



Welcome to GENESIS MEDICA, LLC

PATIENT INFORMATION FORM

ALL FORMS MUST BE FILLED IN ENTIRELY

DATE: _____

PATIENT INFO

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB: _____

PHONE NUMBER: [H] _____ [C] _____ [W] _____

STREET ADDRESS: _____ APT # _____ CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ SEX: M F T EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____ FULL-TIME PART-TIME UNEMPLOYED

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

SPOUSE'S NAME: _____ SPOUSE'S DOB: _____

DO YOU HAVE A LIVING WILL / ADVANCE DIRECTIVE? YES NO

ETHNICITY: HISPANIC/LATINO NON-HISPANIC RACE: _____ LANGUAGE: _____

EMERGENCY CONTACT

NAME: _____ PHONE #: _____ RELATION: _____

GUARANTOR / PATIENT INFORMATION

NAME: _____ DOB: _____ RELATION: _____

INSURANCE INFORMATION

SELF-PAY

PRIMARY INSURANCE NAME: _____ ID #: _____

POLICY HOLDER NAME: _____ DOB: _____

SECONDARY INSURANCE NAME: _____ ID #: _____

POLICY HOLDER NAME: _____ DOB: _____

AUTHORIZATIONS – TREATMENT/MEDICALRECORDS/BILLING CONSENT

AUTHORIZATION AND RELEASE FOR GENESIS MEDICA, LLC-I VOLUNTARILY CONSENT TO THE ADMINISTRATION AND COSTS OF MEDICAL AND/OR SURGICAL PROCEDURES FOR MYSELF OR MY DEPENDENT.

ASSIGNMENT OF INSURANCE BENEFITS / GUARANTEE OF PAYMENT

I AUTHORIZE PAYMENT DIRECTLY TO GENESIS MEDICA, LLC and AFFILIATES FOR ALL BENEFITS PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY ALL CHARGES THAT ARE NOT PAID OR BILLED TO INSURANCE OR ANY THIRD PARTY PAYER. I UNDERSTAND THAT I MUST PAY IN FULL TODAY FOR ALL SERVICES RENDERED UNLESS MY INSURANCE IS ACCEPTED. I ALSO UNDERSTAND THAT IF MY INSURANCE IS ACCEPTED I MUST PAY ALL APPLICABLE INSURANCE CO-PAYS, OR CO-INSURANCE, AND DEDUCTIBLE FOR SERVICES. I UNDERSTAND ALL SERVICES RENDERED ARE NON-REFUNDABLE UNDER ANY CIRCUMSTANCE. I UNDERSTAND THAT IF I DO NOT PAY WITHIN 90 DAYS UPON RECEIPT OF MY BILLING STATEMENT, MY ACCOUNT WILL BE TRANSFERRED OVER TO A CREDIT COLLECTION AGENCY.

RELEASE OF RECORDS

I AUTHORIZE GENESIS MEDICA, LLC and AFFILIATES TO RELEASE (VERBAL OR WRITTEN) CONFIDENTIAL MEDICAL INFORMATION TO ANY PERSON OR ENTITY INCLUDING MY INSURANCE CARRIER, EMPLOYER (IF TREATMENT IS RELATED TO EMPLOYER PURPOSES), OR OTHER HEALTH CARE OPERATIONS WHICH MAY BE LIABLE TO ME OR MY PRACTITIONER(S) FOR CHARGES FOR THE TREATMENT AND FOR QUALITY MANAGEMENT, UTILIZATION REVIEW, TRANSFER, AND FOLLOW-UP PURPOSES. I ALSO HEREBY AUTHORIZE GENESIS MEDICA, LLC and AFFILIATES TO CHECK MY EXTERNAL RX HISTORY FOR PURPOSES OF TREATMENT. I ALLOW GENESIS MEDICA, LLC and AFFILIATES TO RETRIEVE, REVIEW AND SEND MY MEDICAL RECORDS VIA ELECTRONIC HEALTH RECORDS SYSTEMS.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____



GENESIS MEDICA, LLC

MEDICAL HISTORY

[PLEASE FILL IN COMPLETELY, ALL INFORMATION IS REQUIRED]

REASON FOR VISIT: _____ DATE: _____

LAST NAME: _____ FIRST: _____ MI: _____ DOB: ____/____/____

ADDRESS: _____ APT #: _____ PHONE #: _____

GENDER: M F T E-MAIL ADDRESS: _____

DO YOU CURRENTLY HAVE A PCP-PRIMARY CARE PHYSICIAN? NO YES: _____

WHEN WAS YOUR LAST VISIT TO YOUR PCP?: LESS THAN 6 MONTHS MORE THAN 6 MONTHS MORE THAN 1 YEAR

WHICH PHARMACY DO YOU USE?: _____ LOCATION: _____

CURRENT MEDICATION(S): NONE

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

DRUG: _____ DOSAGE: _____ FREQUENCY: _____

MEDICATION ALLERGIES: NONE YES: _____

OTHER ALLERGIES: _____

HAVE YOU EVER HAD AN ALLERGY TEST? NO YES IF YES, WHEN? _____ WHERE? _____

MEDICAL HISTORY: DOES NOT APPLY DEPRESSION KIDNEY DISEASE HEART DISEASE ANEMIA SEIZURES DIABETES

CANCER (TYPE) _____ HIGH BLOOD PRESSURE THYROID DISORDER ASTHMA HIGH CHOLESTEROL

OTHER(S) EXPLAIN: _____

SURGICAL HISTORY: NONE

TYPE: _____ YEAR: _____ TYPE: _____ YEAR: _____

TYPE: _____ YEAR: _____ TYPE: _____ YEAR: _____

FAMILY HISTORY: NONE DEPRESSION KIDNEY DISEASE HEART DISEASE ANEMIA SEIZURES DIABETES

CANCER (TYPE) _____ HIGH BLOOD PRESSURE THYROID DISORDER ASTHMA HIGH CHOLESTEROL

OTHER(S) EXPLAIN: _____

SOCIAL HISTORY: NONE SMOKER? NO YES, PACKS PER DAY?: _____ LENGTH OF USE? _____

SUBSTANCE ABUSE? NO YES IF YES, LIST SUBSTANCE(S): _____ LENGTH OF USE? _____

ALCOHOL ABUSE? NO YES IF YES, HOW MUCH? _____ LENGTH OF USE? _____

OFFICE USE ONLY

CHIEF COMPLAINT: _____

BP _____ TEMP _____ PR _____ RR _____ O2 _____ HT _____ WT _____ LMP: _____

FLU _____ STREP _____ MONO _____ OTHER TESTING/RESULTS: _____



GENESIS MEDICA, LLC

FINANCIAL AGREEMENT

Patient's Name: _____ SS #: _____

IMPORTANT: THIS IS NOT AN APPLICATION FOR CREDIT. CHARGES FOR ALL SERVICES RENDERED BY GENESIS MEDICA, LLC and AFFILIATIONS ARE DUE AND PAYABLE IN FULL SIXTY (60) DAYS FROM THE DATE SERVICES WERE RENDERED. We will assist the Patient in the processing of insurance claims as a courtesy only. We accept no responsibility for any processing procedures, acts, omissions and/or neglect. PATIENT AND RESPONSIBLE PARTY ARE SOLELY RESPONSIBLE TO PAY FOR ALL SERVICES PROVIDED.

IN CONSIDERATION of the provision of services to the Patient, named herein, the Patient and the responsible party understand and agree that:

1. Payment for services rendered is due in full sixty (60) days from the date services were rendered. Any **balance unpaid after sixty (60) days** from the date services were rendered will be considered **"delinquent"**.
2. The Patient and responsible party must pay all costs of collection, including reasonable attorney's fees, if the delinquent balance is referred to an attorney for collection.
3. **ANY BALANCE UNPAID AFTER NINETY (90) DAYS FROM THE DATE SERVICES WERE RENDERED WILL BE SUBJECT TO INTEREST AT THE ANNUAL PERCENTAGE RATE OF TEN (10%) PERCENT WHEN THE ACCOUNT HAS BEEN PLACED FOR COLLECTION.**
4. In the event the Patient submits payment by check and that check is returned for **"INSUFFICIENT FUNDS"** by the Bank, we will add Fifteen (\$15.00) Dollars to the balance owned by the Patient.
5. This Agreement shall be binding upon the Patient and responsible party for all charges incurred by the Patient for a Two (2) year period from the date of this Agreement.
6. No statement by an employee or agent of ours will contradict, void or nullify this Agreement, nor shall the Patient rely on any statements or opinions made by us that an insurance carrier will pay the bill.

Authorization is hereby given to **GENESIS MEDICA, LLC and AFFILIATIONS** to submit my claim directly to my insurance on my behalf. I understand that by signing this form, my signature is not needed each time a claim is submitted on my behalf. I further authorize my insurance carrier to forward payment directly to **GENESIS MEDICA, LLC and AFFILIATIONS**

I HEREBY AUTHORIZE YOU TO RELEASE ALL MEDICAL AND BILLING INFORMATION NECESSARY TO SECURE PAYMENT FROM ANY INSURANCE CARRIER, ON MY BEHALF.

I have read and fully understand all the above of the conditions. Once I sign this agreement I am responsible for all charges, and if necessary, costs of collection and a reasonable attorney's fee, as stated above:

I acknowledge receipt of a copy of this agreement. Dated: _____

WITNESS: _____ PATIENT: _____

RESPONSIBLE PARTY (If other than Patient) _____

RELATIONSHIP TO PATIENT (SPOUSE/PARENT/OTHER) _____



GENESIS MEDICA, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Consent of Notifications

I give permission to Genesis Medica, LLC and _____ [Full Name/Relationship] Affiliates to notify my health information.

I give permission to Genesis Medica, LLC and Affiliates to leave any health-related information in my voice mailbox.

If you will be contacting me regarding an appointment, lab or other tests, consultations, I prefer you call this phone number:

(_____) _____ HOME / CELL / WORK

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____



HEALTH INFORMATION EXCHANGE (HIE) PATIENT AUTHORIZATION FORM

Patient Informati	Last Name:	First Name:	Middle:
	Date of Birth:	Other Possible Names:	
	Phone #:	Street Address:	
	City:	State:	Zip:

A Health Information Exchange ("HIE") is a safe way for health care providers to get the most up-to-date health information about you. The HIE will allow Genesis Medica, LLC and Affiliates to access or share your health information with other healthcare providers. This may improve your overall care through the use of an electronic medical record. By signing this form, you are agreeing that your health information, including test results, lab reports, X-rays, medication lists or any other relevant electronic health information may be shared across participating health care providers.

You acknowledge that you read this form, was given opportunity to ask questions and got answers you understood.

1. I understand that this authorization will expire one year from the date of my signature below, however will Auto-Renew if not withdrawn.
2. I understand that I may revoke this authorization at any time by submitting a *Patient Withdraw Authorization* Form and submitting it to Genesis Medica, LLC and Affiliates in writing. I understand that if I withdraw authorization, no new health information may be shared with the HIE and the health information already submitted to the HIE may not be used unless it already has been used in reliance on my previous authorization. This authorization will be shortened, extended or will cease to be effective on the date the written instructions are received except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations. However, other state and federal laws may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. I understand that my refusal to sign this authorization will not jeopardize my right to healthcare and payment for my healthcare except where disclosure of my health information is required for the provision of healthcare or to obtain payment for healthcare.
5. I understand that I can request a copy of this form after I sign it. A photocopy of this form will be considered as valid as the original.

Print Name of Patient

Print Date of Birth

Signature of Patient/Legal Representative

Date

Time

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)



Patient Name: _____

Date: _____

DRUG ABUSE SCREENING TEST - DAST-10

These Questions Refer to the Past 12 Months

1	Have you used drugs other than those required for medical reasons?	Yes	No
2	Do you abuse more than one drug at a time?	Yes	No
3	Are you unable to stop using drugs when you want to?	Yes	No
4	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5	Do you ever feel bad or guilty about your drug use?	Yes	No
6	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7	Have you neglected your family because of your use of drugs?	Yes	No
8	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10	Have you had mental problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Guidelines for Interpretation of DAST-10

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior-feedback and advice
3-5	Moderate level	Harmful behavior-feedback and counseling; possible referral for specialized assessment
6-8	Substantial level	Intensive assessment and referral