PATIENT HISTORY & IDENTIFICATION FORM

NAME: _____ AGE: _____
LAST NAME FIRST MI

BIRTH DATE: _____ ☐ M ☐ F ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER
RESPONSIBLE PARTY NAME: _____ RELATIONSHIP TO PT _____
HOME ADDRESS: _____ PHONE: ( ) -
CITY: _____ STATE: _____ ZIP: _____
EMAIL _____
PT'S SOCIAL SECURITY #: _____ DRIVER'S LIC#: _____
EMPLOYER'S NAME: _____ PHONE: ( ) -
REFERRED BY: _____
EMERGENCY CONTACT: _____ PHONE: ( ) -
ALCOHOL USE : _____/MONTH HISTORY OF ABUSE: ☐ YES ☐ NO
SMOKER: ☐ YES ☐ NO IF YES, HOW MANY YEARS? _____ HOW MANY PER DAY? _____

ARE YOU ALLERGIC TO ANY MEDICATION (IF SO, WHAT ARE THEY AND WHAT TYPE OF REACTION)

_____
CURRENT MEDICATIONS (NAME, DOSAGE, AND STRENGTH): _____

_____
CURRENT NARCOTICS AND STRENGTHS: _____

_____
LAST FLU SHOT: _____ LAST TD: _____ LAST TB TEST: _____

LAST TIME YOU RECEIVED A COMPLETE PHYSICAL WITH BLOODWORK (LIST DOCTOR AND DATE):

_____
HOSPITALIZATIONS:

WHEN	REASON	LOCATION	DOCTOR
WHEN	REASON	LOCATION	DOCTOR
WHEN	REASON	LOCATION	DOCTOR

PLEASE CHECK ☐ IF YOU HAVE HAD ANY OF THESE SYMPTOMS, PAST OR PRESENT:

☐ SEVERE HEADACHES	☐ SEIZURES	☐ NERVOUS CONDITONS	☐ CHRONIC EAR DISEASE
☐ ARTHRITIS	☐ GALL BLADDER	☐ EYE DISORDERS	☐ PSYCHIATRIC PROBLEMS
☐ DIABETES	☐ LUNG DISEASE	☐ SKIN DISORDERS	☐ UNCONSCIOUSNESS PERIODS
☐ ANXIETY	☐ BLOOD DISEASE	☐ THYROID DISEASE	☐ URINARY TRACT INFECTIONS
☐ ULCERS	☐ HEMORRHOIDS	☐ CHEST PAIN	☐ STROKE/HEART ATTACK
☐ KIDNEY PROBLEMS	☐ GONORRHEA	☐ PERSISTENT COUGH	☐ BOWEL IRREGULARITY

NAME ANY CHRONIC CONDITIONS YOU HAVE: _____
PLEASE CHECK ☐ IMMEDIATE FAMILY MEMBERS (GRANDPARENTS INCLUDED) WITH FOLLOWING:
☐ CANCER ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ HEART DISEASE

TYPE OF CANCER: _____
Do you have a living will? ☐ YES ☐ NO

I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I **AUTHORIZE** DR. JASON T. FRYE AND DR. ERIC O. SHREDER TO ADVISE ME OF ANY INDICATED AND NECESSARY PROCEDURES, DIAGNOSTIC STUDIES AND TREATMENT TO MYSELF OR THE ABOVE NAMED PATIENT. I UNDERSTAND THAT **I AM LEGALLY RESPONSIBLE FOR THE PAYMENT** OF THIS ACCOUNT. I AGREE TO PAY FOR SERVICES RENDERED AT DATE OF VISIT. I AM LEGALLY RESPONSIBLE FOR ALL COLLECTION/LEGAL FEES IF I FAIL TO ADHERE TO THIS AGREEMENT. I UNDERSTAND THAT A SERVICE CHARGE OF $5.00 PER MONTH WILL BE ADDED TO MY BILLING FOR NON-PAYMENT OF SERVICES AFTER THE INSURANCE COMPANY HAS PAID THEIR PORTION/AND FOR NOT PAYING THE COPAYMENT AT THE TIME OF SERVICE.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

PLEASE INITIAL EACH ITEM BELOW

A	ALL **RETURNED** CHECKS WILL HAVE A **$25.00** SERVICE FEE.
B	ALL CO-PAYMENTS ARE DUE PRIOR TO SEEING THE DOCTOR. CO-INSURANCE AND DEDUCTIBLES PAYMENTS ARE DUE DIRECTLY PRIOR TO OR AFTER APPOINTMENT.
C	**DELINQUENT ACCOUNTS** MUST BE PAID BEFORE YOUR NEXT APPOINTMENT OR YOU MUST HAVE FINANCIAL ARRANGEMENTS IN PLACE PRIOR TO YOUR APPOINTMENT.
D	ALL **MISSED APPOINTMENTS** ARE SUBJECT TO A **$25.00** MISSED APPOINTMENT FEE IF YOU HAVE NOT GIVEN THE OFFICE 24 HOUR ADVANCED NOTIFICATION.
E	PLEASE NOTIFY THE FRONT DESK OF ANY CHANGES IN YOUR INSURANCE ADDRESS, PHONE NUMBERS, AND PHYSICAL HEALTH. FAILURE TO UPDATE THE OFFICE WILL DELAY SCHEDULING OF TESTS, LABS, AND SPECIALIST APPOINTMENTS. DR. JASON T. FRYE AND DR. ERIC O. SHREDER WILL FILE CLAIMS TO YOUR INSURANCE AS A COURTESY.
F	**YOU ARE FINANCIALLY RESPONSIBLE** FOR ALL CHARGES INCURRED REGARDLESS OF INSURANCE.
G	ALL DEDUCTIBLES MUST BE PAID UPON RECEIPT OF NOTIFICATION BY EITHER OUR OFFICE IN THE FORM OF A STATEMENT OF NOTICE FROM YOUR INSURANCE.
H	THIS OFFICE REQUIRES FRONT AND BACK COPY OF YOUR INSURANCE CARD AND DRIVER'S LICENSE/PICTURE IDENTIFICATION.
J	YOU WILL BE NOTIFIED OF PROCEDURES OR SERVICES, WHICH MAY NOT BE COVERED, THEN ASKED TO SIGN AN ADVANCED BENEFICIARY NOTICE IF YOU DESIRE TO PROCEED WITH THE SERVICE.
K	IF YOU NEED A REFERRAL TO SEE A SPECIALIST, YOU MUST GIVE THE OFFICE **5-10 WORKING DAYS** PRIOR TO YOUR APPOINTMENT WITH THE SPECIALIST. FAILURE TO NOTIFY THIS OFFICE WILL REQUIRE YOU TO RESCHEDULE YOUR APPT. MANY INSURANCE COMPANIES REQUEST 1 WEEK FOR PRE-AUTHORIZATION AFTER OUR OFFICE SUBMITS THE REQUESTED SERVICE.
L	**UNDER NEW FEDERAL HIPAA GUIDELINES** IF YOUR INSURANCE CARD STATES THAT YOU ARE NOT ASSIGNED TO DR. JASON T. FRYE OR DR. ERIC O. SHREDER, YOU WILL BE ASKED TO SIGN AN ADVANCE BENEFICIARY NOTICE, AND PAY FOR SERVICES RENDERED AT TIME OF SERVICE. YOU ,THE PATIENT, ARE RESPONSIBLE FOR KNOWLEDGE REGARDING YOUR COVERAGE, BENEFITS, DEDUCTIBLE, AND PRIMARYCARE PHYSICIANS (PCP) ASSIGNMENTS. AS IS THE STANDARD IN THE COMMUNITY, THERE WILL BE A $25.00 CHARGE FOR **ALL FORMS** THAT ARE NOT COVERED BY YOUR INSURANCE PROGRAM, DISABILITY, JURY, ETC.
M	I **AUTHORIZE** MY MEDICAL RECORDS TO BE FAXED OR GIVEN TO ANY PROVIDER, COMPANY, OR INSURANCE CARRIER NEEDING INFORMATION FOR PAYMENT OR TREATMENT FOR FURTHER CARE OF AN INDIVIDUAL LISTED ON THIS FORM. **SKIP TO END.**
P	I DO **NOT AUTHORIZE** MY MEDICAL RECORDS TO BE RELEASED. I UNDERSTAND THAT I WILL BE REQUIRED TO PAY FOR THE VISIT'S IN FULL AT THE TIME OF SERVICE, BECAUSE I HAVE CHOSEN NOT TO HAVE MY RECORDS RELEASED FOR THE ABOVE MENTIONED TOPICS. I ALSO UNDERSTAND THAT I WILL BE REQUIRED TO PAY IF THE PERSON OR PLACE THAT IS NOT BEING PERMITTED COPIES IS AN INSURANCE COMPANY OR ATTORNEY FOR THAT BILLING.

SIGNATURE OF PATIENT/GUARDIAN _____

CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

PATIENT IS ADVISED NOT TO DRIVE OR OPERATE MACHINERY ON OPIOD/BENZODIAZAPINES/MUSCLE RELAXER THERAPY

Controlled substance medications (i.e. narcotics, tranquilizers, and muscle relaxers) are very useful, but they have a high potential for misuse and are, therefore, closely controlled by the local, state and federal government. They are intended to relieve pain, to improve function and /or ability to work, not simply to feel good. Because my physician is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. **I am responsible for my controlled substance medications.** If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it **will not** be replaced.
2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from PierPont Family Medicine. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.
3. Refills of controlled substance medication
    a. **Will be made only during PierPont Family Medicine's regular office hours**. Refills will not be made at night, on holidays, or weekends.
    b. **Will be filled for a one month period.** Any deviation from this norm will be at the doctor's discretion.
        1. **I will make monthly follow up appointments (i.e. 30 days + 2/3 Days)** to monitor my medication and receive a new script.
        2. **I will not be able to get refills if I run out early.** I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
    c. **Will only be filled at the same pharmacy.** Changing pharmacies for controlled substances is not allowed. If there is a temporary change or new pharmacy I must contact my physician.
    d. **Will not be made as an "emergency" such as on Friday afternoon** because I suddenly realize I will "run out tomorrow". **I will call at least fort-eight hours ahead** if I need assistance with a controlled substance medication prescription.
4. **I will bring in the containers of all medications prescribed by the physician each time I see him** even if there is no medication remaining. These will be the original containers from the pharmacy for each medication.
5. **I will inform my doctor of any new medication,** or physician directed changes in my current medication.
6. I will submit myself to be tested for **random urine drug screenings (at my cost if necessary).**
7. I understand that all visits for controlled substances are for those appointments only, and that they can not be combined with other appointments if too soon.
8. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habit: exercise, weight control, and the non-use of tobacco, alcohol, and illegal narcotics. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome of my treatment.
9. I understand it is at my physician's discretion to consult with other pain specialists. My care is a team effort and I may be required to visit pain management, physiotherapist, neurologists, and physical therapists.
10. **I understand that if I violate any of the above conditions,** my controlled substance prescriptions and/ or treatments with Pierpont Family Medicine, may be **ended immediately**. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my physician, medical facilities, and other authorities.
11. I am aware that controlled substance medications may alter or have an effect on pregnancy/testosterone levels.
12. **I understand that misuse of narcotics may result in respiratory depression and or death.**

I know that I may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control, and I do know that I may become physically dependent on the medication. This would occur if I am on the medication for several weeks, and when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this contract, and my physician and/or his staff has explained it to me. In addition, I fully understand the consequences of violating said contract.

Patients Signature _____ Date _____

Physicians Signature _____ Date _____