FAMILY PRACTICE CENTER OF NEWTOWN

Patient Intake Form

PATIENT INFORMATION Date:_____

Last Name:	First Name:		Middle Initial:	Social Security Number:	
Street Address:	City:	State:	Zip Code:	Date of Birth:	Age:
Primary Phone #_____ Cell Phone #_____	Email Address:				
☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Life Partner				
☐ Full Time ☐ Part Time ☐ Student ☐ Retired	☐ African American ☐ Asian ☐ Hispanic ☐ White ☐ Other: _____				

PRIMARY INSURANCE

Holder Name: _____

Relationship: _____

Effective Date: _____

Insurance Co: _____

Policy ID # _____

Group ID # _____

Phone: _____

SECONDARY INSURANCE (if applicable)

Holder Name: _____

Relationship: _____

Effective Date: _____

Insurance Co: _____

Policy ID # _____

Group ID # _____

Phone: _____

EMPLOYER

Name: _____

Address: _____

City, State Zip: _____

Occupation: _____

Phone # _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home # _____

Cell # _____

May we share personal medical information? ☐ Yes ☐ No

FAMILY PRACTICE CENTER OF NEWTOWN

Patient Intake Form

Guarantor Information Required for Patients Under 18

GUARANTOR INFORMATION	
Full Name: _____	Relationship To Patient: _____
Date Of Birth: _____ Phone # _____	Social Security # _____
DO YOU AGREE TO TELEMEDICINE APPOINTMENTS?	Yes: _____ No: _____
VISIT RELATED TO AN ACCIDENT?	Yes: _____ No:_____
☐ Auto ☐ Work ☐ Other: _____	Date of Accident: _____

MEDICATIONS (PLEASE LIST PRESCRIPTIONS, OVER THE COUNTER, SUPPLEMENTS, VITAMINS AND HERBS)		
Drug Name:	Dosage:	☐ AM ☐ PM
Drug Name:	Dosage:	☐ AM ☐ PM
Drug Name:	Dosage:	☐ AM ☐ PM
Drug Name:	Dosage:	☐ AM ☐ PM
Drug Name:	Dosage:	☐ AM ☐ PM
Drug Name:	Dosage:	☐ AM ☐ PM

ALLERGIES (DRUGS, FOODS, DYES & ENVIRONMENTAL)

IMMUNIZATIONS		
☐ Flu Shot Date: _____	☐ Pneumonia Shot Date: _____	☐ Covid Shot Date: _____
☐ Tetanus Shot Date:_____	☐ Hepatitis B Shot Date:_____	

FAMILY PRACTICE CENTER OF NEWTOWN

Patient Intake Form

PHARMACY

Pharmacy Name: _____ Phone Number: _____

Address: _____

OPERATIONS

☐ Gall Bladder Date: _____ ☐ Appendix Date: _____ ☐ Hysterectomy Date: _____

HOSPITALIZATIONS (Non Surgical)

Please check yes if you have/had any of the following:

Yes		Yes		Yes	
☐	Anxiety	☐	Head Injury	☐	Respiratory Disease
☐	Anemia	☐	Headaches	☐	Seizures / Convulsions
☐	Arthritis	☐	Heart Disease	☐	Senile Dementia
☐	Asthma	☐	Hepatitis	☐	Sinus Trouble
☐	Blood Disorders	☐	High Blood Pressure	☐	Sleep Disorder
☐	Cancer	☐	Kidney Disease	☐	Spinal Injury
☐	Carotid Artery Disease	☐	Liver Disease	☐	Stomach Disorder
☐	Circulatory Problems	☐	Low Blood Pressure	☐	Stroke
☐	Colitis	☐	Lung Disease	☐	Thyroid Problems
☐	Depression	☐	Migraines	☐	Tinnitus
☐	Diabetes	☐	Neurological Disease	☐	Tuberculosis
☐	Emphysema	☐	Pain	☐	Tumors or Growths
☐	Epilepsy	☐	Prostate Disorder	☐	Ulcers
☐	Gall Bladder Disease	☐	Psychiatric Disorder	☐	Urinary Tract Infection
☐	Hay Fever	☐	Radiation Treatment	☐	Venereal Disease

FAMILY PRACTICE CENTER OF NEWTOWN

Patient Intake Form

FAMILY HISTORY

Parents, siblings and grandparents who have had the following

Anxiety/Depression:	Family Member(s) _____	Age Diagnosed:_____
Blood Disorder:	Family Member(s) _____	Age Diagnosed:_____
Cancer Type: _____	Family Member(s) _____	Age Diagnosed:_____
Diabetes:	Family Member(s) _____	Age Diagnosed:_____
Drug/Alcohol Abuse:	Family Member(s) _____	Age Diagnosed:_____
Glaucoma:	Family Member(s) _____	Age Diagnosed:_____
Hypertension:	Family Member(s) _____	Age Diagnosed:_____
Heart Disease:	Family Member(s) _____	Age Diagnosed:_____
Stroke:	Family Member(s) _____	Age Diagnosed:_____
Other: _____	Family Member(s) _____	Age Diagnosed:_____

WOMEN'S PREVENTIVE CARE

☐ Last GYN Exam Date: _____ ☐ Last Pap Smear Date: _____ ☐ Last Breast Exam Date: _____

☐Last Mammogram Date: _____ Method of Birth Control: _____

Name of GYN: _____

☐ Last Cholesterol Check Date: _____ ☐ Last Blood Stool Check Date: _____

MEN'S PREVENTIVE CARE

☐ Last Prostate Exam Date: _____ ☐ Last Cholesterol Check Date: _____

☐Last Blood Stool Check Date: _____

FAMILY PRACTICE CENTER OF NEWTOWN

Patient Intake Form

SOCIAL HISTORY		
☐ Yes: ☐ No:	Do you smoke?	If yes how many packs per day? _____
☐ Yes: ☐ No:	Do you drink alcohol?	If yes how many drinks per week? _____
☐ Yes: ☐ No:	Do you drink coffee or tea?	If yes how many cups per day? _____
☐ Yes: ☐ No:	Are you on a special diet?	If yes explain:_____
☐ Yes: ☐ No:	Do you use illegal drugs?	If yes explain:_____
☐ Yes: ☐ No:	Blood transfusion?	Date of transfusion: _____
☐ Yes: ☐ No:	Have you engaged in activity, which put you at risk for HIV/AIDS?	If yes explain:_____
☐ Yes: ☐ No:	Do you wish to be tested for HIV/AIDS?	
☐ Yes: ☐ No:	Have you worked with chemical paints, asbestos or other hazardous material?	If yes explain:_____
☐ Yes: ☐ No:	Do you visit the dentist regularly?	If yes how when was your last visit? _____
☐ Yes: ☐ No:	Do you wear your seatbelt?	
☐ Yes: ☐ No:	Do you wear a bike helmet?	
☐ Yes: ☐ No:	Do you have smoke detectors in your home?	If yes do you regularly check the batteries? _____
☐ Yes: ☐ No:	Are you afraid of your significant other?	
☐ Yes: ☐ No:	Is there a gun in your home?	If yes is it locked and separate from ammo? _____
☐ Yes: ☐ No:	Do you want information on "Living Wills"?	
☐ Yes: ☐ No:	Do you have a "Living Will"?	If yes, please provide us with a copy for your chart.
☐ Yes: ☐ No:	Do you have a power of attorney for health care decision making	
☐ Yes: ☐ No:	Does your drivers license indicate you are an organ donor?	

HOW DID YOU HEAR ABOUT US? _____

FAMILY PRACTICE CENTER OF NEWTOWN

Patient Intake Form

AUTHORIZATION FOR TREATMENT & FINANCIAL RESPONSIBILITY: I or my designated guardian authorize the physician to provide treatment and to release medical information to my insurance as maybe necessary for payment of physician claims. I authorize payment directly to the physician of the benefits otherwise payable to me, but not to exceed regular charges for physician claims. I understand that I am financially responsible to the physician for charges not covered by my insurance.

Patient/Guardian Signature:_____ Date:_____

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize my physician to speak with another physician involved in my medical care with copies of the necessary medical records and/or test results requested by the physician, but ordered by my physician. I understand this is for the release of medical information. I authorize my physician to allow my Managed Care Organization to access my chart for quality review purposes.

Patient/Guardian Signature:_____ Date:_____

MEDICARE PATIENTS: Patient's certification, authorization to release information and payment request, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct, I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries/carriers and information needed for Physician claims and other related medical claims. I request payment of claims be made on my behalf for authorized benefits under my health insurance. I herby authorize payment directly to my Physician for Insurance Benefits otherwise payable to me. Payment are not to exceed the balance due of the practices regular charges for those claims. I understand that my Physician will bill HCFA using the form "signature on file" and I am aware that my signature as written below constitutes the "on file" signature.

Patient/Guardian Signature:_____ Date:_____

MEDIGAP BENEFITS: I hereby give my physician permission to ask for Medigap payments for my medical care. I understand that my Medigap insurer needs information about me and my medical condition to make a decision about these payments. I give permission for that information to my Medigap insurer. I request that payment of authorized Medigap benefits be made to PHCS Physician Services on my behalf for any services furnished by my Physician. I authorize any holder of medical information needed to determine these benefits of the benefits payable for related service.

Patient/Guardian Signature:_____ Date:_____

CONSENT OF TREATMENT FOR MINOR/INCAPACITATED PATIENTS

I hereby authorize the Physician to provide medical treatment to: _____

Patient is unable to consent to medical treatment due being a minor or: _____

Guardian Signature: _____ Print Name:_____ Date:_____

Family Practice Center of Newtown
638 Newtown Yardley Rd
Newtown, PA 18940
Phone: 215-968-1616

FAMILY PRACTICE CENTER OF NEWTOWN

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

AUTHORIZATION AND RELEASE: I, hereby authorize the Provider, Facility, or Individuals listed below to release, request, and discuss my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, and fax to the following family members, physicians, clinics and/or hospitals:

Psychotherapy Notes:_____ check here for authorization of psychotherapy notes.

FAMILY MEMBER/ CARE TAKER: _____ Phone [H]: _____

Relationship: _____ Phone [M]: _____

Address: _____

_____

FAMILY MEMBER/ CARE TAKER: _____ Phone [H]: _____

Relationship: _____ Phone [M]: _____

Address: _____

_____

PHYSICIAN/ OTHER: _____ Phone [H]: _____

Type: _____ Fax [F]: _____

Address: _____

_____

May we identify ourselves over the phone? ☐ **Yes** ☐ **No** **May we leave messages?** ☐ **Yes** ☐ **No**

Length of Authorization: ☐ **6 months** ☐ **1 year** ☐ **3 years** ☐ **From:** _____ **To:** _____

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, request, or discussion of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

_____ _____

Patient / Guardian Signature *(If guardian, print name)* Date

FAMILY PRACTICE CENTER OF NEWTOWN
638 Newtown Yardley Rd, Suite 2E
Newtown, PA 18940
215-968-1616

FAMILY PRACTICE CENTER OF NEWTOWN

CREDIT/DEBIT CARD AUTHORIZATION

PATIENT NAME: _____ DOB: _____

Patients are responsible for all charges and services that are not covered by their insurance provider. In accordance with our office's payment policies, we ask that you review the following terms and conditions and provide an alternative payment method. I understand that the Provider will submit billing claims to my insurance provider for reimbursement, but I am solely responsible for all charges and services I receive from the Provider, including those covered by my insurance.

1. I understand that payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider.

2. I understand that my signature and payment information will be held on file for future use.

3. I understand that I may receive a monthly statement for any outstanding balance that is not satisfied by a charge to my payment method and that I am responsible for paying the balance by its due date.

4. I understand this authorization will remain in effect until the expiration of the credit card.

5. **I understand that no charges will be made to my credit/debit card without being notified.**

ACKNOWLEDGMENT AND AUTHORIZATION:

By signing this form (i) I acknowledge that I have received, reviewed, and understand the Provider's payment policies, (ii) I authorize the Provider and/or its designated payment agent to charge my credit/debit card in accordance with the payment policy, and (iii) I certify that I am an authorized cardholder or user of this credit/debit card.

Name on Card: _____ Email Address: _____

Credit Card #: _____ CVV: _____ Billing Zip Code: _____

Expiration Date: _____

Card Type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover ☐ Debit

Cardholder's Signature: _____ Date: _____

FAMILY PRACTICE CENTER OF NEWTOWN
638 Newtown Yardley Rd, Suite 2E
Newtown, PA 18940
215-968-1616

FAMILY PRACTICE CENTER OF NEWTOWN

MEDICAL RECORDS RELEASE AUTHORIZATION

==========

PATIENT INFORMATION:

Patient Name:_____ Date of Birth:_____

Address:_____

Primary Number:_____ Cell Number:_____

==========

MEDICAL RECORDS REQUEST FROM:

Physician/Facility Name:_____

Address:_____

Phone Number:_____ Fax Number:_____

==========

AUTHORIZATION:

I herby grant permission for you to release confidential health information about me by releasing a copy of my medical records or a summary or a narrative of my protected health information to the Physician/ Facility listed below:

Family Practice Center of Newtown

Dr. Catherine Spratt-Turner DO

638 Newtown Yardley Road, Suite 2E, Newtown, PA 18940

Phone: 215-968-1616 / Fax: 215-860-1976

Signature:_____ Date:_____

FAMILY PRACTICE CENTER OF NEWTOWN

NOTICE OF PRIVACY PRACTICES

PATIENT NAME: _____ **DOB:** _____ **Date:** _____

I have received, reviewed, and understand this practice's Notice of Privacy Practices written in plain language. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me an updated Notice of Privacy Practices upon request.

Patient/Guardian Signature:_____ Date:_____

If guardian, print name:_____

FAMILY PRACTICE CENTER OF NEWTOWN
638 Newtown Yardley Rd
Newtown, PA 18940
215-968-1616

HIPAA NOTICE OF PRIVACY PRACTICE

PLEASE KEEP THIS COPY FOR YOUR RECORDS

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how our practice may use and share your health information with others to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to view and amend your Protected Health Information ("PHI"). PHI information is information about you and the services you have received. This would include information such as your name, address, date of birth, diagnosis, treatment, or other information that could identify you and your past, present, or future physical or mental health or treatment you receive.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION:

Your PHI may be used and shared by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you, paying our claims for health care provided to you, and any other use permitted or required by law.

Treatment: We will use and share your PHI information to provide, coordinate, or manage your health care and any related services. This includes coordinating or managing your health care with a third party (for example, sending PHI information to a specialist as part of a referral/referral).

Payment: Your PHI information will be used, as necessary, to receive payments for claims related to the services provided to you. For example, obtaining approval for a hospital stay may require that your PHI be shared with the health plan to obtain approval for hospital admission or by submitting billing information to your insurance company or state payer such as Medicaid or Medicare. We may also disclose your PHI to our partners such as the billing company, the claims processing company, and other third parties who process insurance claims.

Company Operation: We may use or disclose, as necessary or appropriate, your PHI information to support our health care operations. These activities include, but are not limited to, quality assessment activities, employee review activities, medical student training, licensing, health supervision audits or inspections, marketing, and fundraising activities, and conducting or arranging for other business activities. In addition, we may use a registration sheet at the registration desk where you will be asked to sign your name and indicate your doctor. We may also call you by name in the waiting room when your doctor is ready to see you. We may also provide your PHI to our attorneys, accountants and consultants to ensure that we comply with applicable laws.

Appointment Reminders: We may use and disclose your PHI information to contact you and remind you of your medical appointments by phone or email.

Treatment Alternatives: We may use and disclose your PHI information to inform you of possible treatment options and health-related benefits and services that may be of interest to you.

ADDITIONAL USES AND DISCLOSURES:

As described below, we may use and disclose your PHI information in various other situations without your authorization.

As Required by Law: We may disclose your PHI information when required to do so under federal, state, or local law.

For Public Health Activities: We may disclose your PHI information to public health or other authorities charged with the prevention or control of disease, injury, and disability or uploaded with the collection of public health data.

Abuse and Neglect: We may disclose your PHI information to public officials who are authorized by law to receive reports of abuse, neglect, and domestic violence.

Health Oversight Activities: We may also disclose your PHI information to organizations that provide oversight of health care facilities and services, such as government agencies and benefit programs.

For Legal Proceedings: We may disclose your PHI information in the course of judicial or administrative proceedings, including in response to a subpoena or court order.

For Law Enforcement Purposes: We may disclose your PHI information to law enforcement officials in certain circumstances where we suspect criminal conduct or to report a crime on our premises or in emergency situations.

A Coroner and For Organ Donation: We may disclose your PHI information to coroners or medical examiners for the purpose of identifying a deceased person, determining the cause of death, or as otherwise required. We may also disclose your PHI information to funeral directors, as necessary, to carry out their duties.

For Research: We may disclose your PHI information to researchers if an institutional review board has approved such disclosures because appropriate safeguards have been taken to ensure the protection of your PHI information.

To Prevent Serious Harm: We may disclose your PHI information when necessary to prevent a serious threat to the safety and health of the public or a person, including yourself.

Government Functions: We may disclose your PHI information to military officers if you are an active military member or to determine veterans' eligibility and/or benefits. We may also disclose your PHI information for national security, intelligence activities, the protection of the President, and to determine the suitability of officers to work in a public office. If you are an inmate of a correctional facility, we may disclose your PHI information to correctional facility officers.

Workers' Compensation: We may disclose your PHI as we are authorized to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illnesses.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES:

Other uses and disclosures not described in this notice will only be made with your authorization or opportunity to object unless required by law. This includes most uses and disclosures of psychotherapeutic notes (where applicable), uses and disclosures for marketing purposes, and disclosures that constitute a sale of your PHI information. You may cancel any authorization you have granted, at any time in writing.

HIPAA NOTICE OF PRIVACY PRACTICE

PLEASE KEEP THIS COPY FOR YOUR RECORDS

YOUR RIGHTS:

The following are statements of your rights in relation to PHI information.

You have the right to inspect and request a copy of your PHI information as long as we maintain your medical record. You must request a copy of your PHI in writing. In certain circumstances we may deny your request and you may have the right to request that our denial be reviewed. Depending on the reason for the denial, another licensed medical professional may be chosen by us to review your application and the associated denial.

You have the right to request a restriction of your PHI information. This means that you may ask us not to use or share any part of your PHI for the purpose of Treatment, Payment, or Health Care Operations except in cases of emergency. You may also request that any part of your PHI not be disclosed to family, friends, or other individuals who may be involved in your care. While we will consider any reasonable request for restrictions, we are not required to grant your request unless you request a restriction of certain disclosures of your PHI to a health plan when you have paid for our services in full without charging the health plan.

You have the right to request that your PHI information be disclosed to you on a confidential basis. This includes sending an email to an address other than your home. Your request should indicate how or where you wish to be contacted. We will accommodate reasonable requests.

You have the right to obtain a paper copy of this notice from us upon request at any time. You may ask us for a paper copy of this notice at any time.

You may have the right to request that we amend your PHI if you believe it is incorrect or incomplete, as long as we keep your medical record. To request that we modify your PHI information, you must request it in writing to our office and explain why the modification is necessary. We may deny your request if a) we have not created the PHI, b) the request relates to information we do not maintain, c) the request relates to information that you do not have the right to inspect, such as psychotherapy notes, d) we determine that your PHI is correct and complete. If we deny your request for amendment, you have the right to submit a statement of disagreement to us and we can prepare a response to your statement and provide you with a copy of that response.

You have the right to receive accountability for certain disclosures, if any, of your PHI information. Disclosure accounts do not apply to disclosures made for treatment, payment, and health care operations or for disclosures we have made to you or at your request. The first accountability requested in a twelve (12) month period is free of charge, but we may charge you the costs of producing additional accounts during the same twelve (12) month period. The request for a surrender must specify the applicable dates and must be in writing.

You will receive notifications of breaches of your unsecured PHI. If your PHI information maintained by our office or its business associates has been breached, we will notify you of the situation and take reasonable steps to mitigate any damage that may result from the breach.

You have the right to file a complaint with our office or with the Secretary of Health and Human Services if you believe we have violated your privacy rights. You can file a complaint with us by notifying our office. Filing a complaint will not affect your health care services in any way.

HIPAA NOTICE OF PRIVACY PRACTICE

PLEASE KEEP THIS COPY FOR YOUR RECORDS

We reserve the right to change the terms of this notice. If we make revisions, you will be informed by posting the revised notice in the waiting area and on our website.

We are required by law to protect the privacy of your information, provide this Notice of our privacy practices, follow the practices described in this notice, and notify you after a breach of your unsecured PHI information. If you have any questions or complaints, please contact our office.

ACKNOWLEDGEMENT

The notice provides, in detail, the uses and disclosures of my protected health information that this practice may perform, my individual rights, how I can exercise these rights, and the practice's legal obligations with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes with respect to all protected health information residing in, or controlled by, this practice. If there are policy changes, this practice will provide me with an updated Notice of Privacy Practices upon request.