



EDGEWORTH INTERNAL MEDICINE
AN OFFICE OF HERITAGE VALLEY MEDICAL GROUP
100 HAZEL LANE, SUITE 100, SEWICKLEY, PA 15143
PHONE: 412-749-4240
FAX: 412-749-6822

HANS J. FUCHS, M.D - *STEPHANIE L. PERRY, M.D., F.A.C.P* - *ANASTASIA BARTHELEMY, PA-C*

Dear _____

We would like to welcome you to our office and thank you for choosing Heritage Valley Medical Group Edgeworth Internal Medicine. Our hours of operation are Monday through Thursday 8am-4:30pm, and Fridays 8am-3pm.

Enclosed you will find a patient registration form and a medical history form to complete prior to your appointment. Please bring the completed forms with you to your appointment, which is scheduled for:

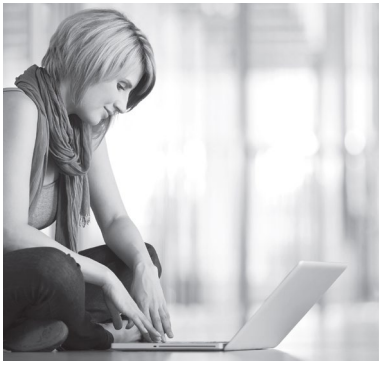
Heritage Valley Medical Group Edgeworth Internal Medicine
100 Hazel Lane St. 100 Sewickley, PA 15143

We ask that you arrive at our office at least 15 minutes before your appointment time so that we may make a copy of your insurance card and review your completed new patient form. Also, if you are taking any medications on a regular basis, please bring a list of these medications. In addition, if you have copies of your previous medical records, please bring them with you or contact your former physician and have them sent prior to your appointment, if possible.

If you have any questions, feel free to call our office. We look forward to seeing you.

Sincerely,

Heritage Valley Medical Group Edgeworth Internal Medicine
<http://www.heritagevalley.org/pages/internal-medicine-associates> (CHANGE WEB ADDRESS)



Health Link Patient Portal

Before your appointment we encourage you to become a member of the Health Link patient portal in order to securely communicate and view your health information online.

To sign up go to www.heritagevalley.org/healthlink or download the app from Apple's App store or Android's Google Play by searching the app name FollowMyHealth.

Instead of calling:

- Communicate by sending your physician non urgent secure messages
- Request prescription renewals
- Request an appointment
- View lab results and read summaries from physician office, Convenient Care visits
- Securely review your health information (allergies, medications, conditions, etc.)

We also will communicate non urgent results and messages to you.

Be sure to save your username and password once you are registered.

For help with Health Link, contact: healthlink@hvhs.org or 724-773-8344

**Heritage Valley Medical Group Edgeworth Internal Medicine offers Walk-In Hours for minor illnesses (illness symptoms of 3 days or less)
No Appointment Necessary with our Physicians Assistant!**

Edgeworth Walk-in Hours
100 Hazel Lane, Suite 100

**TEMPORARILY SUSPENDED DUE TO
COVID**

Minor Illnesses include – Abrasions, allergies, bladder infection, bronchitis, cough, colds, ear infection, fever, influenza, insect bites, minor burns, pink eye, poison ivy, shingles, sinus infection, sore throat, sprains, strains.

***If we determine that your issue is more involved you may be asked to schedule an appointment outside of Walk-in Hours or with your PCP**

Please continue to schedule any chronic illnesses, disease management problems and physicals

IMPORTANT NOTICE – 05/2019

1. PLEASE ARRIVE ATLEAST **15** MINUTES PRIOR TO YOUR APPOINTMENT TIME IN ORDER TO SIGN IN AT THE KIOSK AND COMPLETE ANNUAL PAPERWORK. IF YOU ARE LATE TO YOUR APPOINTMENT YOU MAY BE ASKED TO RESCHEDULE.
2. YOU MUST SHOW YOUR INSURANCE CARD AT EACH VISIT.
IF A PCP IS LISTED ON YOUR INSURANCE CARD, IT IS REQUIRED THAT YOU HAVE THE CORRECT PHYSICIAN LISTED, OR YOU MAY BE ASKED TO RESCHEDULE YOUR APPOINTMENT UNTIL THE CORRECT CARD IS RECEIVED.
3. PLEASE LET THE CHECK-IN STAFF KNOW IF THERE HAS BEEN A CHANGE IN YOUR ADDRESS OR PHONE NUMBER.
4. IF YOU HAVE A COPAY, YOUR INSURANCE COMPANY REQUIRES YOU TO PAY AT THE TIME OF YOUR VISIT.
5. IF YOU DO NOT HAVE INSURANCE, **YOU WILL BE REQUIRED TO PAY AT THE TIME OF YOUR VISIT.**
6. MEDICATIONS: WITH EACH APPOINTMENT BRING A LIST OF ALL THE MEDICATIONS THAT YOU ARE TAKING INCLUDING OVER THE COUNTER MEDICATION.
7. REFERRALS REQUIRE 5 – 7 DAYS NOTICE. IF YOU CALL THIS OFFICE THE SAME DAY AS YOUR APPOINTMENT TO SEE THE SPECIALIST, WE CANNOT GUARANTEE THAT YOUR INSURANCE WILL COVER YOUR VISIT.
8. DUE TO THE CHANGES IN YOUR INSURANCE, IT IS THE PATIENT RESPONSIBILITY TO KNOW WHERE TO GO FOR BLOOD WORK, X-RAYS AND ALL DIAGNOSTIC TESTS. THIS OFFICE CANNOT BE HELD RESPONSIBLE FOR ANY BILL THAT THE PATIENT RECIEVES FOR HAVING SERVICES AT THE WRONG LOCATION.
9. CONFIRMATION CALLS ARE DONE 24 HRS PRIOR TO YOUR APPOINTMENT. YOU **MUST** CONFIRM YOUR APPOINTMENT. IF YOU ARE UNABLE TO CONFIRM AT THE TIME THE CALL IS PLACED, YOU MUST CALL US DURING BUSINESS HOURS AT BETWEEN 8AM-4:30PM AT 412-749-4240. **YOU MAY NOT BE SEEN WITHOUT CONFIRMING YOUR APPOINTMENT**
10. IF YOU **DO NOT SHOW** FOR AN APPOINTMENT OR **DO NOT CANCEL 24 HOURS PRIOR** TO YOUR APPOINTMENT YOU WILL BE CHARGED A **\$25 FEE.**
10. PRESCRIPTION REQUEST/REFILLS REQUIRE 24 HOUR NOTICE AND WILL ONLY BE DONE DURING BUSINESS HOURS.

HERITAGE VALLEY MULTISPECIALTY GROUP
EDGEWORTH INTERNAL MEDICINE
PATIENT INFORMATION

Date _____ Referring Dr. _____ Social Security # _____

Patient Name _____ Date of Birth _____
Last First Middle

Address _____ City _____ State _____ Zip _____

Home Phone # (____) _____ Day Phone # (____) _____ Cell Phone # (____) _____

Sex _____ Race _____ Ethnicity _____ Occupation _____
F – Full Time R - Retired
P – Part Time N – Not Employed

Marital Status _____ S – Single D – Divorced F – Full Time
M – Married W – Widowed L – Legally Separated Student Status _____ P – Part Time N – Not A Student

Employer _____ Employer Phone # _____

Employer
Address _____ City _____ State _____ Zip _____

***HEALTH LINK** – Please provide us with a current email address to securely view your results and health information online

Email Address _____

SPOUSE OR PARENT (please complete even if spouse/parent is uninsured)

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

(only if different from Patient)

Check here if the address is the same as patient's

I authorize payment of insurance benefits to Sewickley Valley Medical Group _____
Sign Here

I also authorize release of any medical records As necessary to... _____
(Please CIRCLE OPTION AND PRINT name) Sign Here

- Myself _____
- Spouse _____
- Other _____

Please provide us with a family contact and phone Number in the event we are unable to reach you _____

DO YOU HAVE A LIVING WILL OR AN ADVANCED DIRECTIVE YES _____ NO _____

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I, _____ DOB _____ authorize HVMG IMA to release results and other communications to myself...(Please Circle Options)

Myself Only

My spouse (print name) _____,

Other (print name) _____.

Circle Answer - I authorize HVMG IMA to (**Leave** / **Not leave**) messages regarding results and other communication regarding my medical care, etc. on the voicemail of my preferred phone...

Phone number(s) _____.

Patient Signature **X** _____ Date: _____