

# OLYMPUS FAMILY MEDICINE

## New Patient Registration Form

### PATIENT INFORMATION

LEGAL NAME: \_\_\_\_\_  
Last First MI

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER: Male Female SOC SEC #: \_\_\_\_-\_\_\_\_-\_\_\_\_  
MM DD YYYY

CURRENT ADDRESS:

Street Address Apartment Number  
City State Zip

Please Indicate Your Preferred Contact Method Below:

- Cell Ph: \_\_\_\_\_  
 Home Ph: \_\_\_\_\_  
 Work Ph: \_\_\_\_\_  
 Email: \_\_\_\_\_

PARTNER NAME: \_\_\_\_\_ Marital Status: S M D W  
Last First

EMERGENCY CONTACT: \_\_\_\_\_ Phone # \_\_\_\_\_  
Last First MI

PREFERRED PHARMACY (Name & Address): \_\_\_\_\_

HOW DID YOU HEAR ABOUT US (circle)? Insurance Friend Family Member Internet Facebook Other

### INSURANCE INFORMATION

#### Primary Insurance Plan

INSURANCE PLAN NAME: \_\_\_\_\_ Phone # \_\_\_\_\_

INSURANCE CARD: Member ID # \_\_\_\_\_ Group # \_\_\_\_\_  
(Policy Number)

INS. PLAN ADDRESS: \_\_\_\_\_ Listed PCP: YES NO  
Street Address  
City State Zip  
(If YES, please indicate PCP name)

PRIMARY INSURED'S NAME: \_\_\_\_\_  
Last First MI

PRIMARY'S DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ PATIENT'S RELATIONSHIP TO PRIMARY: Self Child Spouse Other: \_\_\_\_\_  
MM DD YYYY

#### Secondary Insurance Plan (If Applicable)

INSURANCE PLAN NAME: \_\_\_\_\_ Phone # \_\_\_\_\_

INSURANCE CARD: Member ID # \_\_\_\_\_ Group # \_\_\_\_\_  
(Policy Number)

INS. PLAN ADDRESS: \_\_\_\_\_ Listed PCP: YES NO  
Street Address  
City State Zip  
(If YES, please indicate PCP name)

PRIMARY INSURED'S NAME: \_\_\_\_\_  
Last First MI

PRIMARY'S DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ PATIENT'S RELATIONSHIP TO PRIMARY: Self Child Spouse Other: \_\_\_\_\_  
MM DD YYYY

## PRESENT HEALTH SYMPTOMS

Please review and mark **ALL** items that have applied to you **within the last month** (including today):

**OVERALL:**     NONE     WEIGHT LOSS     WEIGHT GAIN     FATIGUE     LOSS OF APPETITE

**EYES:**         NONE     EYE PAIN     DOUBLE VISION     SEVERE REDNESS     CRUSTING

**EARS:**         NONE     EAR PAIN     HEARING LOSS     RINGING IN EARS     DIZZINESS

**NOSE:**         NONE     RUNNY NOSE     NASAL CONGESTION     NOSEBLEEDS     SINUS PAIN/PRESSURE

**MOUTH/THROAT:**  NONE     SORE THROAT     SORES IN MOUTH     TOOTH PAIN     HOARSENESS  
 PROBLEMS SWALLOWING

**CHEST/HEART:**  NONE     CHEST PAIN     RACING/POUNING HEART     LEG PAIN /LIMP W/WALKING  
 PROBLEMS BREATHING WITH LYING DOWN

**RESPIRATORY:**  NONE     COUGH     WHEEZING     SHORTNESS OF BREATH  
 COUGHING UP BLOOD OR MUCUS WITH BLOOD

**STOMACH:**     NONE     HEARTBURN     NAUSEA/VOMITING     ABDOMINAL PAIN     VOMITING UP BLOOD

**BOWELS:**      NONE     DIARRHEA     CONSTIPATION     BLACK/BLOODY STOOLS  
 UNUSUAL CHANGE IN STOOL SIZE/SHAPE/COLOR

**URINARY TRACT:**  NONE     BLOOD IN URINE     INCREASED URINATION     DIFFICULTY URINATING  
 PAIN WITH URINATION     WAKING TO URINATE \_\_\_\_\_ TIMES PER NIGHT

**REPRODUCTIVE:**

**FEMALES:**     NONE     MENSTRUAL PAIN     BREAST PAIN     VAGINAL DISCHARGE     PAIN W/INTERCOURSE  
 PREGNANT     BREASTFEEDING     FIRST DAY OF LAST MENSTRUAL PERIOD:

**MALES:**      NONE     TESTICULAR PAIN     PENILE DISCHARGE     LUMP/ SWELLING IN SCROTUM/ TESTICLE(S)

**MUSC/SKEL:**  NONE     BACK PAIN     PAIN IN MUSCLES/JOINTS     LIMITED RANGE OF MOTION IN JOINTS

**SKIN:**         NONE     RASH     REDNESS     CHANGING MOLES/WARTS OR OTHER LESIONS  
 SORES

**NEUROLOGICAL:**  NONE     SEIZURES     PROBLEMS WITH COORDINATION  
 MEMORY/SENSORY PROBLEMS     WEAKNESS / NUMBNESS / TINGLING

**ENDOCRINE:**  NONE     UNUSUAL CHANGES WITH SKIN OR HAIR     INCREASED SENSITIVITY TO TEMPERATURE CHANGES

**BLOOD:**        NONE     BLEEDING GUMS     FREQUENT NOSEBLEEDS     SWOLLEN GLANDS  
 SWOLLEN HANDS OR FEET     UNUSUAL BRUISING

**IMMUNE:**      NONE     SNEEZING     ITCHY EYES     FREQUENT SINUS, EAR OR RESPIRATORY INFECTIONS

**MENTAL HEALTH:**  NONE     MOOD SWINGS     EMOTIONAL CHANGES     THOUGHTS OF HURTING SELF OR OTHERS  
 ANXIETY/DEPRESSION

## PAST MEDICAL HISTORY

Please indicate any of the following medical conditions you **have now** or have **ever had** in the past:

ASTHMA                       EMPHYSEMA                       CHRONIC BRONCHITIS                       SEASONAL ALLERGIES

SINUS INFECTIONS                       ARTHRITIS                       OSTEOPOROSIS                       GOUT

HIGH CHOLESTEROL                       HIGH BLOOD PRESSURE                       HEART ATTACK                       STROKE

GLAUCOMA                       ANEMIA                       CHRONIC HEARTBURN                       GALL BLADDER DISEASE

BLEEDING DISORDER                       ULCERS                       THYROID DISORDER                       DIABETES

KIDNEY DISEASE                       TUBERCULOSIS                       HEPATITIS (type) \_\_\_\_\_                       DEPRESSION/ANXIETY

MENTAL ILLNESS                       EPILEPSY/SEIZURES                       MIGRAINES                       ADHD

CANCER (type): \_\_\_\_\_                       OTHER \_\_\_\_\_

## STD/HIV HISTORY & RISK FACTORS:

NONE                       UNPROTECTED SEX                       IV DRUG USE

OCCUPATIONAL EXPOSURE                       HIV / AIDS                       TRANSFUSION (Before 1980)

HEPATITIS (type) \_\_\_\_\_                       CLOSE CONTACT WITH STD / HIV POSITIVE PERSON

HISTORY OF PREVIOUS STD (type) \_\_\_\_\_

## PREVIOUS SURGERIES AND/OR HOSPITALIZATIONS

SURGERY OR ILLNESS	HOSPITAL	YEAR

**SOCIAL HISTORY**

Please complete the following sections. This information is important for guiding medical decisions related to your care.

OCCUPATION / EMPLOYER: \_\_\_\_\_ RECENT CHANGE? YES  NO

EDUCATION:  High School  Some College  Degree RELIGIOUS PREF: \_\_\_\_\_

EXERCISE HABITS:  Rarely  1-3 times/week  >3 times/week # OF CAFFEINATED BEVERAGES PER DAY: \_\_\_\_\_

PLEASE INDICATE YOUR ETHNIC ORIGIN:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> WHITE   | <input type="checkbox"/> BLACK / AFRICAN AMERICAN | <input type="checkbox"/> AMERICAN INDIAN / ALASKA NATIVE                |
| <input type="checkbox"/> ASIAN (Please Specify)                            | <input type="checkbox"/> HISPANIC / LATINO        | <input type="checkbox"/> NATIVE HAWAIIAN / PACIFIC ISLANDER             |
| <input type="checkbox"/> CHINESE   | <input type="checkbox"/> VIETNAMESE               | <input type="checkbox"/> INDIAN <input type="checkbox"/> PERSIAN        |
| <input type="checkbox"/> JAPANESE  | <input type="checkbox"/> TAIWANESE                | <input type="checkbox"/> PAKISTANI <input type="checkbox"/> INDEONESIAN |
| <input type="checkbox"/> KOREAN  | <input type="checkbox"/> CANTONESE                | <input type="checkbox"/> ARMENIAN <input type="checkbox"/> OTHER ASIAN  |
| <input type="checkbox"/> 2 OR MORE ETHNIC ORIGINS: (Not Hispanic / Latino) |   |   |

**TOBACCO, ALCOHOL & DRUG HISTORY**

RECREATIONAL DRUG USE?  YES  NO

CURRENT TOBACCO USE?  YES  NO

PAST TOBACCO USE?  YES  NO

TYPE OF TOBACCO?  SMOKE  DIP  CHEW

AMOUNT DAILY (quantity): CIGARETTES: \_\_\_\_\_ PACK(S): \_\_\_\_\_ CAN(S): \_\_\_\_\_

YEARS OF USE: CIGARETTES: \_\_\_\_\_ PACK(S): \_\_\_\_\_ CAN(S): \_\_\_\_\_

HAVE YOU QUIT?  YES, DATE (month/year): \_\_\_\_\_  NO

WOULD YOU LIKE TO QUIT?  YES  NO

ALCOHOL USE?  YES  NO

IF YES, NUMBER OF DRINKS IN AN AVERAGE: DAY: \_\_\_\_\_ WEEK: \_\_\_\_\_ MONTH: \_\_\_\_\_

**ALLERGIES**

Are you **allergic** to any medications or other substances? Y  N  If yes, please list item and reaction(s) below:

Medication Allergies	Reactions
Other Allergies	Reactions

**CURRENT MEDICATIONS**

Medication	Dosage	Frequency	Reason Prescribed

## FAMILY MEDICAL HISTORY

Please complete the following table regarding the medical history of your family members:

	FATHER	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	MOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER	<input type="checkbox"/> BRO <input type="checkbox"/> SIS	<input type="checkbox"/> BRO <input type="checkbox"/> SIS	<input type="checkbox"/> BRO <input type="checkbox"/> SIS
Deceased?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- If deceased, please list cause of death									
AGE (present or at time of death)									
<b>HEALTH HISTORY</b>									
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK/HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OBESITY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GALLBLADDER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THYROID DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY/SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANEMIA/BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DEPRESSION / ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL ILLNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD/ ADD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIES: (Please list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER (Type)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIES: (Please list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEREDITARY DISEASES: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Information: \_\_\_\_\_

\_\_\_\_\_

# OLYMPUS FAMILY MEDICINE

## CONSENT FOR TREATMENT

I, \_\_\_\_\_, hereby authorize employees and agents, including Physicians, Physician Assistants, and Nurse Practitioners, of *Olympus Family Medicine* to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice. If the doctor is unable to see me due to appointment availability, I may be offered an appointment with the physician assistant or nurse practitioner.

This facility has on staff a Physician Assistant and/or Nurse Practitioner to assist in the delivery of medical care. Physician Assistants and Nurse Practitioners are not doctors. These providers are graduates of a certified training program and are licensed by the state board. Under the supervision of a Physician, a Physician Assistant may diagnose, treat, and monitor common acute and chronic diseases, as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervising Physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. A mid-level provider may render such medical services that are within his/her education, training and experience, as approved by the Physician's discretion.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by **not** signing this consent, *Olympus Family Medicine* will not be able to provide medical care, except in case of emergency.

**If Patient is a Minor:**

I, \_\_\_\_\_, give my consent and authorization for *Olympus Family Medicine*,  
(Parent's Name)  
including physicians, physician assistants, nurse practitioners and medical assistants, to provide medical evaluation and treatment to my child, \_\_\_\_\_, when I am not available.  
(Minor's Full Name)

I understand such treatment may include invasive and minor surgical procedures and that the staff of *Olympus Family Medicine* will make reasonable attempts to contact me prior to initiating treatment if consent is needed.

The duration of this consent is indefinite and continues until revoked in writing or until the child reaches the age of eighteen. I understand that by **not** signing this consent, *Olympus Family Medicine* will not be able to provide medical care, except in case of emergency.

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient

**OLYMPUS FAMILY MEDICINE**  
**ACKNOWLEDGMENT OF RECEIPT OF**  
**NOTICE OF HEALTH INFORMATION PRACTICES**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by the staff of *Olympus Family Medicine* in providing and arranging your medical care.

*Olympus Family Medicine* is furnishing you with the attached notice, which provides information about how we may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by the law.

**HIPAA PRIVACY ACT INFORMATION RELEASE FORM**

May *Olympus Family Medicine* release medical information to anyone other than yourself?

**YES**, please release information to the following:                       **NO**, only release information to me.

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Check which of the following methods we may leave detailed information pertaining to your health:

Phone # \_\_\_\_\_

Voice Mail # \_\_\_\_\_

Email (Non-Encrypted) \_\_\_\_\_

By signing this form, you acknowledge that you have received a copy of *Olympus Family Medicine's* Notice of Health Information Practices and have provided instructions regarding release of your individual healthcare information.

\_\_\_\_\_  
Signature of Patient, Parent, or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient

# OLYMPUS FAMILY MEDICINE

## PAYMENT AND PATIENT POLICIES

Below you will find our patient policies. These are non-negotiable and are not to be altered. Failure to initial agreement with ALL of the following policies will result in your inability to receive care from Olympus Family Medicine. Thank you for your understanding in this matter.

### Please Initial All Below

x\_\_\_\_\_ **Co-Payments, Co-Insurance and Deductibles:** ALL co-payments, co-insurance and deductibles MUST be paid at time of service. The amount paid when services are rendered is an estimated amount based on the information we receive from your insurance company. Final determination of charges will be made after your insurance has been filed. We will send you a statement for any remaining balance. For your convenience, we accept MasterCard, Visa, Discover, and American Express. **Procedures-** most insurance companies require patients to pay a separate Surgical Deductible for procedures such as cryo-surgery, biopsies, device insertion, and other surgical procedures. Check with your insurance BEFORE the procedure is performed. You are responsible for payment of the deductible at the time of service.

x\_\_\_\_\_ **Insurance:** All patients must provide a valid Driver's License and an **active** insurance card at the time of service. If you fail to provide us with correct insurance information, you will be required to pay the full amount of the service. It is YOUR responsibility to know your benefits. Please notify the receptionist of any insurance changes when arriving for your appointment. We file your insurance as a courtesy to you. **ALL payments are due at the time of service** including copays, co-insurance, and deductibles.

x\_\_\_\_\_ **You are responsible for knowing your insurance policy and benefits.** Your health insurance policy is a contract between you and your insurance company. As a courtesy, we file your claim with your insurer if you agree to have payments made directly to *Olympus Family Medicine*. If your insurance company does not provide payment within 90 days of the filing date, YOU will be required to pay the full amount. If we later receive a check from your insurer, we will issue you a refund.

x\_\_\_\_\_ **You are responsible for payment of all charges for services NOT covered by your insurance company.** We do our best to determine your insurance benefits and coverage; however, due to the constant changes in insurance coverage, we cannot guarantee that Medicare or other insurance companies/policies will cover the services rendered. Your insurance company will make the final determination upon receipt of the claim. Medicare patients might have an addition ABN form to sign for potential non-covered services and testing.

x\_\_\_\_\_ **Billing:** Our billing is out-sourced to *Wallace Medical Billing*. Any balances owed to *Olympus Family Medicine* are due upon receipt of the billing statement. Please call *Wallace Medical Billing* at 1-800-274-7068 for all billing inquiries. All billing questions concerning laboratory or radiology must be directed to the facility where services were performed (*LabCorp, Quest, etc.*).

x\_\_\_\_\_ **Delinquent Accounts:** If your account becomes delinquent after 30 days, you will be assessed a \$5.00 fee per billing cycle, every 30 days. If payment is not made, your account will be turned over to a collection agency due to delinquency and you will be required to pay all balances in full **before** further services are rendered.

x\_\_\_\_\_ **Appointments:** Please arrive 10 minutes before your appointment time to update any changes in contact information or insurance. We require **24-hour** notice to cancel or reschedule an appointment. Failure to do so, including late cancellations and missed appointments, will result in a **\$50** charge. No-shows will not be tolerated. Patients who repeatedly miss their appointments may have their care terminated with *Olympus Family Medicine*.

x\_\_\_\_\_ **Laboratory Results and Radiology Results:** In general, all labs and radiology results will be discussed at routine follow up appointments. Routine results are typically available for the provider to review in 5 business days. Some specialty labs can take up to 10 business days. Your provider will determine if you need an appointment or if the results can be discussed over the phone. Results for sexually transmitted disease require an appointment. All billing questions concerning laboratory or radiology must be directed to the facility where services were ordered.

x\_\_\_\_\_ **Call Back Requests:** The doctor will NOT take calls for non-urgent conditions during regular business hours. Returned calls and messages are typically conducted at the end of the business day; however, the provider will call you within **24 hours**. Please leave a detailed message along with your name, date of birth, and phone number.

x\_\_\_\_\_ **Medication Refills:** We require **24 hours for routine medication refills**. Please do NOT have the pharmacy fax a refill request to our office. Please do NOT let your medications run out before calling us to request a refill. NO medications will be refilled on weekends. You MUST make an appointment for antibiotics and narcotics.

**Narcotics will NOT be prescribed without an appointment.**

x\_\_\_\_\_ **Pharmacy:** If your insurance company requires you to use a specific pharmacy in order to receive prescription medicine benefits, please notify us. If your insurance company requires prescriptions to be sent from the doctor's office to the mail-order pharmacy, please fill out ALL appropriate forms with the required information and we will fax them to the number you provide.

x\_\_\_\_\_ **Forms:** All requests to fill out forms such as FMLA, disability, leave of absence, jury duty exemptions, and others require an office visit. The physician or provider reserves the right to deny signing requested forms.

x\_\_\_\_\_ **Referrals:** If you need a referral, we will submit the referral paperwork to a specialist. If the specialist has NOT contacted you within **3 days**, please call us. Before booking an appointment with a specialist, YOU are responsible for checking that the specialist or facility is in-network on your insurance plan. We may send referrals to the physician or facility of your choice. **All HMO's** require a referral BEFORE seeing a specialist and require 72 hours to process.

x\_\_\_\_\_ **Medical Records:** Medical records will be released after a signed release is received from the patient. Patients requesting copies of medical records will be charged a base fee of \$25.00. ALL medical record requests will be addressed within 10 business days of receipt of both the patient release and payment.

x\_\_\_\_\_ **Inclement Weather:** In the case of inclement weather, we follow the Frisco ISD policy for closures and delayed openings. We will call you to reschedule your appointment on the first business day we are open.

x\_\_\_\_\_ **Annual Physicals:** Please allow 8-12 weeks to schedule an annual physical. Two weeks prior to your appointment, please come in for lab work. The focus of an Annual Physical Exam is preventive care. The provider will review your lab work, perform a physical assessment, answer questions, update your treatment plan, and refill maintenance medications for chronic conditions. Acute issues will not be addressed at an Annual Physical appointment. You must schedule a follow-up appointment to discuss those conditions. It is the patient's responsibility to know and understand their insurance coverage. If any services recommended by your provider are not covered under your insurance plan, you must decline the service before it is performed in office. Otherwise, the cost of the denied service will be your responsibility.

*Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our above policies.*

**By signing this form, you acknowledge that you have read and understand all of *Olympus Family Medicine's* Patient and Payment Policies listed above. You also attest that all of the information provided previously on this form is accurate and reliable to the best of your knowledge.**

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient, Parent or Legal Guardian



# AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize the following office or entity to disclose my individually identifiable health information as described below:

**Doctor/Hospital Name:** \_\_\_\_\_

\_\_\_\_\_  
Street Address Suite Number

Phone # \_\_\_\_\_

Fax # \_\_\_\_\_

\_\_\_\_\_  
City State Zip

This information may include, but is not limited to, material concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

\_\_\_\_\_  
Print Patient Name Date of Birth Social Security Number

**Purpose of Information Release:** Continuity of care for Primary Care Physician Office

**Description of Information to be Released:** (Check all that apply)

All Available Medical Records (Including, but not limited to all below listed options.)

*Please only release the following specified information:*

Hospital Admission Records / Operative Reports / Billing Records / Discharge Records

Radiology Reports & Films

Consultation Reports

Laboratory / Pathology Reports

Emergency Room Records

Physician's Orders

Physician's Notes & Progress Notes

History & Physical

Nurse's Notes

Specific Dates: \_\_\_\_\_

The health information described herein shall be released to:

**Olympus Family Medicine**

4461 Coit Road, Suite 307

Frisco, Texas 75035

**Phone: 972-377-0322 Fax: 972-502-9515**

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying this office in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
OR Legal Authority (attach supporting documentation)

4461 Coit Road, Suite 307 · Frisco, TX 75035 · Ph. 972-377-0322 · Fax 972-502-5515