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HERITAGE VALLEY HEALTH SYSTEM

Heritage Valley Medical Group
Robert L. Grieco, M.D
2580 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.

Sincerely Yours,

Robert L. Grieco, MD

Your Appointment Information:

- We ask that you please arrive at your appointment 15 minutes early with your **completed** new patient packet.
- If you do **not** have your packet completed please arrive 30 minutes early to complete this.

Please bring your insurance card, photo ID, and medication list.

Appointment Date & Time: _____

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: ___/___/___

Heritage Valley Health System

✓ Heritage Valley Medical Group ____ Heritage Valley Pediatric ____ 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.

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

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

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

HVMG – Dr. Robert L. Grieco, M.D.
Office Policies

Hours of Operation
Monday – Friday 7:30am to 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 appoiment time, your appointment will be rescheduled.

- Please remember to bring your insurance card 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.

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 days. We will not provide early refills.
- If you feel like your current dose is 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 medial practice.
- Substance abuse is a known problem. Your medication is you 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 any 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.

Acknowledgment
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

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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.

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

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.

OR

- 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 SIGNATURE _____ **Date:** _____
(or Guardian/POA)

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HERITAGE VALLEY
Health System

AUTHORIZATION FOR RELEASE OF INFORMATION TO BE SENT TO OUR PRACTICE

(Please print clearly)

PATIENT INFORMATION:

Name: First_____ Middle_____ Last_____

Social security number_____ Date of birth_____

I THE UNDERSIGNED, HEREBY AUTHORIZE:

Practice or Doctor's Name:_____ Phone #_____

Address: Street_____ City_____ State_____ Zip_____

TO PROVIDE:

Heritage Valley Medical Group – Dr. Robert Grieco

Dr. Robert Grieco, M.D. **Kathleen Nicol, CRNP**

2580 Constitution Blvd. Beaver Falls, PA 15010

Phone: 724-773-6880 Fax: 724-770-7993

WITH THE FOLLOWING INFORMATION:

☐ **Medical Records Summary** (includes doctors' notes, hospital records, laboratory and diagnostic tests within past two years, medication list, problem list, most recent EKG, immunization record, and living will/advance directives). If records are being sent for a specialist consultation, the most pertinent records will be sent.

☐ *Other*_____ For dates of service: from_____ to_____

PURPOSE OF DISCLOSURE: ☐ I am transferring to this practice ☐ Other_____

Expressed Authorization: ******Signature Required******

I understand that my medical record may contain information related to:

- ***Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV***
- ***Psychiatric Care***
- ***Treatment for alcohol and/or drug abuse.***

☐ I give my consent for release of this information: _____
Signature Date

☐ I **DO NOT** give consent for release of this information: _____
Signature Date

This authorization for release of information is valid for 90 days from the date of signature, unless revoked by written notice to the providing institution, provided the notice is received prior to the release of information. I understand that signing this authorization is voluntary, and Heritage Valley Health System cannot deny me treatment for not agreeing to sign this authorization. I understand that I may see a copy of the information described on this form and that there may be a fee associated with copying. I understand that once the above information is disclosed, it may not be under control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure. I understand that this authorization may be revoked at anytime. I understand that if I do revoke the authorization, I must do so in writing and present my written revocation to be filed in my medical record, which will not apply to information that has already been disclosed in response to this authorization. *If I have questions about the disclosure of my health information, I may contact the Office Manager or the Privacy Officer of Heritage Valley Health System.* I hereby certify that I have read this authorization and agree to its terms.

_____ Date
Required: Signature of Patient

_____ Relationship Date
*Signature if other than patient **(use P.O.A. documentation)**

_____ Signature
of witness Date

Release of Med Records: 5/17/2007, 1/30/15