Patient / Client Biographical Information

Name: _____ Date: _____

SSN: _____

DOB: _____

Race: _____

Ethnicity: (ex: "American") _____

Primary Language: _____

Email Address: _____

Home Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____

Marital Status: _____ Pharmacy: _____

Spouse's name: _____

Emergency contact name: _____

Phone: _____

Authorized to make medical decisions: Yes / No

The following information is needed to process your claim:

Occupation: _____ Work Phone: _____

_____ ext: _____

School / Work Address: _____

_____

_____

You will need your insurance card to complete this next section. If you are having difficulty completing, please ask for help or leave blank.

Health Care Insurance: _____

Your name as it appears on your card: _____

Policy number: _____ Provider Services Number: _____

Group number: _____ Copay: _____

Medicare number: _____

Relationship to insurance subscriber? (Self, Parent, Other) _____

Insurance subscriber Name? _____

What is their occupation? _____

What is their DOB? _____

What is their ID number (from their insurance card)? _____

Is your current illness/injury related to:	YES	NO
Employment?		
Auto accident?		
Other accident?		

Patient name: _____ Date: _____

SSN: _____

DOB: _____

Work place, occupation: _____

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

1. What problems do you have today that you would like to have addressed?

_____

_____

_____

2. What medical problems do you have? (please check and explain below)
What surgeries have you had?

High Cholesterol	_____	Cancer	_____
Heart disease / Heart Attack	_____	Seizure / Epilepsy	_____
Stroke / mini-stroke	_____	Kidney disease	_____
high blood pressure	_____	Liver disease	_____
carotid artery disease	_____	Heart burn / GERD	_____
peripheral vascular disease	_____	Back pain	_____
blood clots / PE	_____	Arthritis	_____
aneurysm	_____	Vision problems	_____
Passing out	_____	Skin conditions	_____
Falls / Gait dysfunction	_____	Irritable Bowel	_____
Pneumonia	_____	Anxiety	_____
Asthma	_____	Depression	_____
COPD / emphysema	_____	Diabetes	_____
Tuberculosis (TB)	_____	Thyroid Disease	_____
Stomach ulcers	_____	Anemia	_____
		HIV	_____

Other? Please explain any above. List all SURGERIES with dates. _____

_____

_____

Date of colonoscopy _____ **Date of upper GI (stomach) scope** _____

3. What vaccines have you had?

		Dates?
Pneumonia	_____	_____
Flu	_____	_____
Hepatitis B (3 shots)	_____	_____
Hepatitis A (2 shots)	_____	_____
MMR (measles, mumps, rubella)	_____	_____
Chicken Pox	_____	_____
Tetanus	_____	_____
HPV/Gardacil	_____	_____
Shingles/Zoster	_____	_____

Others? _____

4. List the medications in the form of the example below. Include vitamins and herbals.

Drug	Dose/mg	Frequency
Snake oil	500mg	daily

5. Do any medical conditions run in your family?

	Who?	Age of diagnosis?	Deceased? Y/N
High Cholesterol			
Heart disease			
Stroke / mini-stroke			
High blood pressure			
Carotid artery disease			
peripheral vascular disease			
Blood clots / PE / DVT			
Aneurysm			
Seizure / Epilepsy			
Kidney disease			
Liver disease			
Arthritis			
Diabetes			
Thyroid disease			
Breast Cancer			
Lymphoma / Leukemia			
Colon Cancer			
Ovarian Cancer			
Prostate Cancer			
Other Cancers-what type?			
Other conditions?			
Other conditions?			

6. Do you see any other specialists / physicians?

Name, type of doctor: _____

7. Please complete below.

Current or previous smoker? _____
Packs a day? _____
Years smoking? _____ Quit date? _____

Alcohol use? _____ How many years? _____

Drug use? _____ How much? _____ How often? _____
What drugs? _____

Marital Status: _____

Any excessive exposures at work or home? (dust, fums, chemicals, noise?)

_____

Are you a caretaker for a family member? _____

8. What medications do you have an allergy or intolerance?
Food or environmental allergies?

_____

_____

Please check below which of the following are a concern to you now or have had within the last 6 months.

weight gain _____
weight loss _____
fevers / chills _____
weakness _____
fatigue _____
change in appetite _____
night sweats _____
day sweats _____

vision change _____
eye swelling _____
eye discharge _____
excessive tearing _____
eye dryness _____
loss of peripheral vision _____
eye itching _____
eye pain _____

nose bleeds _____
bleeding of gums _____
toothache _____
sinus problems _____
loss or decrease in hearing _____
ringing in ears _____
pain in ears, nose, mouth _____
sore throat _____

chest pain or chest pressure _____
palpations _____
heart murmur _____
difficulty breathing at night _____
ankle swelling _____
dizziness _____
passing out _____

shortness of breath with activity _____
shortness of breath at rest _____
heart arrythmia _____

cough _____
excessive sputum _____
wheezing _____
Pain with deep breathing _____
pain with deep breathing _____
history of TB _____

snoring _____
restless legs _____
insomnia _____
excessive sleeping/sleepiness _____

difficulty swallowing _____
abdominal pain _____
nausea _____
vomiting _____
diarrhea _____
constipation _____
blood in stools _____
black or tarry stools _____
increased gas (either end) _____
difficulty with bowel movements _____

kidney stones _____
pain with urination _____
increased urinary frequency _____
increased night urinating _____
bloody/pink urine _____
urinary incontinency _____

Concerns continued from previous page:

muscle aches _____
swollen joints _____
red / inflamed joints _____
loss of motion of joints _____
muscle weakness _____
back pain _____
neck pain _____

skin dryness _____
skin redness _____
rash _____
moles _____
itching _____
excessive hair growth _____

confusion _____
forgetfulness _____
tremor _____
dizziness / vertigo _____
headaches _____
numbness / tingling anywhere _____
loss of use of limb _____
seizure/epilepsy _____

increased urinary urgency _____

nervousness / anxiety _____
depression _____
suidicide thought or actions _____

breast masses _____
nipple discharge _____
change in skin on breast _____
excessive hair growth _____
heat intolerance _____
cold intolerance _____
increased thirst _____
goiter _____
flushing _____

easy bruising _____
blood transfusion _____
anemia _____
enlarged glands / lymph nodes _____
frequent infections _____
seasonal allergies _____
food allergies _____

Men only

difficulty achieving erection _____
difficulty maintaining erection _____
enlarged prostate _____
Sexaully transmitted disease _____

Women only

Age of first menstrual period _____
Age of menopause _____
Last menstrual period _____
Number of days of bleeding _____
number of days of cycle _____
Number of pregnancies _____
Number of births _____
excessive hair growth _____
Date of last Pap smear? _____
Date of last mammogram? _____
Sexually transmitted disease _____

Do you have an advanced directive? ☐ **Yes** ☐ **No**

Do you have any travel plans? Overseas? Elsewhere? **Date:**

_____

_____

Patient's signature **Date**

_____ _____

The above is true and correct to the best of my belief.

Doctor's signature upon review.

_____

Office Charges for Adult Medicine & Aesthetics, LLC

Please initial each item after you have read and understand it. Please ask us if you have any questions concerning our charges.

_____ **Non- covered services.** Any non-covered service will be billed to you and you will be responsible for that bill. Some of these non-covered services are listed below. Others may include removals of skin tags or anything considered cosmetic*. We are not required to bill your insurance company or Medicare for cosmetic services and we may do so at our discretion. **Appointments for psychiatric conditions or counseling may not be covered and obesity related visits may not be covered.** Often laboratory work or in-office tests may not be covered and we cannot predict with certainty what tests are not covered nor are we responsible for knowing what your insurance does not cover.

*All laser treatments and chemabrasion are considered cosmetic.

_____ **Preventative Services. Some insurance plans do not cover or directly pay for an annual physical exam.** Medicare is one of them. It is our practice that all patients receive an annual, full history and physical examination. We will bill your insurance appropriately and they will likely pay most of the costs from this appointment (the costs of treating your conditions), however, any preventative services not covered during an exam or the balance of the cost will be billed to you and you will be responsible for that bill.

_____ **OMT (Osteopathic Manipulative Treatments).** Some insurance plans do not cover OMT. If your plan does not cover chiropractic care, it is likely that OMT from an Osteopathic Physician will not be covered. We will bill your insurance appropriately for any osteopathic treatments performed unless it is known that your plan does not pay for OMT. If OMT is not covered by your plan or payment is denied for OMT, you will be responsible for that bill. If your insurance company does not cover OMT performed on the day of a medical appointment, you will be responsible for the charges for OMT and we will not bill your insurance company for it.

_____ **Vaccines.** Certain vaccines are not covered by your insurance. Often vaccines for travel are not covered. Any vaccine that you may receive that is not immediately known to be covered by your healthcare plan will be billed to you and paid for prior to administration of the vaccine. We will then bill your insurance company and if we are paid by them for the vaccine, we will reimburse you for the amount you have paid us.

_____ **Phone calls to the Doctor.** It is our policy to see all patients in appointments for medication refills, acute illnesses, counseling, review of tests and laboratory studies. There are few exceptions. To provide high-quality care to you and to decrease our chances of "missing something" which may have adverse affects on you, we insist that you have face-to-face contact with a provider. In the event that you or a family member in regards to you needs to talk to the doctor, a $20 charge per phone call will be billed to you either at your next visit or separately in the mail. Phone calls that are extended and involve counseling or discussion of medical issues will be billed an additional $10 every 5 minutes after the first 5 minutes of call time. Please do not call for medication refills after hours or on weekends. We do not provide refills over the phone.

_____ **Missed or Late Appointments.** If you are more than 10 minutes late for your appointment you may be asked to reschedule and you will be billed as a Missed Appointment. We strive to keep all appointments on time and to be able to spend time with our patients. We will not rush to see a late patient in half the time allotted or to cut into another patient's appointment. Often you may be asked to come in early to complete paperwork. If you arrive on time for your appointment but not early enough to complete paperwork when asked to arrive earlier, you may be billed for a Missed Appointment and asked to reschedule. Each Missed or Late Appointment will be billed to you at $50 per appointment. After three Missed or Late Appointments you may be dismissed from the practice. It is best if you arrive at least 5 minutes before any scheduled appointment in which you have not been asked to arrive earlier.

_____ **Billing fees.** Your co-pay is due at the time of your appointment and is to be paid before you see the doctor. If you do not bring your co-pay you may not be seen by the doctor and asked to reschedule your appointment. If you are seen by the doctor without paying your co-pay first, you will be billed for your co-pay in addition to a $20 billing/processing fee.

_____ **Late fees.** Any monies owed to Adult Medicine & Aesthetics, LLC will be billed to you. We allot a 30-day grace period to pay bills from the date the bill was generated. After the 30-day grace period, a $10 late charge is applied for every 30 days past the end of the grace period. Payments postmarked after the 30-day grace period ends will be considered late. If you are having difficulty paying a bill, please speak to us about a payment plan immediately. We take non-payment seriously and we cannot continue to offer quality healthcare to our patients if we do not have the monies to pay our staff and overhead. We report non-payment over 90-days to the Credit Bureau and send it to an outside collections agency.

_____ **Collection fees.** If your account is transferred over to a collections company, you will be responsible for any fees incurred during the collections process. Any reduced fees that our office applied in an effort to help you pay your account may be reversed & reapplied if you have not made a good faith effort to pay your account.

_____

Signature Date

_____

Print Name

Witness: _____ Date_____

Adult Medicine & Aesthetics
Christine Daecher, DO
2010 Market St
Camp Hill, Pa 17011
Phone: (717) 737-5544
Fax: (717) 214-6872

Signature on File

- "I request that 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 Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service."

Name (Please Print)_____

Signature_____ Date_____

Medicare Policy Number_____

Witness_____

- "I request that payment of authorized Medigap 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 medicare information about me to release to Medigap Services and its agents any information needed to determine these benefits or the benefits payable for related service."

Name (Please Print)_____

Signature_____ Date_____

Medigap Policy Number_____

Witness_____

Adult Medicine & Aesthetics, LLC
Christine Daecher, DO
2010 Market Street
Camp Hill, Pa 17011
Phone: (717) 737-5544
Fax: (717) 214-6872

Signature on File

- I authorize the use of this form on all my insurance submissions.
- I authorize the release of information to all my Insurance Companies and their affiliates, which may include my primary insurance company and any prescription drug benefits manager companies.
- I understand that I am responsible for my bill.
- I authorize Dr. Daecher to act as my agent in helping me obtain payment from my Insurance Companies.
- I authorize direct payment to Adult Medicine & Aesthetics, LLC and Dr. Daecher.
- I permit copy of this authorization to be used in place of the original.

Name (Please Print):_____

Signature:_____ Date:_____

Witness:_____

Access to Health Information

I designate the following people to have access to my medical records and health information to me.

This includes making and receiving phone calls to the office on my behalf, receiving copies of labs and tests, picking up copies of medical records, or making inquiries about my health.

Allowing others access to my records may also include access to my social security number, my insurance information, my account information, HIV status, mental health information, and drug and alcohol addiction information about me.

I understand that allowing others access to my records can be revoked at anytime by letting the staff at Adult Medicine & Aesthetics, LLC know my wishes. I must follow up any verbal changes with clarification in writing and this may be done with a simple written statement by me.

I understand that by letting others share in my health care that this does not mean that my doctor will call my agents to review all care. If my agents desire to be active partners in my health, they must attend my office visits.

1. Name:_____

Relationship:_____

2. Name:_____

Relationship:_____

3. Name:_____

Relationship:_____

4. Name:_____

Relationship:_____

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High Deductible Health Plans/Metallic health plans

New and established patients are expected to pay for services at the time of service. In most cases, you will be charged the cash pay discounted price and this is available upon request and may vary depending on the time and complexity of your visit.

The office will bill your insurer for your visit. After the claim (bill) has returned with any further payments and allowable charges (amount the insurer agrees the visit is worth), you may receive a refund, credit or a bill for any outstanding monies owed.

As an Example 1:
You are billed and pay $50 for a simple office visit. The claim is submitted to your insurer and is returned to this office and to you stating that the allowable is $60. You will be billed for $10.

As an Example 2:
You are billed and pay $50 for a simple office visit. The claim is submitted to your insurer and is returned to this office and to you stating that the allowable is $40. You will receive a credit to your account of $10.

As an Example 3:
You are billed and pay $150 for an office visit. The claim is submitted to your insurer and is returned to this office and to you stating that the allowable is $40. You will receive a credit to your account of $110; however, since this is a relatively high credit, you will receive a call and have the option to have the credit applied to your account or paid back to you in the form of a check.

Name (Please Print) _____

Signature _____ Date _____

Witness: Courtney Gesler / Christine Daecher, DO

Signature _____ Date _____

Lost Prescription Policy

Due to the large volume of requests for prescription medications due to:

- lost prescriptions,
- misplaced prescriptions,
- change of insurance,
- change of pharmacy,
- prescriptions expired due to failure to turn in to the pharmacy

We reserve the right to charge you $5.00 per prescription. To re-write prescriptions lost takes our valuable time and is not covered by insurance. We can no longer continue this service for free.

We will continue to refill prescriptions that have expired as scheduled for no charge. We will continue to give you prescriptions at your appointment for no additional charge.

Under no circumstances will we refill/rewrite/call in/fax to the pharmacy any narcotic or other DEA controlled medications for the above bulleted reasons.

Name:_____ Date_____

Signature:_____

Witness:_____

Christine Daecher, DO, **Adult Medicine & Aesthetics,LLC** 2010 Market St. Camp Hill, PA 17011
Phone:717-737-5544 Fax:717-214-6872
www.livewell-feelgood.com

Christine Daecher, DO

Adult Medicine & Aesthetics, LLC.
2010 Market St.
Camp Hill, PA 17011
Phone: 717-737-5544 Fax: 717-214-6872

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received, reviewed and understand the Privacy Practices used by Adult Medicine & Aesthetics, LLC, published by the U.S. Department of Health & Human Services Office for Civil Rights. I understand that Medicare, Medicaid and/or my health insurance company may request and have access to my health records without my permission.

Printed Name

Signature Date

Release of Health Information

I give Adult Medicine & Aesthetics, LLC permission to release my medical information to other physicians' offices, hospitals, nursing homes, or pharmacies involved in my care. By signing this, I am not giving permission for my records to be released to family members, insurance companies, employers or anyone else unless designated by me.

Signature Date

Pharmacy / Electronic Medication Interchange Consent

I give Adult Medicine & Aesthetics, LLC permission to import and export medication lists from my pharmacies. I understand that this is a function of electronic medical records and the electronic prescription clearinghouse (Ex: SureScripts) that may be enabled and disabled at anytime. I understand that without this consent the office may still get information from the pharmacy and my insurer about my prescription drug benefits and any electronic/faxed refill requests initiated by me or the pharmacy.

Signature Date

HL7 Partners Interchange Consent

I give Adult Medicine & Aesthetics, LLC permission to import and export information to external entities though the Electronic Medical Record. "HL7 Partners" may include but are not limited to labs, other facilities, state vaccine registries, and federal and state governments for quality reporting.

Signature Date