Last Name:	First Name:	M.I.	Previous Name:
Mailing Address:		Apt#:	
City/ State/ Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred method of contact for reminder calls & other electronically generated messages: (Please select only one) Voice Text			If voice, select preferred number Home Cell Work
Family Physician:	Date of Birth:		Sex: Male Female
Marital Status:	Social Security #:	Employer Name:	
Emergency Contact Phone#:	Relationship to Patient		

Responsible Person

Last Name:		First Name:
Date Of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip		Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Email Address:	Can we leave a message regarding your medical care & test results? Yes No
Race: White American Indian or Alaska Native Asian Hispanic Black or African American Native Hawaiian or Pacific Islander Other Decline	Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline
Preferred Language: English Bosnian Indian(Including Hindi & Tamil) Sign Language Spanish Russian Other	

Primary Medical insurance	Secondary Medical Insurance
Ins. Co Name:	Policy Holder Name:
Policy Holder Name:	PolicyHolder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security#:	Policy Holder's Social Security#:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder

I have read and agree to Pine Top Medical of payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby sign to Pine Top Medical all money to which I am entitled for medical expenses related to the services performed from time to time by Pine Top Medical, but not to exceed my indebtedness to Pine Top Medical. I authorize Pine Top Medical to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $25.00 returned check fee will be charged for checks returned due to insufficient funds. By choosing text messaging and/or email as a communication method, I acknowledge that Pine Top Medical is not liable for any wireless charges I may Incur and that unencrypted patient information may be sent to me via text message or email.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Pine Top Medical, I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Primary Health Medical Group's Privacy Notice. ☐ Initials

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____ Date: _____

PINE TOP
MEDICAL
Dr. E. Doug Larsen, DO.

Patient Rights and Responsibilities

Pine Top Medical is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take responsible steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Ensuring payment for services is timely made, either by insurance or by direct payment.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

This statement does not constitute a contract for service. Receipt of this Statement does not establish a Physician-Patient relationship with Pine Top Medical. This Statement is for general information purposes only.

♦ Social, Educational and Work History ♦

Marital Status: Age of children, if any?

Are you sexually active: Yes/ No Do you have sex with: Men / Women / Both Use protection: Yes / No

Have you ever had a Sexually Transmitted Disease: Yes / No Last menstrual period / /

Do you drink alcohol: Yes/ No How often in the past year: How many on a typical day:

Are you a current smoker: Yes/ No How many years: Former smoker: Yes/ No Year you quit:

How many packs per day: Other forms of tobacco:

How soon after you wake up do you smoke your first cigarette: Are you interested in quitting: Yes/ No

Do you use any form of non-prescription drug: Yes/ No What type:

What type of exercises do you perform, duration & frequency:

In what type of residence do you live (i.e., house, assisted living, nursing home):

Referred By: Pharmacy:

Ethnicity: Race: Language:

Email:

♦ Family Health History ♦

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Problems
Father:				
Mother:				
Brother(s):				
Sister(s)				

♦ Review of Systems ♦

Please review the following symptoms and circle those that are a problem for you

Change in appetite	Chills	Fever	Headache	Lightheadedness
Weight gain/ loss	Allergy cough	Watery eyes	Decreased hearing	Ear pain
Sinus pain	Sore throat	Chest pain	Respiratory cough	Hemoptysis
Shortness of breath	Wheezing	Dyspnea on exertion	Palpitations	Abdominal pain
Constipation	Diarrhea	Heartburn	Nausea	Vomiting
Anemia	Bleeding problems	Blood in urine	Frequent urination	Arthritis
Joint Stiffness	Muscle aches	Painful joints	Hives	Rash
Skin lesion(s)	Dizziness/ fainting	Tingling/ numbness	Anxiety	Depressed mood

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests.

	Month/Year		Month/Year		Month/Year
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia vaccine		Pap smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy {EGO)	
Hepatitis B Vaccine		Bone Density		Heart stress test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

♦ EMERGENCY CONTACTS ♦

Name	Phone	Relation	Can this person have access to your medical information
			Yes/ No
			Yes/ No
			Yes/ No
			Yes/ No

New Patient Medical History (please complete both sides prior to your first appointment)

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition/ Disease	Year Began	Condition / Disease	Year Began
☐ Hypertension		☐ Coronary Artery Disease	
☐ High Cholesterol		☐ Heart Attack/ MI	
☐ Hypothyroid (low thyroid)		☐ Cancer	
☐ COPD, Emphysema or Asthma		Other(s)	
☐ Diabetes			
☐ GERO/ Heartburn			
☐ Depression or Anxiety			
☐ Heart Problems			

♦ Past Surgical History ♦

Operation	Month/Year	Operation	Month/Year

♦ Allergies ♦

Medication	Reaction	Medication	Reaction

♦ Medications ♦

Medication	Strength	Number of pills Taken & frequency	Medication	Strength	Number of pills Taken & frequency
Example: Tylenol	*500 mg*	*1 - twice daily*			

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PATIENT FINANCIAL POLICY

Thank you for choosing Pine Top Medical as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW

Please present your insurance card(s) at each visit. It is your responsibility to notify our office of any change in patient information (i.e. name, address, insurance information, etc.). You are responsible for payment on any balances remaining or denied claims. ·

Co-pays: We will collect your deductible, co-payment, or payment for non-covered services, along with any patient balance due the time of your visit. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with Pine Top Medical. We accept cash, checks, Visa, Master Card and Discover.

Insurance Claims: Insurance is a contract between you and your insurance company. In most cases, we will bill your primary insurance company as a courtesy to you. You are required to disclose all insurance information, including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete and accurate information may result in patient responsibility for the entire bill. You agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. If we do not receive payment from your insurance within 45 days, you will be billed for any unpaid balance, which will incur interest at the rate of 1.5% from the date of service.

Past Due Balances: All balances are to be paid in full within 30 days. If payment on your account is not done in a timely manner, your account may be referred to a collection agency and reported to the credit bureau. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs, including attorneys' fees and court costs. Pine Top Medical may record a Hen to perfect its right to recover past due balances.

Medicare Patients: We will submit to Medicare for all your covered services. If you have a supplemental insurance, we will also submit that for you as a courtesy. If payment is not received from your supplemental insurance within 30 days of being submitted, we will invoice you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your
charges until your Medicare deductible is met.

Medicaid Patients: We are a participating provider with Medicaid. We will submit to Medicaid for your covered services. Any unpaid portion is your responsibility.

HMO-PPO Patients: If we participate with your plan, we will submit your services to your insurance for you. Your co-payment will be collected at the time of service-no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has the physician you are seeing in our office as your PCP. If your plan requires you to have an authorization to

PINE TOP
MEDICAL
Dr. E. Doug Larsen, DO.

To see a specialist, you will need to obtain that from our office prior to seeing the specialist. 72 hours notice is required to obtain all referrals. We cannot obtain retroactive referrals. If we do not participate with your plan, we will verify your out-of-network benefits, file your services, and we expect payment of your portion of the services at the time of your visit.

Workers' Compensation: It is the patient's responsibility to provide our office with employer authorization and/or contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then, becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your claim is denied by your primary medical insurance carrier, you will be responsible for payment in full.

Self-Pay Patients: Patients without insurance coverage will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our office manager prior to seeing the doctor to make payment arrangements.

Minors: The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release may be required for unaccompanied minors.

No Show Or Missed Appointments: We understand there may be times when you are unable to keep an appointment. 24 hours notice must be provided to prevent incurring a cancellation fee. If an appointment is missed without proper notice you may be charged a $50.00 fee. Remember, whether you do or do not have insurance, you are ultimately :financially responsible for payment of your services. If you have any questions regarding our financial policy, please contact our office manager.

Medical Records Requests: Patients, their agents, representatives or legal counsel requesting copies of medical records will be charged a reasonable fee for copying and staff time.

Pine Top Medical reserves the right to terminate the Physician-Patient relationship for failure to pay balances past due, in accordance with our Patient's Rights and Responsibilities. Please direct all financial and/or billing questions to our staff.

I have read and understand the Patient Financial Policy and agree to be bound by it.

_____ _____

Signature (Patient or Responsible Party) Date

_____

Printed Name

PINE TOP
MEDICAL
Dr. E. Doug Larsen, DO.

Pine Top Medical Office Policy

Prescription refills

Timely management of your prescription medication needs is very important to us. Your participation in managing your medication needs is appreciated. By following these guidelines, it will help ensure your medication are efficiently maintained.

- Please have your prescriptions refilled during business hours, not on the weekends or holidays. This is best accomplished during your scheduled physician visit.
- **Call your pharmacy first:** they will notify our office of your medication needs.
- Please call for refills at least four days prior to running out of your medication.
- When calling for a refill, allow up to 48·hours for the physician to review your request and call your pharmacy.
- In-complete or missing information may result in a delay in prescription authorization. It is always best to have your pharmacy contact us.

Return phone calls

Managing your medical concerns on days when you are not scheduled for a provider visit is also very important to us. Please keep in mind that your physician sees a variety of patients. Please be aware that the physician or nurse may not call you back until after clinic hours, depending on the urgency of your request. Urgent or emergency problems will be addressed within two hours. When calling for lab results, allow 48 hours for the physician to review your results and nurse to return your call. If you have an emergency that requires immediate attention, please go directly to the nearest emergency department or dial 911.

Please remember this facility **does not** prescribe chronic narcotics.

Late arrival policy

Please try to be on time for your scheduled appointment. If you are more than 15 minutes late, you may be asked to reschedule your appointment. If you find it impossible to be on time, please contact our office. If you are unable to make your appointment and need to reschedule a 24 hour notice is required. If your appointment is missed without proper notice you may be charged a $50.00 fee.

Paperwork

Any paperwork IE: FMLA, disability paper work, handy cap paperwork may be charged a $25.00 fee. That needs to be rendered before paperwork will be completed.

Signature: _____ Date: _____

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HIPAA Form

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, a federal law. Administrative Simplification section of this Act is of Concern to our practice and requires us to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals and employers
- Healthcare Transactions & Code Sets for transmitting electronic data
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services.
It will be the policy of Pine Top Medical to release confidential information with signed consent by home telephone, answering machine, work telephone, voicemail and cellular phones.
Whenever returning telephone calls and the answering machine picks up, it is our policy NOT to leave confidential information if there is no recorded message identifying the residence. Confidential information will NOT be left with an unauthorized person who may answer your telephone.
If you would like to have your medial information released to someone other than yourself, please complete the following:

I authorize Pine Top Medical to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone	□Yes □No
Answering Machine	□Yes □No
Work Telephone	□Yes □No
Voice Mail	□Yes □ No
Cellular Phone	□Yes □No

Please List authorized persons:

Spouse/Fiancé:_____ Phone:_____
Parent/Guardian:_____ Phone:_____
Brother/Sister:_____ Phone: _____
Friend/Other: _____ Phone:_____

_____ _____
Patient Signature Date