TriStar Medical Group Family Physicians

Consent for Treatment and Payment Agreement

I hereby authorize TriStar Medical Group Family Physicians to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to TriStar Medical Group Family Physicians of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to TriStar Medical Group Family Physicians, all insurance or third party payments that I receive for services rendered to me immediately upon receipt. Patient Initial: ____________

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

I assign the benefits payable for services to TriStar Medical Group Family Physicians. Patient Initial: ____________

I request this authorization also apply to all other insurance. Patient Initial: ____________

I acknowledge that I have been given TriStar Medical Group Family Physicians Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official. Patient Initial: ____________

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is Authorized to receive information	Release info (please circle)	Allowed in exam room (please circle)	
Voicemail phone # ________________	Y N	N/A	(Lab and test results will be left on VM if marked Y.)
__________________________________	Y N	Y N	
__________________________________	Y N	Y N	

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure**

Do you have a Living Will? Y N

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature____

Date______________________________________ Patient Date of Birth______________________________

New Patient Info Form

Patient: ______________________________ **DOB** __________________ **Ht:** _________**Wt:** ________ **Temp:** ________
Date: _________________________________ **Hp:** ______/______ **Pulse:** ________

HISTORY

CHIEF COMPLAINT:

HISTORY of PRESENT ILLNESS: • For an "Extended" history, document at least four of these elements

- **Location** ____
  (Where is the pain/problem?)
- **Quality** ____
  (Example: color of sputum)
- **Severity** ____
  (How severe is the pain/problem?)
- **Duration** ____
  (How long have you had this pain/problem? or when did it start?)
- **Timing** ____
  (Does this pain/problem occur at a specific time?)
- **Context** ____
  (Where were you at the onset of this pain/problem?)
- **Associated signs/symptoms** _______________________
  ____
  (What other associated problems have you been having?)
- **Modifying factors** ___________________________________
  ____
  (What makes this pain/problem worse or better? or have you had any previous episodes?)

MEDICAL HISTORY:
- **For a "Pertinent" history - at least 1 specific item for ANY ONE of the 3 histories**
- **For a "Complete" history - at least 1 specific item for EACH ONE of the 3 histories**

• ***Patient Medical History***

Condition		
Diabetes	No	Yes
Hypertension	No	Yes
Cancer	No	Yes
Stroke	No	Yes
Heart trouble	No	Yes
Arthritis/gout	No	Yes
Convulsions	No	Yes
Bleeding tendency	No	Yes
Acute infections	No	Yes
Venereal disease	No	Yes
Hereditary defects	No	Yes

Previous Hospitalizations/Surgeries/Serious Injuries **When?**
____
____
____
____

Medications
____
____
____
____

• ***Patient social history***

Marital status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____
Use of alcohol: Never ____ Rarely ____ Moderate ____ Daily ____
Use of tobacco: Never ____ Previously, but quit ____ Current packs/day ____
Use of drugs: Never ____ Type/Frequency ________________________
Excessive exposure at home or work to: Fumes ____ Dust ____ Solvents ____ Air-borne particles ____ Noise ____

• ***Family Medical History***

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

SYSTEM REVIEW:

Document the positive & pertinent negative responses
- For an "EXTENDED" system review - at least 2 systems
- For a "COMPLETE" system review - at least 10 systems (Dictate responses to pertinent systems, then state: "All other systems negative")

- **CONSTITUTIONAL SYMPTOMS**
  - Good general health lately .... No Yes
  - Recent weight change .... No Yes
  - Fever .... No Yes
  - Fatigue .... No Yes
  - Headaches .... No Yes
- **EYES**
  - Eye disease or injury .... No Yes
  - Wear glasses/contact lenses .... No Yes
  - Blurred or double vision .... No Yes
  - Glaucoma .... No Yes
- **EARS/NOSE/MOUTH/THROAT**
  - Hearing loss or ringing .... No Yes
  - Earaches or draining .... No Yes
  - Chronic sinus problems or rhinitis .... No Yes
  - Nose bleeds .... No Yes
  - Mouth sores .... No Yes
  - Bleeding gums .... No Yes
  - Bad Breath or bad taste .... No Yes
  - Sore throat or voice change .... No Yes
  - Swollen glands in neck .... No Yes
- **CARDIOVASCULAR**
  - Heart trouble .... No Yes
  - Chest pain or angina pectoris .... No Yes
  - Palpitation .... No Yes
  - Shortness of breath with walking or lying flat .... No Yes
  - Swelling of feet, ankles or hands .... No Yes
- **RESPIRATORY**
  - Chronic or frequent coughs .... No Yes
  - Spitting up blood .... No Yes
  - Shortness of breath .... No Yes
  - Asthma or wheezing .... No Yes
- **GASTROINTESTINAL**
  - Loss of appetite .... No Yes
  - Change in bowel movements .... No Yes
  - Nausea or vomiting .... No Yes
  - Frequent diarrhea .... No Yes
  - Painful bowel movements or constipation .... No Yes
  - Rectal bleeding or blood in stool .... No Yes
  - Abdominal pain or heartburn .... No Yes
  - Peptic ulcer (stomach or duodenal) .... No Yes
- **GENITOURINARY**
  - Frequent urination .... No Yes
  - Burning or painful urination .... No Yes
  - Blood in urine .... No Yes
  - Change in force of strain when urinating .... No Yes
  - Incontinence or dribbling .... No Yes
  - Kidney stones .... No Yes
  - Sexual Difficulty .... No Yes
  - Male - testical pain .... No Yes
  - Female - pain with periods .... No Yes
  - Female - irregular periods .... No Yes
  - Female - vaginal bleeding .... No Yes
  - Female - # of pregnancies ______ # of miscarriages ______
  - Female - date of last pap smear ______________________
- **MUSCOLOSKELETAL**
  - Joint Pain .... No Yes
  - Joint Stiffness .... No Yes
  - Weakness of muscles or joints .... No Yes
  - Muscle pain or cramps .... No Yes
  - Back pain .... No Yes
  - Cold extremities .... No Yes
  - Difficulty in walking .... No Yes
- **INTEGUMENTARY (skin, breast)**
  - Rash or itching .... No Yes
  - Change in skin color .... No Yes
  - Change in hair or nails .... No Yes
  - Varicose Veins .... No Yes
  - Breast Pain .... No Yes
  - Breast lump .... No Yes
  - Breast discharge .... No Yes
- **NEUROLOGICAL**
  - Frequent or recurring headaches .... No Yes
  - Light headed or dizzy .... No Yes
  - Convulsions or seizures .... No Yes
  - Numbness or tingling sensations .... No Yes
  - Tremors .... No Yes
  - Paralysis .... No Yes
  - Stroke .... No Yes
  - Head Injury .... No Yes
- **PSYCHIATRIC**
  - Memory loss or confusion .... No Yes
  - Nervousness .... No Yes
  - Depression .... No Yes
  - Insomnia .... No Yes
- **ENDOCRINE**
  - Glandular or hormone problem .... No Yes
  - Thyroid disease .... No Yes
  - Diabetes .... No Yes
  - Excessive thirst or urination .... No Yes
  - Heat or cold intolerance .... No Yes
  - Skin becoming dryer .... No Yes
  - Change in hat or glove size .... No Yes
- **HEMATOLOGIC/LYMPHATIC**
  - Slow to heal after cuts .... No Yes
  - Bleeding or bruising tendency .... No Yes
  - Anemia .... No Yes
  - Phlebitis .... No Yes
  - Past transfusion .... No Yes
  - Enlarged glands .... No Yes
- **ALLERGIC/IMMUNOLOGIC**
  - History of skin reaction or other adverse reaction to:
    - Penicillin or other antibiotics .... No Yes
    - Morphine, Demerol, or other narcotics .... No Yes
    - Novocaine or other anesthetics .... No Yes
    - Aspirin or other pain remedies .... No Yes
    - Tetanus antitoxin or other serums .... No Yes
    - Iodine methiolate or other antiseptics .... No Yes
  - Other drugs/medications ______________________
  - Known food allergies ______________________