

TWIN FORKS FAMILY PRACTICE, LLC PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION					
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	BIRTH DATE:	SOCIAL SECURITY NUMBER:	CIRCLE: Male Female
MAILING ADDRESS:			STREET ADDRESS (if different):		
HOME PHONE: ()	CELL PHONE: ()	WORK PHONE: ()	CIRCLE: Single Married Separated Divorced Widowed		
OCCUPATION:	EMPLOYER:	EMPLOYER ADDRESS:			
GUARANTOR (Primary insurance policyholder or responsible party, if different than patient)					
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	BIRTH DATE:	SOCIAL SECURITY NUMBER:	CIRCLE: MALE FEMALE
MAILING ADDRESS:			STREET ADDRESS (if different):		
HOME PHONE: ()	CELL PHONE: ()	WORK PHONE: ()	RELATIONSHIP TO PATIENT:		
OCCUPATION:	EMPLOYER:	EMPLOYER ADDRESS:			
EMERGENCY CONTACT					
NAME OF EMERGENCY CONTACT:			ADDRESS:		
HOME PHONE: ()	CELL PHONE: ()	WORK PHONE: ()	RELATIONSHIP TO PATIENT:		
<p style="text-align: center;"><u>Assignment of Benefits</u></p> <p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician(s) of <i>TWIN FORKS FAMILY PRACTICE, LLC</i>. I understand that I am financially responsible for any copay, co-insurance and/or deductible balance. I understand that I may be financially responsible for any charges that are denied by my insurance. I also authorize <i>TWIN FORKS FAMILY PRACTICE, LLC</i> or insurance companies to release any information required to process my claims.</p>					
_____			_____		
Patient/Guardian Signature			Date		

TWIN FORKS FAMILY PRACTICE, LLC HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Today's Date:

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio			
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox	
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?			
	Rank salt intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi	<input type="checkbox"/> Med	<input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

TWIN FORKS FAMILY PRACTICE, LLC

Donna M. Prill, MD

Kristen J. Casillo, RPA-C

34 East Montauk Highway, Suite 4
Hampton Bays, New York 11946
631-728-0505
631-728-4038 (FAX)

**Patient Authorization for Use and Disclosure
of Protected Health Information**

The Department of Health and Human Services has established a HIPAA "Privacy Rule" in an attempt to insure that the Personal Health Information (PHI) of patients is protected for privacy. The "Privacy Rule" was also created to provide a standard for certain health care providers to obtain their patient's consent for use and disclosure of health information about the patient for the function of their health care facility, to carry out treatment, submit insurance claims and collect payment for their services.

As a patient of this practice we want you to know that we respect the privacy of your personal medical records and will take reasonable precautions to secure and protect that privacy. When it is appropriate, we provide the minimum information necessary to only those we feel are legitimately in need of your PHI.

You may refuse to consent to the use or disclosure of your PHI by submitting a statement in writing. However under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI.

You have the right to review our privacy practices at any time, to request restrictions and revoke consent in writing. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I hereby authorize Twin Forks Family Practice, LLC to use and or disclose Protected Health Information about me to the extent needed for the function of their health care facility, to carry out treatment, submit insurance claims and collect payment for their services.

PATIENT/LEGAL GUARDIAN
SIGNATURE

DATE

I hereby give permission to Twin Forks Family Practice, LLC to speak to the following family members, home health care providers or friends regarding appointments, financial and insurance issues or specific health care information.

NAME:

RELATIONSHIP:

PATIENT/LEGAL GUARDIAN
SIGNATURE

DATE

I hereby give permission to Twin Forks Family Practice, LLC to leave a detailed message with a family member, on my answering machine, voice mail or email which may include information regarding appointments, financial and insurance issues or specific health care information.

PATIENT/LEGAL GUARDIAN
SIGNATURE

DATE

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PRIVACY PRACTICES

As a patient of ***Twin Forks Family Practice*** we want you to know that we respect your privacy and the confidentiality of your personal medical records and will take reasonable precautions to secure and protect that privacy. When it is appropriate, we provide the minimum information necessary to only those we feel are legitimately in need of your Personal Health Information (PHI) or to those you have designated, in writing, as persons we may speak to regarding your PHI.

The following procedures have been implemented in an attempt to safeguard your privacy and comply with the Department of Health and Human Services HIPAA "Privacy Rule":

- Patient Names
Patients will be addressed by either their first name (John) or last name (Mr. Smith) to avoid disclosure of full names to others who may be in the office
- Telephones
Personally identifiable information, such as date of birth, will be obtained from callers to verify to whom we are speaking on the telephone
- Waiting Room
Twin Forks Family Practice has eliminated the use of patient sign in sheets to prevent anyone from seeing a list of patient names
- Electronic Medical Records (EMR)
Twin Forks Family Practice has implemented state of the art EMR. EMR secures patient records containing individually identifiable health information in a secure environment so that they are not readily available to those who do not need them. All PHI is scanned into the computer system which eliminates the need for paper patient charts.
- Shredding
All paper with personally identifiable information will be shredded after being scanned into the computer system
- Medical Records Requests
Requests for medical records must be in writing on letterhead and received by mail or fax
- Outgoing faxes
All outgoing faxes must include a "Confidential Transmission" warning
- Messages
Live person, voice mail, answering machine or email messages from Twin Forks Family Practice, LLC will only request a call back from patient or guardian unless a "permission to leave detailed message" statement signed by the patient is on file
- Employees
All personnel will be trained in and must adhere to office policy regarding Privacy Practices.

I have received a copy of ***Twin Forks Family Practice, LLC Privacy Practices***.

PATIENT/LEGAL GUARDIAN
Print Name

RELATIONSHIP TO PATIENT

PATIENT/LEGAL GUARDIAN
SIGNATURE

DATE

TWIN FORKS FAMILY PRACTICE, LLC
OFFICE POLICY

In a continuing effort to provide quality healthcare to our patients and have the office run as efficiently as possible, Twin Forks Family Practice is implementing the following office policy effective January 1, 2009.

Office visits

- Please be as forthcoming as possible when asked the reason for your visit so that you can be scheduled appropriately.
- It is important that you prioritize the 1 or 2 issues to be addressed at each appointment. Urgent visits will address only the urgent problem.
- It is not a reasonable expectation to have many medical problems addressed appropriately in a 15 or 30 minute visit.
- Please make every effort to arrive for your appointment on time.

Lab or radiology orders

Orders for tests should be discussed at an office visit. Telephone requests for lab or radiology orders prior to office visits will no longer be provided. Mammography orders will be provided after a clinical breast examination.

Test results

Regardless of what you may have been told at either the lab or radiology, please allow at least 7 to 10 days for this office to receive test results and review them. Normal test results will likely be relayed to you by phone or mail. Abnormal test results may require an office visit to discuss and you will be notified to schedule an appointment.

Call backs

Patients requesting a call back from Dr. Prill or Kristen will be asked the reason for the call back. It is impossible for the providers to return every phone call and so they must prioritize the requests. If no reason is given for the call back, you may not receive a call back. In some instances, the question can be answered by office staff.

Medications

- After Memorial Day, the office will no longer have a refill line.
- In most instances, prescriptions require an office visit. You are provided with enough refills until it is time to return to the office. When you have received your last refill of medication from your pharmacy it is time to schedule an appointment. If you want to change or start a new medication, please schedule an appointment. Controlled substances require an appointment.
- Faxed or phoned requests for refills from local or mail order pharmacies will no longer be accepted.
- Please come to your office visit prepared with a list of your current medications and those that will soon need to be refilled.

Thank you for your cooperation.

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FINANCIAL POLICY

If you have insurance:

It is the office policy of Twin Forks Family Practice to collect all copays at the time of each visit. If your insurance company applies a deductible or co-insurance to your claims, you will be billed for the balance due. Please be advised that if the claim is denied by the carrier, the financial responsibility for the medical bills will be yours and payable at our usual and customary fees.

If you do not have insurance:

Financial responsibility for the medical bills is yours and payable at our usual and customary fees. Payment in full is expected at the time of each visit and will include a fee for the office visit and any procedures performed.

Workers' Compensation:

Prior to your visit you will need to provide Twin Forks Family Practice with the accident date, claim number and your employer's workers' compensation insurance carrier information. Upon verification that you have an open workers' compensation claim, no payment is necessary at the time of the visit. Please be advised that if the claim is denied by the carrier, the financial responsibility for the medical bills will be yours and payable at our usual and customary fees.

No-Fault:

Prior to your visit you will need to provide Twin Forks Family Practice with the accident date, claim number and your no-fault insurance policy and carrier information. If the no-fault policy is not in your name, we will need full information on the policyholder. Upon verification that you have an open no-fault claim, no payment is necessary at the time of the visit. Your auto insurance policy may include a deductible. If a deductible is applied to your Twin Forks Family Practice office visits, you will be billed for that deductible. Please be advised that if the claim is denied by the carrier, the financial responsibility for the medical bills will be yours and payable at our usual and customary fees.

For your convenience we accept cash, checks, credit cards and debit cards. **A fee of \$25 will be assessed for returned checks.**

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copays and deductibles are my responsibility.

I authorize my insurance benefits be paid directly to Twin Forks Family Practice, LLC.

I authorize Twin Forks Family Practice, LLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

PATIENT/LEGAL GUARDIAN
Print Name

RELATIONSHIP TO PATIENT

PATIENT/LEGAL GUARDIAN
SIGNATURE

DATE

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TO ALL PATIENTS

Effective February 5, 2007 this office is implementing the following policy regarding no show appointments.

A \$50 fee will be charged to the account of patients failing to provide 24 hour notice of the cancellation of scheduled appointments. This policy will affect all patients, new and established.

As a courtesy, this office provides patients with printed appointment cards and confirmation phone calls. The quantity of no shows is excessive and this policy is being implemented in an effort to improve that situation. As it is our desire to provide our patients with timely appointments, we would appreciate as much notice as possible when cancelling appointments so that we may schedule another patient in that time slot.

I AM AWARE OF THIS OFFICE'S NO SHOW POLICY

Signature

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Complete this form if you want a copy of your medical records transferred to this practice from another physician

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____
(name, address and phone number of former physician or practice)
to release healthcare information of the patient named above to:

TWIN FORKS FAMILY PRACTICE, LLC

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This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: _____

All healthcare information

Other: _____

If Applicable:

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

