Primary Care Associates of Sewickley
100 Hazel Lane Suite 200
Sewickley PA 15143

PATIENT NAME:_____ **DATE OF BIRTH:** ____/____/_____

PLEASE STATE THE REASON FOR YOUR VISIT TODAY:

_____

_____

CURRENT MEDICAL CONDITIONS:

_____ _____

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS

Pharmacy Name & Phone: _____

Please include birth control, vitamins, herbal supplements and over-the-counter medications used regularly.

[ ] No current medications

Medication	Strength	Frequency	Reason for taking

Past Surgical History (please include procedures, i.e. endoscopy, colonoscopy, biopsies etc)

[ ] No surgical history

Surgery/Procedure	Date

Patient Name:_____ Birthdate:____/____/____

SOCIAL HISTORY

Relationship Status:_____

Are You Sexually Active?: [ ] Yes [ ] No

Sexual Orientation: _____

Alcohol use: [ ] Yes [ ] No **If yes, # of drinks/week:** _____

Drug use (recreational, including marijuana): [ ] Yes [ ] No

IV drug use (past or present): [ ] Yes [ ] No

Smoking Status:

[ ] Nonsmoker Second Hand Smoke Exposure: [ ] Yes [ ] No

[ ] Current smoker _____ packs per day for _____ years Interested in quitting? [ ] Yes [ ] No

[ ] Former smoker _____ packs per day for _____ years Quit date:_____/_____/_____

Nicotine Substances Used: [ ]cigarettes [ ]cigars [ ]chewing/pipe tobacco [ ]e-cigarettes/vaping

Diet: [ ] balanced [ ] vegetarian [ ] vegan [ ] other (list):_____

Caffeine Use: [ ] Yes [ ] No **If Yes, How Much?** _____ **Exercise:**_____times/week

Do you use a seatbelt: [ ] Yes [ ] No **Does your home have smoke detectors:**[ ] Yes [ ] No

Occupation: _____

Do you have an advanced directive? [ ] Yes [ ] No

ALLERGIES

[ ] No known drug allergies

Medication	Reaction		Medication	Reaction

HEALTH MAINTENANCE

Vaccine	Date	Vaccine	Date
Influenza		Pneumonia (Prevnar, Pneumovax)	
Tetanus (Tdap/Adacel, Td)		Shingles (Zostavax, Shingrix)	

Date of last colon cancer screening (colonoscopy, FIT Test, ColoGuard): _____/_____/_____

Have you ever had a stress test or cardiac catheterization? [ ] Yes (_____/_____/_____) [ ] No

Do you see a dentist every 6 months? [ ] Yes [ ] No

Have you had an eye exam in the last 2 years? [ ] Yes (_____/_____/_____) [ ] No

Patient Name:_____ Birthdate:____/____/____

Females:

Have you ever been pregnant? [ ] Yes [ ] No

#of pregnancies:_____ # of live births:_____ # miscarriages:_____ #abortions:_____

Date of last pap smear: _____/_____/_____ Date of last mammogram: _____/_____/_____

Date of last DEXA (bone density) scan:_____/_____/_____

Type of birth control:_____

If none, would you like to discuss options today? [ ] Yes [ ] No

FAMILY HISTORY

Medical Condition	Mother	Father	Sibling	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father
Anemia (Low Blood Count)							
Asthma							
Autoimmune Disease (Lupus, Rheumatoid Arthritis)							
Bleeding Disorders							
Cancer (List Types)							
Clotting Disorder (DVT, PE)							
Congestive Heart Failure							
COPD/Emphysema							
Diabetes							
Gastrointestinal Disorders (Crohn's, Ulcerative Colitis)							
Genetic Disorders							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease (Hepatitis, Cirrhosis)							
Mental Health Conditions (Depression, Anxiety, Suicide, Alcohol/Drug Addiction)							
Neurological Disorders (Epilepsy, MS, ALS)							
Osteoporosis							
Stroke							
Thyroid Disorder							

Heritage Valley Health System
Corporate Compliance Program

HIPAA Privacy Practice Acknowledgment Statement

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

_____ _____

Patient Name *(Please Print)* Date of Birth

_____ _____

Patient Signature Date

List any family or friends (if any) that we may talk to regarding your healthcare.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

List any family or friends (if any) that you authorize to pick up healthcare information such as medical records, prescriptions, medical supplies, etc. on your behalf.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Print the telephone number(s) you would like to receive calls about your appointments or test results.

_____ May we leave a detailed message at this number? ☐ Yes ☐ No

(Telephone Number)

_____ May we leave a detailed message at this number? ☐ Yes ☐ No

(Telephone Number)

I understand that this authorization will stay in effect until revoked by me in writing.

Primary Care Associates of Sewickley

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

ID # OR AGREEMENT # | GROUP #

EFFECTIVE DATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one Parent
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:_____

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

ID # OR AGREEMENT # | GROUP # | EFFECTIVE DATE

HOLDER'S RELATIONSHIP TO PATIENT: Circle one Parent
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:

DO YOU HAVE OTHER INSURANCE THAT WILL PAY THIS ACCOUNT? **You are required to complete an additional form.**
□ Automobile □ Workmen's Comp □ None □ Other_____

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 Pediatric Group/ Heritage Valley OB/GYN/ Heritage Valley Medical Group/ 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

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

Signed: _____ DATE: _____

Please tell us how you heard about our practice: □Friend/family □Newspaper □Internet □Website □Other_____

Rev 9/2010

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

Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

Authorization For Release of Protected Health Information:

For Access, Use, and Disclosure

To be completed by the patient or patient representative:
Please PRINT legibly with black, permanent ink. All sections with an asterisk (*) must be completed

*** Section 1- I authorize the following facility(s):**

☐Heritage Valley **Beaver**
☐Heritage Valley **Sewickley**
☐Heritage Valley Sewickley-**Kennedy** Campus
☐HVMG Physician Office (please specify) _____
☐Other: _____

*** Section 2- To release information from the record of:**

_____ _____ _____
Patient First and Last Name | Date of Birth | Medical Record Number (if known)

_____ _____
Patient Address (Street, City, State, and Zip Code) | Patient Phone Number

*** Section 3- The information will be released to (indicate self, if records are for you, the patient):**

_____ _____ _____
Facility/Provider/Person to Receive Records | Phone Number | Fax Number (if known)

_____
Facility/Person's Address (Street, City, State, and Zip Code)

*** Section 4- The following information or copies of (please check the records desired):**

☐Consultation Reports
☐History & Physical Exam
☐Physician Orders
☐Discharge Summary
☐Medication Records
☐Physician Progress Note
☐Laboratory Report/Tests
☐Operative Report
☐Pathology Report
☐EKG Report
☐Nurses Notes
☐Emergency Department Report
☐Entire Clinical Record
☐Radiology Report
☐Radiology CD/Images
☐Other (please specify):
_____
_____
_____

*** Section 5- From the Following Dates of Service:**

_____ OR _____
Specific Date of Service | Date Range (From/To)

*** Section 6- Reason for Request:**

☐Continuing treatment/care
☐Personal use
☐Other: _____

*** Section 7- I would like to receive my records via:**

☐Paper & Mail
☐ Paper & Pick-up
☐CD & Mail
☐Email: _____ (Please print clearly)
☐Fax: _____ (Please print clearly)

Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

Authorization For Release of Protected Health Information:

For Access, Use, and Disclosure

***Section 8-Patient Rights:**

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 the control of Heritage Valley Health System and may not be protected by federal privacy regulations, therefore there is a potential for unauthorized re-disclosure by the recipient. I understand that this authorization may be revoked by me at any time. 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 Director of Medical Records or the Privacy Officer of Heritage Valley Health System. I hereby certify that I have read this authorization and agree to its terms.

Signature of Patient _____ Date/Time _____

OR

Signature of Patient's Legal Representative _____ Relationship to Patient _____ Date/Time _____

(Proof of legal representation is required-Healthcare Power of Attorney, Death/Short Certificate, etc.)

To be completed by staff if signed by legal representative:

Signature of Staff Obtaining Consent _____ Date/Time _____

☐ **Copy of legal representation Obtained**

OR

Verbal Consent (to be completed ONLY if unable to sign/authorize):

We, the undersigned, attest to the fact that the patient named above is **physically** unable to sign this release/consent. The signatures below indicate the patient understood the nature of this release/consent and freely gave his/her verbal consent.

Witness Printed Name _____ Witness Signature _____ Date/Time _____

Witness Printed Name _____ Witness Signature _____ Date/Time _____

***Section 8a-*SENSITIVE INFORMATION*:** I understand that me medical record may contain information relating to AIDS, HIV, psychiatric care, and/or treatment for drug and/or alcohol use.

☐ **I give consent** for use and disclosure of this type of information:

Signature of Patient _____ Date/Time _____

☐ **I DO NOT give consent** for use and disclosure of this type of information:

Signature of Patient _____ Date/Time _____

Section 9-*Expiration:*

Authorization expiration date or event: _____

****This authorization is valid for six (6) months from the date of signature, unless a sooner expiration date/event is noted above, or unless the authorization is revoked by written notice.**