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HERITAGE VALLEY
Health System

Heritage Valley Medical Group
Robert L. Grieco, M.D.
2620 Constitution Blvd
Beaver Falls, PA 15010
Phone: 724-773-6880 Fax: 724-770-7993

Dear Patients,

We would like to thank you for choosing us as your primary care provider. We value you and your family and strive to do the best we can to improve your health. To better serve you we have found it necessary to implement a few office policies along the way. Any questions or concerns may be addressed by my office coordinator Tamill at 724-773-6880.

Sincerely Yours,

Robert L. Grieco, MD

Dr. Robert L. Grieco, M.D.
2017 Office Policies

Hours of Operation

Monday and Wednesday 7:00am – 5:30pm

Tuesday, Thursday and Friday 7:00am – 4:00pm

(May be subject to change due to Holidays and extenuating circumstances)

Appointments

New patients are required to have appropriate paperwork filled out prior to appointment or come in 30 minutes prior to appointment time to fill them out. If these forms are not filled out or you do not arrive 30 minutes prior to your appointment time, your appointment will be rescheduled.

- Please remember to bring your insurance care and a photo ID.
- Co pays and self payments are expected at the time of service with no exceptions.

Established patients should arrive 10 minutes prior to your appointment time so we can review and update your information.

- Notify us immediately of any changes in your name, address, phone number or insurance.
- Co pays and self payments are expected at the time of service with no exceptions.

If you are more than 15 minutes late your appointment will be rescheduled.

Cancellations and No Show

We require 24 hours notice for cancellations. If you fail to cancel or cancel less than 24 hours prior to your appointment a fee will be applied.

- $25.00 for established patients.
- $50.00 for new patients.

After 3 cancellations or no shows we reserve the right to discharge you from the practice.

Medications

- We do not treat chronic pain. Pain management phone numbers will be provided.
- Medication management decisions will only be made with the doctor. You will need to schedule an appointment.

Controlled Substances

The treatment of some conditions involves the use of controlled substances. If your therapy includes this type of medication:

- Prescriptions will not include refills.
- The provided quantity must last the duration of the prescription. For example, a 30 day supply must last 30 day. We will not provide early refills.
- If you feel your current dose s not appropriate you must make an appointment. **Do not** take it upon yourself to increase the dose.
- We reserve the right to ask you to bring your medication in for a pill count to ensure appropriate medication usage.
- We reserve the right to ask for random urine drug screens to ensure appropriate medication usage.
- These types of medications can only be managed by a single medical practice.
- Substance abuse is a known problem. Your medication is your responsibility. Medications or prescriptions that have been misplaced, lost or stolen will not be replaced. The only exception to this rule is with a police report regarding a stolen medication.

Prescription Refills

We require 48 to 72 **business hours** for refills.

- Refills can be requested by calling our office and picking option #2 for our prescription line. Prescriptions will be filled in the order the calls come in.
- It is your responsibility to ensure you do not run out of your medications and allot the appropriate amount of time for refills.

Insurance

Our office accepts most insurance programs. If you should have and questions or concerns as to whether or not you will be covered in our office please contact the member service number on the back of your insurance card.

Referrals and Authorizations

We require at least 7 business days for these services. It is your responsibility to know if your insurance requires a referral. We will not be responsible for any referrals requested after the date of service that you were seen.

Acknowledgement

I have read and fully understand the office policies presented to me at this time.

_____ _____

Print Name D.O.B

_____ _____

Patient/Guardian/POA Signature Date

Heritage Valley Health System

____ Heritage Valley Medical Group ____ Tri State Pediatric Group ____ Tri State OB/GYN

PATIENT INFORMATION

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE

M F

ADDRESS: STREET CITY STATE ZIP TELEPHONE # MARITAL STATUS

( ) S M W Sep Div

SOCIAL SECURITY # E-MAIL ADDRESS RACE (CIRCLE ONE) ETHNICITY (CIRCLE ONE) OCCUPATION (CIRCLE ONE)

American/AK Indian; Black/African American Not of Hispanic Origin

CELL# ALTERNATE# Asian/Pacific Islander; White Hispanic Origin FT PT RET Not Employed

Unknown/ Decline Unknown/ Decline

EMPLOYER OR NAME OF SCHOOL ADDRESS TELEPHONE # ARE YOU A STUDENT?

( ) Yes No Part time Full time

SPOUSE, PARENT OR GUARDIAN INFORMATION *(If under 18, name of parent with whom you reside)*

NAME: LAST FIRST MIDDLE INITIAL SEX BIRTHDATE

M F

ADDRESS: STREET CITY STATE ZIP TELEPHONE # RELATIONSHIP TO PATIENT

( ) Spouse Parent Other

SOCIAL SECURITY # EMPLOYER NAME AND ADDRESS EMPLOYER TELEPHONE #

( )

INSURANCE INFORMATION ****PLEASE HAVE CARDS READY FOR STAFF TO COPY****

NAME OF **PRIMARY INSURANCE CO.**

INSURED'S NAME (**Subscriber of insurance**) SUBSCRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one
Self Spouse Natural Child with financial responsibility Step Child
Natural Child without financial responsibility Adopted Child Foster Child
Significant Other Life Partner Grandchild Organ donor
Other :Specify:_____

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

AMOUNT OF CO-PAY FOR OFFICE VISITS and SPECIALIST'S VISITS:

NAME OF **SECONDARY INSURANCE CO**

INSURED'S NAME (**Subscriber of insurance**) SUBSRIBER'S BIRTHDATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one
Self Spouse Natural Child with financial responsibility Step Child
Natural Child without financial responsibility Adopted Child Foster Child
Significant Other Life Partner Grandchild Organ donor
Other Specify:_____

ID # OR AGREEMENT # GROUP # EFFECTIVE DATE

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT?
You are required to complete an additional form.

o Automobile o Other _____
o Workmen's Comp o None

Will patient be best served in a language other than spoken English? : ° No ° Yes If yes, please specify _____

EMERGENCY CONTACT

PLEASE NAME A PERSON *WHO DOES NOT LIVE WITH YOU* TO CONTACT IN CASE OF AN EMERGENCY OR IN THE EVENT WE ARE UNABLE TO REACH YOU.

NAME / RELATIONSHIP: TELEPHONE # - HOME ( )
TELEPHONE # - WORK ( )

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to either: **Heritage Valley Medical Group/ Tri State Pediatric Group/ Tri State OB/GYN/ as noted above.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED: _____ DATE: _____
PATIENT OR RESPONSIBLE PARTY

TURN OVER TO NEXT PAGE

PATIENT NAME: _____ D.O.B._____

ASSIGNMENT OF BENEFITS

MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related service.

We do accept Medicare assignment, however, you are responsible for your Medicare deductible. Many co-insurance plans do not cover the Medicare deductible and you will be billed. It is your responsibility to know if your co-insurance does not cover this. In addition, if the 20% after Medicare is not paid by your co-insurance, it is your responsibility to contact them regarding this. Please note: we will file your co-insurance one time only.

I have read the above and fully understand my financial obligation.

_____ _____ _____

Date Patient Signature HIC #

MEDIGAP PATIENTS:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to _____ (Name of Medigap insurer) and its agents any information needed to determine these benefits payable for related service.

I have read the above and fully understand my financial obligation.

_____ _____ _____

Date Patient Signature HIC #

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o **BLUE SHIELD PATIENTS**
We participate in a variety of Pennsylvania Blue Shield plans in addition to Blue Shield plans of other states. You will be billed for any applicable co-payments and deductibles. **I understand that payment for office visits is due in full at the time of the visit.**

o **COMMERCIAL HEALTH INSURANCE PATIENTS**
As a courtesy to our patients, when we have your complete insurance information, a claim is automatically submitted to your insurance carrier unless we are instructed otherwise. In some cases, you will receive payment. You are personally responsible for payment of the entire account. We will assist you; however, any questions related to delayed payment or denial should be directed to your insurance company and not to our office.

o **HMO AND PPO PATIENTS**
We participate in numerous HMO and PPO programs. Due to the varied guidelines defined by each plan, it is your responsibility to know your specific plan. Additionally, in certain programs, you will be responsible for any co-payments that apply.

o **SELF PAY PATIENTS**
Payment for services rendered is due at the time of service unless other arrangements have been made prior to your appointment. Your prompt payment is appreciated. We do not want your health care to be a financial hardship to you. If you have any difficulties, our billing department will help to establish a payment program to accommodate your needs.

I have read the item checked above and fully understand my financial obligation.

_____ _____

Date Patient Signature

Robert L. Grieco, M.D.

Health Insurance Portability and Accountability Act Compliance Program
(HIPAA)
I acknowledge I have received a copy of the Notice of Privacy for Protected Health Information

Release of Information

- I authorize the release of my medical information to be given to or discussed with the following:
  - Spouse: _____
  - Mother: _____
  - Father: _____
  - Child(ren): _____ _____
    _____ _____
    _____ _____
  - Other: _____ _____
    _____ _____
- I **DO NOT** authorize the release of my medical information to be given to or discussed with anyone other than myself.

Messages

If you are unable to reach me:

- You may leave a detailed message on my voicemail/answering machine.
- Please leave a call back number only on my voicemail/answering machine.

This Release of Information will remain valid indefinitely unless revoked by me in writing.

_____ _____
Print Name D.O.B

_____ _____
Patient/Guardian/POA Signature Date

NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____ **Birth date:** ____/____/____ **Date:** ____/____/_____

Referring Physician: _____ Address: _____
Pharmacy Name: _____ Phone Number: _____-_____-_____

Reason for today's visit: _____
Please describe this problem: _____
_____

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin**? ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES** (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐ **NO** and Never have ☐ **YES** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Do you drink alcohol? ☐ **NO** and Never have ☐ **Socially Only** ☐ **Daily** ☐ **Beer/ Wine** ☐ **Hard Liquor**
Occupation: _____ Hand Dominance: ☐ **RIGHT** ☐ **LEFT**

Please describe any family health issue below:

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER			
FATHER			
SIBLING(S)			
OTHER HEREDITARY ILLNESS			

Patient Signature: _____ **Date:** ____/_____/_____

Physician Signature: _____ **Date Reviewed:** ____/____/____

HEALTH HISTORY FORM 2

Do you have or have you ever had any of the following:

Symptoms/ Illness	NO	YES, Explain	Symptoms/ Illness	NO	YES, Explain
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			**Last Mammogram**		**Date: ____/____/____**
Hepatitis			Changes in Moles		
HIV/ Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**GENITOURINARY**		
Mobility/ Joint Problems			Genital or Oral Herpes		
GASTROINTESTINAL			S.T.D.'s		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/ Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
CARDIOVASCULAR			**Eyes**		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/ DVT			**ENT**		
Blood Clots in Lungs/ Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
RESPIRATORY			**PSYCHIATRIC**		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/ Depression		

Please list any other conditions/ illnesses not indicated above: _____

_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: _____ **Date:** ____/____/____

Physician Signature: _____ **Date Reviewed:** ____/____/____

HERITAGE VALLEY MEDICAL GROUP

HERITAGE VALLEY HEALTH SYSTEM
CORPORATE COMPLIANCE PROGRAM
Receipt of Notice of Privacy Practices
Acknowledgement Statement

I acknowledge I have received a copy of Heritage Valley Health Systems Notice of Privacy Practices for Protected Health Information.

_____

Patient Name *(please print)*

_____

Patient Signature

_____

Date

_____

In the event of the patients emergency condition, signature of person receiving Notice for patient.

****

***FOR OFFICE USE ONLY**
COMMENTS

_____

_____

_____

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HERITAGE VALLEY HEALTH SYSTEM

Heritage Valley Health System
Notice of Privacy Practices for Protected Health Information

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

Heritage Valley Health System (HVHS) CONTINUES TO BE COMMITTED TO PROTECTING THE PRIVACY OF YOUR MEDICAL AND BUSINESS INFORMATION. It has been our practice not to disclose your medical information for any purpose without your written authorization. We are now required by law to provide you with this statement to inform you in writing how your medical information will be used and disclosed.

Protected Health Information, or PHI, is defined by the federal government as, individually identifiable health information that is or has been electronically maintained, electronically transmitted by a covered entity, or information when it takes any other form. PHI is a part of health information, including demographic information, collected from the individual and is created or received by a healthcare provider, relates to past, present, or future health or condition of the individual or payment for the provision of care. PHI identifies the individual directly or affords that the individual can reasonably be identified. Covered entity is defined as a healthcare provider who transmits any health information in electronic form.

We are required by law to maintain the privacy of your protected health information and to provide you with this Notice of our legal duties and privacy practices. HVHS is required by law to follow the terms of this Notice. HVHS reserves the right to change the terms of the Notice and to make any revision necessary to the protected health information we maintain. Once given, you may revoke your authorization in writing at any time. Other uses and disclosures not described in the Notice will not be made without your authorization.

Following any revisions made to this Notice, HVHS will make these changes available through distribution of the revised Notice by posting the revised Notice in HVHS facilities and on the HVHS website.

How your Medical Information May Be Used and Disclosed:

- HVHS will use your medical information as part of providing patient care. For example, your medical information will be used by the healthcare professionals providing your care, by the business office to bill for the services provided, and by selected care and quality employees who review medical information to assure quality and medical necessity of services provided.
- HVHS may contact you to provide appointment reminders or information about treatments, alternatives, or other health-related benefits and services that may be of interest to you.
- During inpatient treatment at a HVHS facility, the hospitals and consulting physicians are considered an Organized Health Care Arrangement (OHCA). This means related health information can be shared for purposes of treatment, payment, or healthcare operations.
- Unless you object, while an inpatient or outpatient of HVHS, and with the exception of behavioral health patients, HVHS:
  - will include general information, including your name, location in the hospital, your condition described in general terms, and your religious affiliation in a list or directory of individuals located in the facility where you are hospitalized. This information, except for the religious affiliation, will be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name.
  - disclose to family members, other relatives or close personal friends who are responsible for your care the medical information directly relevant to that person's involvement with your care.
  - use or disclose your medical information to notify a family member or personal representative of your location, general condition, or death.
- HVHS may also:
  - disclose your medical information to a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.
  - use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation, and intervention.

- disclose medical information when requested by a licensed state or federal agency for accreditation purposes.
- disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and /or legal proceedings.
- disclose your medical information in the course of certain judicial or administrative proceedings.
- disclose your medical information for law enforcement purposes or other specialized government functions.
- disclose your medical information to a coroner, medical examiner, or a funeral director.
- if you are an organ donor, disclose your medical information to an organ donation and procurement organization.
- use or disclose your medical information for certain research purposes.
- use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or the public.
- disclose your medical information as authorized by laws relating to worker's compensation or similar programs.
- may contact you to raise funds for the hospital.

Your Rights Regarding Your Medical Information:

Your rights related to your medical information are as follows:

- You have the right to request restrictions on certain uses and disclosure of your medical information. HVHS is not required by law to agree to your requested restrictions except when disclosure is to a health plan for services paid exclusively by the patient.
- You have the right to receive communications from HVHS in a confidential manner.
- Your have the right to inspect and obtain a copy of your medical information. This right is subject to certain specific exceptions. You will be charged a fee for any copies of your medical information.
- You have the right to request an amendment to your medical information. HVHS may deny your request for certain specific reasons. If HVHS denies your request a written explanation for the denial and information on further rights will be provided to you.
- You have the right to receive an accounting of the disclosures of your medical information made by HVHS for six years prior to your request, effective after April 14, 2003. By law, disclosures for treatment, payment, health care operations, and certain other specific disclosures are not included in the accounting.
- If you do not wish to be contacted for fundraising efforts, you may notify us in one of three ways.
  In writing: Heritage Valley Health Systems Foundations, 420 Rouser Road, Suite 102, Moon Township, PA., 15108
  By calling: 412-749-7121
  Or e-mailing: foundation@hvhs.org
- You have the right to receive a paper copy of HVHS' Notice of Privacy Practices for Protected Health Information. You have a right to submit a complaint to HVHS and/or to the United States Department of Health and Human Services if you believe HVHS has violated your privacy rights. To complain to HVHS or to request additional information on your privacy rights, please contact HVHS' Privacy Officer by calling (724) 773-3473 or by writing to HVHS Privacy Officer, Heritage Valley Health System, 1000 Dutch Ridge Road, Beaver, PA, 15009. If you choose to file a complaint you will not be retaliated against in any way.
- Per the federal Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification final rule published January 25, 2013, unless a specific exception as identified in 45 CFR 160 or 164 exists, you have a right to be notified of any unauthorized access, use or disclosure of your medical or business information which compromises the security or privacy of such information.

Your Medical Information and Health Information Exchanges (HIE):

HVHS participates in Health Information Exchanges (HIE). Generally, a HIE is an organization that regional hospitals, physicians, and other healthcare providers participate in to exchange patient information in order to facilitate health care, avoid duplication of services (such as tests) and to reduce the likelihood that medical error will occur. By participating in the HIE, HVHS may share your health information with other providers or participants of other health information exchanges, by example P3N (Pennsylvania Patient & Provider

Network) and Healtheway (a national network that allows providers to exchange information). This health information could include, but is not limited to:

- Test Results. By example, the following tests and results: laboratory including microbiology; pathology; radiology/diagnostic imaging; GI; cardiac; neurological.
- Health Maintenance documentation
- Problem list documentation
- Allergy list documentation
- Immunization profiles
- Medication lists
- Progress notes
- Consultation notes
- Discharge instructions
- Inpatient operative reports
- Emergency Room visit discharge summary note
- Urgent Care visit progress notes
- Clinical Claims Information

Ancillary healthcare related services providers may include, but are not limited to:

- Organ Procurement
- Diagnostic Testing
- Pharmacies
- Durable Medical Equipment Suppliers
- Home Health Services

All Participating Providers have agreed to a set of standards relating to its access, sharing, use and disclosure of health information available through the HIE. These standards are intended to comply with all applicable state and federal laws. As a result, you understand and agree that unless you notify your healthcare Provider that you do not wish for your health information to be available through the HIE ("Opt-Out"):

• Health information that results from any Participating Provider providing services to you will be made available through the HIE. For clarity, if you Opt-Out, your health information will no longer be accessible through the HIE. However, your opt-out does not affect health information that was disclosed through the HIE prior to the time that you opted out;

• Regardless of whether you choose to opt-out of the HIE, your health information will still be provided to the HIE. However, if you choose to Opt-Out, the HIE will not exchange your health information with other providers. Additionally, you cannot choose to have only certain providers access your health information;

• All Participating Providers who provide services to you will have the ability to access to your information. However, Participating Providers that do not provide services to you will not have access to your information;

• Information available through the HIE may be provided to others as necessary for referral, consultation, treatment and/or the provision of other treatment-related healthcare services to you. This includes providers, pharmacies, laboratories, etc.

• Your information may be disclosed for payment related activities associated with your treatment by a Participating Provider; and your information may be used for healthcare operations related activities by Participating Providers.

• You may Opt-Out at any time by requesting an Opt-Out form from the registration staff at your point of service or in one of two ways.

In writing: Heritage Valley Health System, Medical Records – Release of Information, 1000 Dutch Ridge Road, Beaver, PA 15009

By emailing: roi@hvhs.org

Please allow (2) business days for the processing of your Opt-Out request.

A list of HIE Participating Providers may be found at: www.heritagevalley.org/hie

This Notice is effective as of April 1, 2003. Revisions: 8/2008; 6/2012, 9/2013, 12/2015