BRUNSWICK FAMILY MEDICINE

WELCOME LETTER

Dear Sir or Madam,

First we would like to take the time to thank you for choosing our practice! We will do our best to provide you with the best medical care possible.

Patients are asked to choose a particular provider as their personal clinician to ensure continuity of care. **Please make sure you choose your preference of provider on page 8 of this packet.** All routine office visits will be scheduled with this provider. Appointments needed on a same day basis (sick & acute issues) will be scheduled with your provider if he/she is available, otherwise will be scheduled with provider available.

Enclosed are our New Patient forms. Please complete and return them to us as soon as possible so that a New Patient Appointment can be scheduled. We will need the following at that time:

1. **New Patient Forms** – completed and signed in all areas requiring signature. Please sign the areas requiring a witness in front of a witness prior to returning documents.
2. **Insurance Cards & Photo ID** (for all persons providing paperwork – whether present at time of dropping off forms or not) – we need front and backs of all cards.
3. **List of Medications** (prescription and/or vitamins/supplements)
4. **Contact information for your prior doctor** – we will need name and at least a telephone number – fax number if available (see Release of Records form) – please also provide us with a list of specialists that you see.

At the time of your New Patient Appointment you will need to ***bring your medications in their original bottles*** no matter the frequency at which they are taken (including vitamins/supplements).

Again, thank you for choosing our practice we look forward to working with you.

Sincerely,

Brunswick Family Medicine Staff

****Please note that we DO NOT prescribe pain or "mood" medications ****

BRUNSWICK FAMILY MEDICINE

HIPAA - Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

The Notice of Privacy Practices describes how we may use and disclose your protected health Information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that relates to your past, present or future physical or mental health or condition and related care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care service to you to pay your health care bills, to support the operation of physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected information to provide, coordinated, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to whom you have been referred to ensure that physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that you're relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situation include: Public Health issues as required by law; Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirement; Criminal Activity , Military Activity and National Security; Worker's Compensation; Required Uses and Department of Health and Human Service to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and required Uses and Disclosures: Will Be Made Only with Your Consent, Authorization or Opportunity of Object unless required by law. **You may revoke this authorization,** at any time, in writing, except that your physician or the except to the extent that your physical or the physician's practice has taken an action on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also require that any part of your protected health information not be disclose to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use disclosure of your protected health information, your protection health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice this notice alternative i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the term of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate you filing a complaint.**

This notice was published and become effective on/or before **April 14, 2003.**

BRUNSWICK FAMILY MEDICINE

FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy or your financial responsibility.

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE

We accept: Cash, Check, and Credit Cards

- ✓ Always bring your current health insurance card to the office
- ✓ Please notify us at time of check-in of any changes in insurance, address, telephone number or family status
- ✓ Please pay your copay, co-insurance, deductible or balance on account at the time of check-in
- ✓ You will be expected to pay in full if:
    - o You do not have insurance
    - o We do not participate with your plan
    - o You are unable to present a current member identification card from your insurance carrier

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan and you will be 100% responsible for these charges. It is your responsibility to:

- Ensure our providers actively participate with your insurance carrier
- Know your benefit coverage, as well as your dependents, prior to received services
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits

We will not be held liable for ensuring the accuracy of your insurance information, including, but not limited to verifying current coverage and eligibility, obtaining authorizations, or confirming co-pay, coinsurance, and/or deductible information. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

To summarize, your financial responsibility retains to:

- Denied and Non-covered services
- Services deemed not medical necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pending claims due to lack of patient and/or guarantor information
- Non-Insurance and/or out-of-network benefits

COPAY, COINSURANCE: We are required by our insurance contracts to collect all co-pays and other patient responsible amounts, at the time of service. If there is a balances on your account you will receive a statement and the balance is due prior to your next visit.

DEDUCTIBLE: If you have not met your deductible – we will collect a deposit of $75. If additional balances are accrued you will receive a statement and the balance is due prior to your next visit.

SELF-PAY PATIENTS: Self-Pay patients are required to make a deposit of $85 at the time of service. If additional charges are accrued you will receive a statement and the balance is due prior to your next visit.

RETURNED CHECKS: There is a fee (currently $35) for any checks returned by the bank. We have the right to change this fee without notification.

MISSED APPOINTMENTS "NO SHOW": Unless you contact our office at least 3 hours prior to your scheduled appointment time you will be considered to have no showed for that appointment. When we reserve appointment time for patients who do not come, we deprive other patients in need of care. After your 3rd no show visit you may be dismissed from our practice and asked to find a new physician within 30 days. Extenuating circumstances will be considered.

FORM COMPLETION: An appointment may be required any time you need a form completed by the physician in order to ensure proper information is given. A fee may be assessed for all forms requiring the physician to complete and/or sign. The first 5 pages will be completed for $10 and each additional page will be $5. At the time the patient presents paperwork to be completed, the form completion fee will be calculated and is to be paid at that time. Forms will not be completed unless fees have been paid. The form fees are in addition to any copay/coinsurance/deductible amount due when appointments are necessary.

LAB/X-RAY/DIAGNOSTIC SERVICES: We are not responsible for any billing or billing issues associated with any lab tests, x-rays, or diagnostic services. These services are provided by an outside provider. Please contact them directly with any questions or concerns regarding your bill.

PAYMENTS: Unless other arrangements are approved by us, the balance on your account is due and payable when the statement is issued, and is past due if not paid upon receipt. All balances must be paid or arrangements must be made prior to your next visit.

INSURANCE RELEASE: You understand that your health plan may not cover services rendered. You are responsible for the charges not covered.

DIVORCE: In care of divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

COPIES AND TRANSFER OF RECORDS: All past due balances will be collected prior to medical records being copied or transferred. We will transfer records to a new primary care physician at no cost as a courtesy to the patient one time. All additional transfers will be done for a fee.

WAIVER OF LIABILITY OF INSURANCE

I,_____, do understand that the care I receive may not be covered under my insurance plan. In signing this Document, I accept full responsibility to pay Brunswick Family Medicine and its affiliates the charges for today's visit. I understand that Brunswick Family Medicine will not bill private individuals for care rendered. If I cannot present documentation of current insurance coverage, all payment must be made at the time services are rendered.

If insured, I agree that if the charges for today are not considered reimbursable by my insurer, and therefore the insurer denies payment, I will submit payment upon notification.

_____ _____

Signature Date

CONSENT

I,_____, give Brunswick Family Medicine permission to release my medical records to my insurance carrier and to any other medical facility involved in the treatment of my care.

_____ _____

Signature Date

HIPAA PRIVACY NOTICE & FINANCIAL POLICY

I, _____ , have received a copy of the HIPAA Privacy Notice & Financial Policy from Brunswick Family Medicine.

_____ _____

Signature Date

NO SHOW POLICY NOTICE

Patient Name: _____ Date of Birth : _____
(please print)

Dear Patient (or Responsible Party),

Effective immediately (July 1, 2013), Brunswick Family Medicine, PA has instituted a formal policy regarding "no shows". A "no show" is defined as a scheduled appointment that the patient does not keep and does not call to cancel.

POLICY:

We understand there are extenuating circumstances beyond your control that may lead to missed appointments, but we request that you call us as much in advance as possible to cancel (*at least* 3 or more hours prior to appointment time).

When we reserve appointment time for patients who do not come, we deprive other patients in need of care. After your 3rd no show visit you may be dismissed from our practice and asked to find a new physician within 30 days.

By signing below I acknowledge that I fully understand the above policy. I am aware that possible termination from Brunswick Family Medicine, PA may occur in the event I miss 3 scheduled appointments without giving proper notice.

_____ _____
Patient or Responsible Party's Signature Today's Date

PATIENT DEMOGRAPHICS

Provider Choice* □ Dr. Slade Suchecki □ Dr. Rick Hernendez

*****All items with an asterisk (*) are required fields*****

Last Name*_____ First* _____ MI _____

Address* _____ City* _____ ST* _____ Zip* _____

Mailing Address (if different)* _____ City* _____ ST* _____ Zip* _____

Home#* _____ Work #*_____ Cell #*_____

Date of Birth* _____ Marital Status __Married __Single __Widow __Divorced Gender* __M __F

SSN _____ Driver's License No _____ ST _____

Pharmacy Name _____ Phone _____ Fax _____

Emergency Contact _____ Phone _____ Relation to Patient:_____

Address _____ City _____ ST _____ Zip _____

Race* __Asian __American Indian/Alaska Native __Black/African American __White __Native Hawaiian __Other _____

Ethnicity* __Declined __Hispanic/Latino __Not Hispanic or Latino

Person Responsible for the Bill* __Self __Spouse __Parent __Other *(FILL-OUT BELOW IF OTHER THAN SELF)*

Last Name*_____ First* _____ MI _____

Address* _____ City* _____ ST* _____ Zip* _____

Home# _____ Work #:_____ Cell #:_____

SSN _____ Date of Birth* _____ *(required)*

Employer/Organization Name_____

PRIMARY Ins. Company* _____ MUST ALSO PROVIDE INSURANCE CARD!!!

Mail claims to _____ City _____ ST _____ Zip _____

General Phone _____ Claims Phone _____

Group Number _____ Group Name _____ Co-Pay: $10 $20 $_____

Policyholder Name _____ Policy No _____

Policyholder DOB _____ (*required)* Policyholder is __self __spouse __parent

SECONDARY Ins. Company _____ MUST ALSO PROVIDE INSURANCE CARD!!!

Mail claims to _____ City _____ ST _____ Zip _____

General Phone _____ Claims Phone _____

Group Number _____ Group Name _____ Co-Pay: $10 $20 $_____

Policyholder Name _____ Policy No _____

Policyholder DOB _____ (*required)* Policyholder is __self __spouse __parent

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows BRUNSWICK FAMILY MEDICINE to release any information to any of my insurers or physicians as requested by any such insurer or physician. I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, Private Insurance, Group Policy Benefits and Other Health Plans to BRUNSWICK FAMILY MEDICINE do not extend credit. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection. I understand that I am financially responsible to BRUNSWICK FAMILY MEDICINE for all charges not covered, approved or considered necessary by my insurance company. I will pay at the time of service or have an agreeable payment arrangement set with the business office.
Medicare Patients Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to BRUNSWICK FAMILY MEDICINE, PA for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

Signed*_____ Date*_____

Brunswick Family Medicine Employee_____ Date_____

BRUNSWICK FAMILY MEDICINE

HIPAA – Permission to Access Medical Information

In regards to HIPAA our office is not allowed to release any of your medical information to others unless we have your written consent.

I, _____, give permission for the following to have access to my medical information.

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Are we allowed to leave messages on your answering machine or voicemail? (ex. Lab results, xray results, confirm appointments, etc.)

(Please circle one)

YES **NO**

Preferred Number for Appointment Confirmations: _____

From time to time we may need to mail something to you. Is this okay?

(Please circle one)

YES **NO**

Signature of Patient: _____

Date: _____

Brunswick Family Employee: _____

Date: _____

BRUNSWICK FAMILY MEDICINE

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Date of Birth: _____

SOCIAL HISTORY

Marital Status:

□ Single □ Married □ Separated □ Divorced □ Widowed

Alcohol Use:

□ Current Use □ Never □ Quit (when? _____)
How much? _____ Type? _____

Tobacco Use:

□ Current Use □ Never □ Quit (when? _____)
How much? _____ Type? _____

Drug Use:

□ Current Use □ Never □ Quit (when? _____)
How much? _____ Type? _____

GENERAL INFORMATION ABOUT YOU

Employment: Occupation _____ Location _____

□ Full-Time □ Part-Time □ Self □ Stay-At-Home □ Retired

Children:

_____

Hobbies:

_____

Exercise: (type & how often)

_____

Do you have a Living Will?: □ Yes □ No (if yes, please provide us a copy)

CURRENT MEDICATIONS *(name of medication, dosage (mg's), and directions on how to take)*

Please included all prescriptions, over-the-counter medications, vitamins, and supplements

ALLERGIES

Please name and give type of reaction

LIST OF OTHER PROVIDERS

Please included all names, specialty, address, and phone number

YOUR MEDICAL HISTORY

Which of the following conditions are <u>you</u> currently being treated or have been treated for in the past?

Allergy/Dermatology
____ Seasonal Allergies
____ Food Allergies
____ Household Allergies
____ Environmental Allergies
____ Chicken Pox
____ Shingles
____ Eczema
____ Frequent Ear Infections
____ Frequent Sinusitis
____ Psoriasis

Cancer
____ Bone
____ Breast (side?_____)
____ Brain Tumor
____ Cervical
____ Colon
____ Endometrial
____ Hepatic Carcinoma
____ Leukemia
____ Lung
____ Lymphoma
____ Ovarian
____ Pancreatic
____ Renal
____ Skin
____ Thyroid
____ Uterine

Cardiovascular
____ Arrhythmia
____ Carotid Artery Stenosis
____ Congestive Heart Failure
____ Deep Vein Thrombosis
____ High Cholesterol
____ High Blood Pressure
____ Heart Attack
____ Blood Clots
____ Heart Murmur
____ Phlebitis
____ Vascular Disease
____ Valvular Disease

Endocrine
____ Cushing's Disease
____ Diabetes – Type I
____ Diabetes – Type II
____ Gestational Diabetes
____ Hyperthyroidism
____ Hypothyroidism

Renal/Gynecological
____ Renal Failure (acute or chronic)
____ Endometriosis
____ Urinary Incontinence
____ Abnormal PAP
____ Polycystic Kidney Disease
____ Polycystic Ovarian Disease
____ Kidney Stones
____ Recurrent UTI's
____ Erectile Dysfunction

Gastrointestinal
____ Gallstone Disease
____ Cirrhosis
____ Colon Polyps
____ Crohn's Disease
____ GERD/Acid Reflux
____ Hepatitis
____ Irritable Bowel Syndrome
____ Pancreatitis
____ Stomach Ulcer(s)
____ Ulcerative Colitis
____ GI Bleed
____ Diverticulosis

Hematologic
____ Anemia
____ Iron Deficiency
____ Sickle Cell Anemia
____ Vitamin B12 Deficiency

Pulmonary
____ Asthma
____ Chronic Bronchitis
____ COPD/Emphysema
____ Croup
____ Pneumonia
____ Pulmonary Embolism
____ Sleep Apnea
____ Sarcoidosis
____ Tuberculosis
____ Cystic Fibrosis

Musculoskeletal
____ Chronic Pain (where? _____)
____ Fibromyalgia
____ Fractures (where? _____)
____ Gout
____ Rheumatoid Arthritis
____ Osteoarthritis
____ Osteopenia
____ Osteoprosis
____ Polymylagia
____ Sjogren's Diseases
____ Lupus

Neurological
____ Alzheimer's
____ ADD
____ ADHD
____ Autism
____ Cerebral Palsy
____ Stoke
____ Dementia
____ Disc Disease
____ Down Syndrome
____ Headache – migraine
____ Headache – tension
____ Huntington's Disease
____ Meningitis
____ Mental Retardation
____ Multiple Sclerosis
____ Muscular Dystrophy
____ Parkinson's Disease
____ Neuropathy
____ Seizure Disorder
____ TIA

Other
____ Immunodeficiency
____ Glaucoma
____ Cataract
____ Obesity
____ Vitamin D Deficiency

YOUR SURGICAL HISTORY

	details & dates		details & dates
Cosemetic Procedure(s)		Shoulder Surgery or Replacement	
Appendectomy		Hip Surgery or Replacement	
Gall Bladder Removal		Knee Surgery or Replacement	
Colon Resection		C-Section	
Hysterectomy		Cateract Removal	
Lung Resection		Hernia Repair	
Tonsil/Adenoidectomy		Pacemaker Implantation	
Thyroidectomy		Valve Replacement	
Myringotomy (ear tubes)		Other: _____	

FAMILY HISTORY

Please put a checkmark in all applicable boxes **Were you adopted? Yes No**

Illness	Father	Mother	Sibling	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other (Aunts, Uncles)
Heart Disease									
High Cholesterol									
High Blood Pressure									
Diabetes									
Heart Attack									
Stroke									
Kidney Disease									
Liver Disease									
Bleeding/Clotting Disorders									
Asthma									
Anemia									
Colon/Bowel Problems									
Cancer *(specify type)*									
Thyroid Disease									
Depression/Anxiety									
Seizures/Epilepsy									
Other (specify)									
DECEASED? ***(include year of death & cause)***									

BRUNSWICK FAMILY MEDICINE

PREVENTATIVE SERVICES CHECKLIST

Name: _____

Date(s) of Service
(please include month/year)

- Abdominal Aortic Aneurysm Screening _____
- Bone Mass Measurement (DEXA Scan/Bone Density) _____
- Cardiovascular Screenings (Cholesterol Screening/EKG or ECG) _____
- Carotid Doppler _____
- Chest X-Ray or CT Scan of Chest _____
- Colorectal Cancer Screenings (colonoscopy/endoscopy) _____
- Dental Cleaning _____
- Dermatology Evaluation (Annual Skin Check) _____
- Diabetes Screenings _____
- Diabetes Self-management Training _____
- Exercise or Nuclear Stress Test _____
- Flu Vaccine _____
- Hepatits B Vaccine _____
- HIV Screening _____
- Mammogram (screening) _____
- Medical Nutrition Therapy Services _____
- Pap/Pelvic Exam (including breast exam) _____
- Physical (Annual) _____
- Pneumoccocal Vaccine _____
- Prostate Cancer Screening _____
- Shingles Vaccine _____
- Smoking Cessation Counseling (counseling to quit smoking) _____
- Tetanus Vaccine _____
- Vision Screening with Glaucoma Screening _____

BRUNSWICK FAMILY MEDICINE

SLEEP DISORDER SYMPTOMS ASSESSMENT

Name: _____ Date of Birth: _____

(Please circle your answer)

1. Do you snore on most nights (more than 3 times/week)? YES NO
2. Do you, or have you been told, that you stop breathing while sleeping? YES NO
3. Do you wake suddenly during the night? YES NO
4. Do you suddenly wake-up gasping for air? YES NO
5. Do you wake up in the morning feeling tired? YES NO
6. Do you wake up in the morning with a headache? YES NO

Please check any of the following you have:

__ High Blood Pressure
__ Heart Disease
__ Stroke
__ Insomnia
__ Frequent Urination at Night (Nocturia)
__ Diabetes
__ Depression
__ Overweight

Are you currently using a CPAP (for sleep apena)? YES NO

If YES, for how long? _____

Please provide us with a copy of the most recent sleep study done – we will be unable to sign for supplies, etc. unless this is provided to our office!

PAIN MEDICATION *and/or* MOOD/ANXIETY MEDICATION NOTICE

I,_____, do understand that Brunswick Family Medicine does not, under any circumstances, prescribe or refill certain pain medications (including, *but not limited to*, Hydrocodone, Ultram, Tramadol, Oxycodone, Oxycontin, & Methadone) or certain mood/anxiety medications (including, *but not limited to*, Lorazepam, Alprazolam, Clonazepam, Ativan, & Klonopin). If I am on any of these medications prior to becoming a patient at Brunswick Family Medicine I understand that I will have to get these medications from another provider (pain management, psychiatrist, etc.)

please note that we will not refer you to a physician for these medications, we will need physicians contact information and will verify that you are under their care, receiving prescriptions from them prior to your visit with us

_____

Patient Signature (If patient is under 18 years of age, a parent must sign here) Date

_____

Brunswick Family Medicine Employee Date

Please list pain medications and/or mood/anxiety medications along with treating physician & phone number and date of last visit for each medication:

Name of Medication	Treating Physician & Phone Number	Date of Last Visit
Name of Medication	Treating Physician & Phone Number	Date of Last Visit
Name of Medication	Treating Physician & Phone Number	Date of Last Visit
Name of Medication	Treating Physician & Phone Number	Date of Last Visit

BRUNSWICK FAMILY MEDICINE

FORMULARY BENEFITS CONSENT FORM

Formulary Benefit data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By singing below I give permission for ***Brunswick Family Medicine*** to access my pharmacy benefits data electronically through RxHub. This consent will enable ***Brunswick Family Medicine*** to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a histories list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information and information about other prescriptions by other providers using RxHub.

_____ _____

Patient Name (Printed) Date of Birth

_____ _____

Patient/Guardian Signature Date

Slade A. Suchecki, DO
Rick J. Hernandez, MD
3960 Executive Park Blvd., Ste. 600
Southport, NC 28461
Phone (910) 454-4343
Fax (910) 457-9209

Authorization for Disclosure of Health Information

I hereby authorize _____
(prior doctors name or facility name & phone number – fax number if available)
to disclose the following information from the health records of:

Patient name _____ DOB _____

SS#_____

Information to be disclosed:

□ Complete health record □ Laboratory tests □ Diagnostic reports
□ Hospital records □ Progress notes and/or Consultation reports
□ Appointment information □ Other _____

The information will be disclosed to: **BRUNSWICK FAMILY MEDICINE**

Purpose of Disclosure: □ Transfer of Care □ Moving □ Referral □ Continuation of Care
□ Other: _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing/results or AIDS information. ____yes ___no

I understand this authorization may be revoked in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Patient Signature Date Signed

_____ _____
Legal representative (if under 18 years of age) Relationship

_____ _____
Signature of Witness Date