment 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 (unless stated otherwise) to find alternative medical care. During that 30 day period, our Physicians will be able to treat you only on an emergency basis. Once discharged from Lake Erie Medical Group, PC or ancillary, you will not have access to any of the Lake Erie Medical Group, PC facilities or Physicians.

Missed appointments- Our policy is charge for missed appointments not cancelled at least 24 hours in advance. These charges will be your responsibility and billed directly to you. Once a patient has had 3 or more missed appointments, you may be discharged from the practice as well. Please help us to serve you better by keeping your regularly scheduled appointment or canceling at least 24 hours in advance.

Financial Responsibility Form- You will be asked to read and sign our Financial Responsibility Form. This provides you with more information and gives us permission to bill your insurance company for any services incurred during your visit. It also validates your knowledge of our financial policy and your responsibility for any balances on your account. This form is good for one year and you will be asked to sign it at your first visit of the new year.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy as stated above and agree to abide by its guidelines.

Signature of patient or responsible party Date

Due to new banking laws, Lake Erie Medical Group, PC will be using a function that will allow us to convert your patient payment from checks to electronic payments. If you pay by check, please read and sign the following disclosure.
I authorize my check to be converted to an electronic payment, and authorize the merchant, or its collection agent, to electronically charge my account as NSF Fee, not to exceed maximum set by law, if my check is returned for non-sufficient funds (NSF), CANCELLED CHECK.

Signature of patient or responsible party Date

ALLEGHENY HEALTH NETWORK
Lake Erie Medical Group

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices for Allegheny Health Network/Lake Erie Medical, PC (Erie Family Medical Group and Niagara Internal Medicine).

The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the practice has reserved the right to change its privacy practices that are described in the notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Name: (please print) _____

Signature: _____

Date: _____

Lake Erie Medical Group, PC
Erie Family Medical Group
Cecilia Urquico, MD
Maribelle Gauna-Estrada, MD
2501 West 12th Street, Suite 1
Erie PA, 16505
Phone: 814-806-1144
Fax: 814-833-0659

Authorization for Release of Medical Information

Patient: _____

Address: _____

Date of Birth: ____/____/____ Phone: (____) ____-____

I herby authorize _____ to release all my prior medical records to Lake Erie Medical Group, PC.

Specific records to be release: (Check all that apply) **Time Period:**_____

- □ Progress Notes
- □ Laboratory Testing
- □ Radiology Testing
- □ Cardiology Testing
- □ Health Summary
- □ ER Records
- □ Hospital Records
- □ Medication List
- □ Psychiatric/Psychological Eval.
- □ Other: _____

The purpose of release is for:
_____Continuing of Care _____Billing or Insurance Processing _____Other

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I specifically authorize the disclosure of the following type(s) of information if it is not included within the information requested above: _____ (initial) Mental Health
_____ (initial) Drug and/or Alcohol Abuse/Treatment _____(initial) HIV Status

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This authorization will expire upon the following date(s) or event(s): _____

I understand that I have the right to revoke this authorization at any time. I may revoke it to the extent the Lake Erie Medical group has already relied on it, or if this authorization was signed as a condition of obtaining insurance coverage. In order to revoke this authorization, I understand that I must revoke it in writing to Lake Erie Medical Group.

I understand that information used or disclosed by Lake Erie Medical Group to any other person(s) under this authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy protection provided to me by law.

I understand that Lake Erie Medical Group may not require that I sign this Authorization in order to obtain treatment.

Date: ____/____/____ Patient Signature: _____

If you are the legal representative of the person listed above, please circle the basis for your authority and attach proof of authority:

Power of Attorney Guardianship Order Parents of Minor Executor/Administrator Other

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Signature: _____ Date Signed: _____

ERIE FAMILY MEDICAL GROUP

Health History

Patient Name: _____ DOB: _____

Date of Exam: _____

Age: _____ Marital Status: _____ Emergency Contact: _____

Telephone: (H) _____ (C) _____ Occupation: _____

Reason for Visit: _____

PAST MEDICAL HISTORY: Have you ever been diagnosed with any of the following conditions? Please Check.

	Yes	No
(Cardiac)		
High Blood Pressure:	☐	☐
Heart Disease:	☐	☐
High Cholesterol:	☐	☐
Stroke:	☐	☐
Vascular Disease:	☐	☐
PAD:	☐	☐
CAD/MI:	☐	☐
Irregular Heart Beat:	☐	☐
CHF:	☐	☐
Valvular Heart Disease:	☐	☐
Rheumatic Disease:	☐	☐
Carotid Disease:	☐	☐
Heart Murmur:	☐	☐
Aneurysm:	☐	☐
Atrial FIB:	☐	☐
(Endocrinology)		
Diabetes:	☐	☐
Hypo/Hyper Thyroid:	☐	☐
Goiter:	☐	☐
(Gastric)		
Peptic Ulcers:	☐	☐
GERD (Reflux):	☐	☐
Hepatitis:	☐	☐
Gall Bladder:	☐	☐
Pancreatitis:	☐	☐
Colon Polyps:	☐	☐
Diverticulitis:	☐	☐

	Yes	No
Hepatitis:	☐	☐
Jaundice:	☐	☐
Gall Stone:	☐	☐
Cirrhosis(liver disease):	☐	☐
Constipation:	☐	☐
Irritable Bowel:	☐	☐
(Rheumatology)		
Rheumatoid Arthritis:	☐	☐
Osteoarthritis:	☐	☐
Neck/Back Pain:	☐	☐
Osteopenia:	☐	☐
Osteoporosis:	☐	☐
Vit D Deficiency:	☐	☐
(Hematology)		
Cancer:	☐	☐
AIDS / HIV infection:	☐	☐
Anemia:	☐	☐
Skin Cancer:	☐	☐
Vit B12 Deficiency:	☐	☐
(Renal)		
Kidney Disease:	☐	☐
Renal Cyst:	☐	☐
Chronic Kidney Dz:	☐	☐
(Neurology)		
Seizures:	☐	☐
Alzheimer's:	☐	☐
Vertigo:	☐	☐

	Yes	No
Tinnitus:	☐	☐
Vision Problems:	☐	☐
Vision Loss:	☐	☐
Glaucoma:	☐	☐
Cataracts:	☐	☐
Hearing Loss:	☐	☐
Headaches:	☐	☐
Parkinson's:	☐	☐
(Pulmonary)		
COPD:	☐	☐
Asthma:	☐	☐
Other Lung Disease:	☐	☐
Blood Clots: DVT/PE:	☐	☐
Environmental Allergies:	☐	☐
Sinus Infection:	☐	☐
Emphysema:	☐	☐
Sleep Apnea:	☐	☐
(Other)		
Alcoholism:	☐	☐
Anxiety:	☐	☐
Depression:	☐	☐
Fatigue:	☐	☐
Psoriasis:	☐	☐
Skin Disorder:	☐	☐
Tobacco Abuse:	☐	☐
Urinary Incontinence:	☐	☐
BPH:	☐	☐
Prostate Cancer:	☐	☐

Past Surgical History: Have you ever had any of the following operations? Please Circle.

Tonsillectomy/Appendectomy:	Yes	No	If so, when:
Gallbladder Surgery:	Yes	No	If so, when:
Hernia Repair:	Yes	No	If so, when:
Back Surgery:	Yes	No	If so, when:
Thyroid Surgery:	Yes	No	If so, when:
Hip/Knee/Joint Surgery:	Yes	No	If so, when:
Eye Surgery:	Yes	No	If so, when:
Cataract Surgery:	Yes	No	If so, when:
Sinus Surgery:	Yes	No	If so, when:
Heart/Bypass/Valve Surgery:	Yes	No	If so, when:
Hysterectomy/Ovarian Surgery/Tubes Tied:	Yes	No	If so, when:
Breast Surgery:	Yes	No	If so, when:
Vasectomy:	Yes	No	If so, when:
Prostate Surgery:	Yes	No	If so, when:

Any other surgeries, List: _____

ERIE FAMILY MEDICAL GROUP

Health History

Patient Name: _____ DOB: _____

Current Medications: In addition to prescription medication, please include birth control pills, vitamins and supplements.

Medication Name	How Taken	Who Currently Prescribes	Need Rx
			Yes/No
			Yes/No
			Yes/No
			Yes/No
			Yes/No
			Yes/No
			Yes/No
			Yes/No

Preferred Pharmacy:_____ Location:_____

Previous Health Care Providers in the past FIVE years:

Provider Name	City/State	Problem	Still Seeing?	Referral?
			YES/NO	YES/NO
			YES/NO	YES/NO
			YES/NO	YES/NO
			YES/NO	YES/NO
			YES/NO	YES/NO
			YES/NO	YES/NO

Allergic and Adverse Reactions to Medications

Name of Medication	Adverse Reaction

Additional Information:

Last Mammogram?_____ Where?_____ Last PAP?_____ GYN?_____

Last Colonoscopy?_____ Normal?_____ Physician?_____ Repeat Date?_____

Approximate Date of Last Bloodwork?_____ Rectal Exam?_____

Vaccine Dates:

Tetanus?_____ Pneumonia?_____ Flu?_____ Hepatitis B Series?_____

ERIE FAMILY MEDICAL GROUP

Health History

Patient Name: _____ DOB: _____

FAMILY HISTORY:

	Age	Living		Deceased Age	Health Status	Cause of Death
Father:		Yes	No		Good Fair Poor	
Mother:		Yes	No		Good Fair Poor	
Maternal grandfather		Yes	No		Good Fair Poor	
Paternal grandfather		Yes	No		Good Fair Poor	
Maternal grandmother		Yes	No		Good Fair Poor	
Maternal grandfather		Yes	No		Good Fair Poor	
Maternal grandmother		Yes	No		Good Fair Poor	
Brother 1		Yes	No		Good Fair Poor	
Brother 2		Yes	No		Good Fair Poor	
Sister 1		Yes	No		Good Fair Poor	
Sister 2		Yes	No		Good Fair Poor	
Sibling _____		Yes	No		Good Fair Poor	
Sibling: _____		Yes	No		Good Fair Poor	

Cardiolvascular/Pulmonary

Any family history of Allergies?:	Yes	No	If so, who?
Any family history of Asthma?:	Yes	No	If so, who?
Any family history of COPD?:	Yes	No	If so, who?
Any family history of High Cholesterol?:	Yes	No	If so, who?
Any family history of Hypertension?:	Yes	No	If so, who?
Any family history of Atrial Fibrillation/Flutter?:	Yes	No	If so, who?
Any family history of Coronary Artery Disease?:	Yes	No	If so, who?
Any family history of Heart Disease?:	Yes	No	If so, who?
Any family history of Bleeding Problems?:	Yes	No	If so, who?
Any family history of Stroke?:	Yes	No	If so, who?

Endocrine

Any family history of Diabetes?:	Yes	No	If so, who?
Any family history of Thyroid disease/goiter?:	Yes	No	If so, who?

Neoplasms

Any family history of Breast Cancer?:	Yes	No	If so, who?
Any family history of Cervical Cancer?:	Yes	No	If so, who?
Any family history of Ovarian Cancer?:	Yes	No	If so, who?
Any family history of Testicular Cancer?:	Yes	No	If so, who?
Any family history of Prostate Cancer?:	Yes	No	If so, who?
Any family history of Colon Cancer?:	Yes	No	If so, who?
Any family history of Liver Cancer?:	Yes	No	If so, who?
Any family history of Bladder Cancer?:	Yes	No	If so, who?
Any family history of Laryngeal Cancer?:	Yes	No	If so, who?
Any family history of Renal Cancer?:	Yes	No	If so, who?
Any family history of Uterine Cancer?:	Yes	No	If so, who?
Any family history of Lung Cancer?:	Yes	No	If so, who?
Any family history of Leukemia?:	Yes	No	If so, who?
Any family history of Lymphoma?:	Yes	No	If so, who?
Any family history of Other cancer in the Family?:	Yes	No	If so, who?

Musculoskeletal

Any family history of Arthritis?:	Yes	No	If so, who?
Any family history of Osteoporosis?:	Yes	No	If so, who?

Gastroentrology

Any family history of Colon Polyps?:	Yes	No	If so, who?

ERIE FAMILY MEDICAL GROUP

Health History

Patient Name: _____ DOB: _____

FAMILY HISTORY – con't:

Genitourinary

Any family history of Kidney Disease?:	Yes	No	If so, who?

Social/Psychological

Any family history of Alcoholism?:	Yes	No	If so, who?
Any family history of Drug Abuse?:	Yes	No	If so, who?

Neurological

Any family history of Alzheimer's Disease?:	Yes	No	If so, who?
Any family history of Early Deaths?:	Yes	No	If so, who?
Any family history of Parkinson's?:	Yes	No	If so, who?

SOCIAL HISTORY:

Activities

Preventive health practices:	Yes	No
Exercise habits:	Yes	No
Activities:	Yes	No

Other

Marital Status: Married Single Divorced Widowed

Number of children: _____

Sexually Active: Yes No

Currently on Disability? Yes No

Occupation: _____

Military Service: Yes No

Have you traveled outside of Pennsylvania?: _____

Native Language: _____

Habits

Caffeine Use:	Yes	No	How many cups per day? _____
Alcohol Use:	Yes	No	How many drinks per day? _____
Herbal Medicine:	Yes	No	_____
Taking OTC Meds	Yes	No	_____
Illicit Drug Use	Yes	No	_____
Current Every Day Smoker	Yes	No	_____
Current Some Day Smoker	Yes	No	_____
Former Smoker	Yes	No	_____
Never Smoked	Yes	No	_____
Pipe Smoking	Yes	No	_____
Cigars	Yes	No	How many per day? _____

Other

Living Will	Yes	No
Organ Donor	Yes	No

Religious Affiliation _____

Lake Erie Medical Group, PC
Niagara Internal Medicine
145 West 23rd Street
Suite 202
Erie PA, 16502
Phone: 814-580-5600
Fax: 814-455-2584

Authorization for Release of Medical Information

Patient: _____

Address: _____

Date of Birth: ____/____/____ Phone: (____) ____-____

I herby authorize _____ to release all my prior medical records to Lake Erie Medical Group, PC.

Specific records to be release: (Check all that apply) **Time Period:**_____

- □ Progress Notes
- □ Laboratory Testing
- □ Radiology Testing
- □ Cardiology Testing
- □ Health Summary
- □ ER Records
- □ Hospital Records
- □ Medication List
- □ Psychiatric/Psychological Eval.
- □ Other: _____

The purpose of release is for:
_____Continuing of Care _____Billing or Insurance Processing _____Other

---

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_____ (initial) Drug and/or Alcohol Abuse/Treatment _____(initial) HIV Status

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This authorization will expire upon the following date(s) or event(s): _____

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I understand that information used or disclosed by Lake Erie Medical Group to any other person(s) under this authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subject to the privacy protection provided to me by law.

I understand that Lake Erie Medical Group may not require that I sign this Authorization in order to obtain treatment.

Date: ____/____/____ Patient Signature: _____

If you are the legal representative of the person listed above, please circle the basis for your authority and attach proof of authority:

Power of Attorney Guardianship Order Parents of Minor Executor/Administrator Other

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Signature: _____ Date Signed: _____