Heritage Valley Health System

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

PATIENT INFORMATION

NAME: LAST | FIRST | MIDDLE INITIAL | SEX M F | BIRTHDATE

ADDRESS: STREET | CITY | STATE | ZIP | TELEPHONE # ( ) | MARITAL STATUS S M W Sep Div

SOCIAL SECURITY # | E-MAIL ADDRESS | **RACE** (CIRCLE ONE) American/AK Indian; Black/African American Asian/Pacific Islander; White Unknown/ Decline | **ETHNICITY** (CIRCLE ONE) Not of Hispanic Origin Hispanic Origin Unknown/ Decline | OCCUPATION (CIRCLE ONE) FT PT RET Not Employed

CELL# | ALTERNATE#

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 M F | BIRTHDATE

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.**

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

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

ID # OR AGREEMENT # | GROUP # | EFFECTIVE DATE

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

NAME OF **SECONDARY INSURANCE CO**

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

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

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*****

MEDICAL HISTORY DATE: / /

Name: ________________ **Age**: ________ **Birthdate**: ____/____/____

Address: ________________ **Sex**: ( ) Female ( ) Male

________________ **Home Phone**: ________________

________________ **Work Phone**: ________________

Occupation: ________________ **Emergency Contact Name**: ________________

Emergency Contact Phone number: ________________

( ) **Single** ( ) **Married** ( ) **Divorced** ( ) **Widowed** ( ) **Separated**

If married, spouse's name: ________________

Children's Names and ages: ________________

Allergies to Medications, X-Ray Dyes, or Other Substances: ( ) **NO** ( ) **YES**

(If yes, please list name of medicine and type of reaction) :

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

________________ ________________ ________________ ________________

Past Medical History and Review of Systems:

Please circle if you have had problems with or are presently complaining of any of the following:

1. High blood pressure	13.Bronchitis	26.Change in Bowel Habits	38.Arthritis
2. Diabetes	14. Pneumonia	27. Unexplained Weight Loss / Gain	39. Low back Problems
3. Cancer	15.Persistent Cough	28. Hemorrhoids	40. Skin Diseases
4. Heart Disease	16. T.B.	29. Gall bladder Disease	41. Blood Disorders
5. Chest Pain / Tightness	17.Hay fever	30. Colitis	42.Veneral Diseases
6. Shortness of Breath	18. Abdominal Discomfort	31.Hepatitis or Jaundice	43. Anxiety
7. Swollen Ankles	19. Indigestion	32. Thyroid Disease	44. Depression
8. Palpitations	20. Nausea	33.Head or Neck radiation	45.Anemia
9. Lightheadedness	21.Vomiting	34.Headaches	46. Alcohol Abuse
10.Frequent Urination	22.Constipation	35.Kidney Disease	47.Drug Abuse
11.Rheumatic Fever	23. Diarrhea	36. Kidney Stones	48.Gout
12 Asthma	24. Blood in stools	37. Difficulty urinating	49. Ulcers

Other conditions or information: ________________

____

____

____

Gynecologic and Obstetric History:

Age at Onset of periods: ________ **Frequency:** ________ **Length of Periods:** ________

Pregnancies: ________ **Births:** ________ **Miscarriages:** ________

Prolonged or abnormal bleeding: ( ) **NO** ( ) **YES** **Please describe:** ________

Leakage of urine: ( ) **NO** ( ) **YES** **Please describe:** ________

Pelvic Pain: ( ) **NO** ( ) **YES** **Please describe:** ________

Abnormal Discharge: ( ) **NO** ( ) **YES** **Please describe:** ________

History of Abnormal Pap Smear: ( ) **NO** ( ) **YES** **Type of Treatment:** ________

MEDICAL HISTORY

Please list and Supply the Dates:

Operations: ______________________ ______________________

______________________ ______________________

______________________ ______________________

Hospitalizations other than for surgery: ______________________

____

Immunization history – have you had:

Pneumovax immunization: ( ) NO ( ) YES When? __________

Flu Vaccination ( ) NO ( ) YES When? ______

Hepatitis B ( ) NO ( ) YES When ? ______________

Tetanus Booster ( ) NO ( ) YES When? ______

OTHER : ______________________

WHEN WAS YOUR LAST:

Pap Smear : ______________ Breast Exam: ______________ Stool check for Blood: ______________

Mammogram: ______________ Cholesterol check: ______________ Prostate exam: ______________

FAMILY HISTORY:

HAS ANY MEMBER OF YOUR FAMILY (Parents, Grandparents, and Siblings) ever had the following:

ILLNESS	WHICH FAMILY MEMBERS:	APPROX AGE DIAGNOSED?
CANCER (DESCRIBE TYPE)		
HYPERTENSION:		
HEART DISEASE:		
DIABETES:		
STROKES:		
MENTAL DISEASE(Anxiety,depression,etc)		
DRUG OR ALCOHOL ADDICTION:		
GLAUCOMA:		
BLEEDING DISEASES:		
OTHER: ______________		

MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, VITAMINS, HERBS, ETC.)

DRUG NAME:	DOSE:	DRUG NAME:	DOSE:

PREVENTION:

DO YOU WEAR SEAT BELTS ? ( ) NO ( ) YES IF NO WHY? ______________

DO YOU WEAR A BIKE HELMET? ( ) NO ( ) YES ( ) NA

DO YOU SMOKE? ( ) NO ( ) YES If YES, how many packs per day? __________

DO YOU DRINK ALCOHOLIC BEVERAGES? ( ) NO ( ) YES If YES, how much per week? __________

DO YOU DRINK COFFEE OR TEA ? ( ) NO ( ) YES If YES, how many cups per week? __________

If there is a GUN in your home, do you safely store it, unloaded? ( ) YES ( ) NO ( ) NA

Do You Use DRUGS(marijuana,cocaine,crack,etc)? ( ) NO ( ) YES If YES, explain ______________

Have You Ever Engaged in Activity that would put you at high risk for AIDS? ( ) NO ( ) YES-explain ______________

Do You Wish To Be Tested for AIDS? ( ) NO ( ) YES

Have You Ever Worked with Hazardous Chemicals/Materials? ( ) NO ( ) YES If YES, explain ______________

Do You Have A Living Will ? ( ) NO ( ) YES

Do You Have A Donor Card? ( ) NO ( ) YES

Method of Birth Control? ______________________

Are You In A Relationship In Which You Have Been Physically Injured By Your Partner? ( ) NO ( ) YES

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

Dear Patient,

Your medical provider is participating in a government program that encourages the adoption of electronic health records. This technology will lead to reduced health care cost as well as improve the quality of your care and our ability to communicate with you, our patient.

As part of this program, the government requires us to record the following demographic information about you:

Preferred language   Date of Birth
Race   Ethnicity   Gender

The US Centers for Disease Control and Prevention (CDC) provide the options for the race and ethnicity that match the data collection standards defined by the U.S. Office of Management and Budget (OMB) and the U.S. Bureau of the Census (BC).

You can help us by reviewing the list of options below and providing your race, ethnicity, and preferred language information during registration or check-in. If you do not wish to provide this information, you may simply decline. We maintain secure records and assure you that this information will remain confidential.

Thank you for your assistance!

Patient Name:_______________________________________

- *Please provide your Race from the following options:*

__ American Indian or Alaska Native
__ Asian
__ Black or African American
__ Decline
__ Native Hawaiian or other Pacific Islander
__ Unknown
__ White

- *Please provide your Ethnicity from the following options:*

__ Hispanic Origin
__ Decline
__ Not of Hispanic Origin
__ Unknown

- *If you prefer a language other than English, please specify:*

____

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) 773-3434 or by writing to HVHS Privacy Officer, The Medical Center, Beaver, 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, Provider may share certain of your health information with other providers that participate in the HIE (each a "Participating Providers") or participants of other health information exchanges. This health information could include, but is not limited to:

- General laboratory results including microbiology
- Pathology test results including biopsies, Pap smears, etc.
- Radiology results including x-rays, MRIs, CT scans etc.
- Results of outpatient diagnostic testing including GI testing, cardiac testing, neurological testing, etc.
- 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 notes
- Urgent Care visit progress notes

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

Heritage Valley Health System

Beaver Internal Medicine Association
701 Fifth Street, Beaver, PA 15009

Receipt of Notice of Privacy Practices
Acknowledgement Statement

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

______________________________	______________________________
Patient Name (please print)	Date of Birth

____
Patient Signature or Guardian Signature in the event Patient is unable to sign

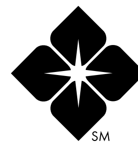
____
Date

If I am unavailable, I authorize the release of test results and treatment plans to be discussed with:

Name	Relationship	Phone
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________

Patient Signature ______________________________

Date ______________________________



HERITAGE VALLEY
HEALTH LINK

What is Health Link (powered by FollowMyHealth)?

Heritage Valley's Health Link is a secure online patient portal that enables patients to:

- Conveniently and securely review their health information online
- View lab results, radiology reports, and read summaries from physician office and ConvenientCare visits
- View discharge summaries from hospital admissions
- Review health information (allergies, medications, conditions, etc.)
- Schedule Physician Office appointments (with participating physicians)
- Link to their child's information for easy access to health information
  …and more!

What is FollowMyHealth?

Hundreds of healthcare organizations and thousands of physicians across the country use FollowMyHealth as the power behind their hospital or clinic's specific patient portal. The FollowMyHealth platform combined with Health Link ensures that you and Heritage Valley will remain "Uniquely Connected… For Life"

How do I become a member of Health Link?

Thank you for wanting to become a member of Health Link. There are three ways to create an account:

1. Receive an invitation at one of our Primary Care Physician Offices.
   - Select the "Request an Invitation" option on a kiosk located in your Primary Care Physician's office during check in.
   - Request an invitation to Health Link from your Primary Care Physician's office staff during your next visit.
2. Receive an "Opt-In" letter upon discharge from Heritage Valley Beaver, Heritage Valley Sewickley, or at one of our outpatient service locations.
   - The letter will contain your Full Name, Heritage Valley Health System Care Card Number, and a unique 12 digit "Opt-In" Code.
   - Create an Account Online at **www.heritagevalley.org\healthlink** by selecting the "Start Account Creation" button and completing the brief Information Form. Please use your Heritage Valley Health System Care Card Number and "Opt-In" Code from your letter.
3. Create an Account Online at **www.heritagevalley.org\healthlink** by selecting the "Start Account Creation" button and completing the brief Information Form.

Are there any features that will be added?

A number of features and enhancements will be added in the coming months which will enable Health Link users to:

- Send secure messages to their healthcare provider
- Request prescription renewals
- Make payments for Heritage Valley bills online using a credit card or electronic check.
- Fill out and submit forms prior to appointments

If you have additional questions regarding Health Link, please email us at healthlink@hvhs.org.