NWO Family Medicine

Patient Information (Please print in pen)

Legal Last Name:	Legal First Name:	Middle Name:	SSN:
Mailing Address:	City:	State:	Zip:	Email Address:

Home Telephone:	Cell Phone:	Other Phone:	Gender: □ M □ F	Status: □Married □Single □Widowed □Divorced
Date of Birth (mm-dd-yyyy):				

If Medicare, are you currently residing in a Skilled Nursing Facility: □ Yes □ No Name of Facility______________________

If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? □ Yes □No
If so, do you know if you have exceeded the Medicare cap? □ Yes □ No

If Medicare, are you currently receiving Home Health Services: □ Yes □ No Type of service:
If yes, Name of Agency:____________________________________ Date of Last Service:

Employer Information

Employer:	Employer Phone:	Employment Status: □ FT □PT □Self □ Retired □Student □None	
Address:	City:	State:	Zip:

Responsible Party (For Minors and/or Dependents for Insurance Purposes)

If Minor, Does child live with: □ Both Parents □ Mother □ Father □ Other ____________________

Mother's Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:
Father's Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:

Emergency Contact

Contact Name:	Phone:	Relationship:

Health Care Primary Insurance

Name of Insurance:	ID #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to patient: □ Self □ Spouse □ Dependent □ Other		

Secondary Insurance

Name of Insurance:	ID #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to Patient: □ Self □ Spouse □ Dependent □ Other______________		

Authorization: I, with my signature, authorize Northwest Ohio Health Partners, Inc. (NWOHP) to provide medical care for me, or to this patient for which I am the legal guardian.
I also authorize NWOHP, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payment for these services to NWOHP, realizing I am personally responsible for the charges incurred, including items determined to be non-covered.

I also acknowledge that I have been given or have been offered a copy of the "Practice's" privacy policy as required by law. I request the following restrictions be placed on the "Practice's" use and/or disclosure of my health information (leave blank if NO).

____

____

Patient/Guardian:____Date:________________________

Health Questionnaire

Name: ______________________________ Today's Date: ____________________
Date of Birth: ________________________

Chief Complaints (Please list, in order of importance, the present health concerns, symptoms, or problems you are experiencing):
____
____
____

Past Medical History: Have you ever had the following (circle Y for yes, N for no. Leave blank if uncertain)?

Acid Reflux	Y	N	Cancer (What Type)	Y	N	Kidney Disease	Y	N
AIDS or HIV+	Y	N	_______________			Lung Disease	Y	N
Alzheimer's	Y	N	Depression	Y	N	Migraines	Y	N
Anemia/Blood Disorder	Y	N	Diabetes	Y	N	Mitral Valve	Y	N
Anxiety	Y	N	Epilepsy	Y	N	Pneumonia	Y	N
Arthritis	Y	N	Glaucoma	Y	N	Polio	Y	N
Asthma	Y	N	Heart Disease	Y	N	Psychiatric Disorder	Y	N
Back Trouble	Y	N	Hemorrhoids	Y	N	Rheumatic Fever	Y	N
Bladder Incontinence	Y	N	Hepatitis	Y	N	Skin Disorder	Y	N
Bladder Infections	Y	N	Hernia	Y	N	Stroke	Y	N
Bleeding Tendency	Y	N	High Cholesterol	Y	N	Thyroid Disease	Y	N
Bowel Disease	Y	N	High or Low BP	Y	N	Transfusions	Y	N
Breast Disease	Y	N	Hives or Eczerma	Y	N	Tuberculosis	Y	N
Bronchitis	Y	N	Infectious Mono	Y	N	Ulcer	Y	N
						Venereal Disease	Y	N

Any other disease (please list) ____
Comments: ____
____

Previous Surgeries

Year	Type of Procedure Done	Surgeon

Social History

Tobacco (past or present)	Y	N	Packs per day _________ for __________ years
Alcohol	Y	N	Drinks per week ________________________
Illegal Drugs	Y	N	Type: ______________________________
Employed	Y	N	Name of Employer: ____________________

Family History: Has any blood relative had any of the following (circle Y for yes, N for no. Leave blank if uncertain)?

			Relationship				Relationship
Asthma	Y	N	______________________	Heart Disease	Y	N	____________________
Anemia	Y	N	__ __________________	High Blood Pressure	Y	N	____________________
Bleeding Tendency	Y	N	______________________	Liver Diseased	Y	N	____________________
Bowel Disorders	Y	N	______________________	Lung Disease	Y	N	____________________
Cancer	Y	N	______________________	Stroke	Y	N	____________________
Diabetes	Y	N	______________________	Thyroid Diease	Y	N	____________________
Epilepsy	Y	N	______________________	Mental Illness	Y	N	____________________

Drug Allergies

Allergic To	Type of Reaction

Medications

Current Medication	Dosage	Times per Day	Prescribed By

Please List the Year you had your last:

Bone Density Test ___________________
Colonoscopy _______________________
Stool Blood Test ____________________
Cholesterol Test ____________________

Tetanus Shot ___________________
Pneumonia Shot ________________
Rectal Exam ___________________
PSA Test (MEN) _______________

Hepatitis Vaccine _______________
Rubella Vaccine ________________
Eye Exam _____________________

For Women Only

Age at Onset of Menstrual Period: __________ Date of Last Menstrual Period: ______________________

Birth Control? Y N Type: ____

Number of Pregnancies: __________ Number of Live Births: __________ Number of Abortions: ______________
Number of Miscarriages: __________

Year of Last:

Breast Exam: __________ Results: ____
Mammogram: _________ Results: ____
Pap Test: ______________ Results: ____

NWO Family Medicine

Explanation of Condition

Patient Legal Name: ____
First MI Last

Condition/Accident/Injury Details

Symptoms first begin on: _____/_____/_____ or have been experiencing for ______days ______ weeks ______months ______ years.

What symptoms are you experiencing? ____

____

What body parts are affected? ____

____

Have any of these body parts been injured before? YES NO If yes, please describe: __________________

____

What medications are you currently taking? ____

____

Give a brief description of the accident. Please include location of the accident (home, work, school, auto, etc.) and a brief description (fall, bump against, collision, cut, struck by, etc.). ______________________________

____

____

Will you seek payment from another party? YES NO If yes, who? BWC MVA Other

If an attorney is involved, please provide name, address, and phone number: ________________________

____

Was this injury sustained in an automobile accident? YES NO If yes, please complete the following:

Motor Vehicle Accident Information

Date of Accident: _________/_________/_________ State Accident Occurred: ______________________ Time: ______________

Auto Insurance Name: ____ Adjuster's Name: ______________________________

Adjuster's Phone Number: _______________________________________ Name of Insured: ______________________________

Claim Number: _________________________ Policy Number: ________________________ MVA Work Related? Y N

We will bill your motor vehicle insurance; however, you are ultimately responsible for your account balance. We do require your health insurance information since most auto coverage is limited. We will bill your health insurance for any remaining balance after your Auto Insurance has paid. **Please note that should your motor vehicle accident require litigation proceedings, you will be required to speak with our financial counselor to arrange monthly payments in order to keep your account current during your hearings.** Once your claim has been settled, any overpayments you have made on the account will be refunded to you at that time.

AUTHORIZATION

I, with my signature, authorize **Northwest Ohio Health Partners, Inc**., and any employee working under the direction of the care provider, to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize **Northwest Ohio Health Partners, Inc**., to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductible, and other amounts that may be deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulation.

Patient/Legal Representative: ____ Date: ____________________

NWO Family Medicine

FINANCIAL POLICY

Regarding Your Insurance:
Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. We make every effort to get claims paid; however, please remember that your insurance policy is a contract between you, your employer, and your insurance company. Any balance remaining after the insurance has paid, is the **patient/guarantor's responsibility** (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.). If NWO Health Partners is not in your insurance plan, the patient/guarantor is responsible for all charges. If you do not have insurance, you are expected to pay in full at time of visit.

In an effort to minimize insurance errors and maximize insurance payment, please bring your most recent insurance card(s) with you to every visit. **Co-payments are to be paid at the time of your visit**. In the event we receive payment from your insurance company for services you have paid for, a refund will be made to you in a timely manner.

Payment Information:
We accept cash, check, and credit/debit card payments. A fee of $30.00 will be applied and collected from your account if payment is returned non-paid. If you have questions regarding your billing, please call our billing representative at 419-427-3096.

Past Due Accounts:
If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. A 10-day notice prior to sending your account to a collection agency will be mailed to you.

No-Show Fee:
Missed or non-cancelled appointments will result in a service fee.

FMLA, Disability, and Drug Company Assistance Forms:
Any patient needing forms filled out by our office will incur a one time $15.00 fee per form. Payment for this service is due at the time of drop-off or pick-up.

Medical Records Copying Fees:
Charges for copying medical records vary depending on whether the individual/organization requesting the information is the patient/personal representative or a non-personal representative. In compliance with the Ohio Revised Code Section 3701.742, if the person requesting records is the patient/personal representative, fees are: $2.88/page for pages 1-10, $.60/page for pages 11-50, and $.24/page for pages 51+.

Fees for a non-personal representative are: $17.70 retrieval fee, $1.17/page for pages 1-10, $.60/page for pages 11-50, and $.24/page for pages 51+.

Film prices for patient/representative and non-representative are: $1.97/sheet or $2.00/disc. Postage paid to send records will also be paid by the requestor.

______________________________________ ________________

Patient/Guarantor Signature **Date**

NWO Family Medicine

PROMEDICA URGENTCARE

Member of PROMEDICA HEALTH SYSTEM

Randy A. Trimpey, MD

Therapeutic Alliance

I will do my best to provide excellent medical care and make your experience with NWO Family Medicine enjoyable and beneficial. However, a rewarding doctor-patient relationship requires effort from both parties. My staff and I will respond to your needs in a timely and professional manner. Please be courteous and arrive to appointments promptly. You may be asked to reschedule if late. A no show fee may be charged if the appointment is not cancelled in a timely manner. Please bring the following items to your appointment: insurance card(s), photo ID, medication bottles, and co-pay.

Prescription refill requests will likely be processed within twenty-four (24) hours, but under certain circumstances may take up to seventy-two (72) hours. Detailed messages will help expedite your request.

Please be aware of your insurance plan's policies. Plans vary by employer and the staff at NWO Family Medicine may not be aware of the benefits and/or restrictions of your individual policy. For example, physicals and vaccinations are considered preventative care and are **not** covered the same as routine visits or sick visits. Insurance plans have different policies concerning referrals to specialists and medical testing (blood work, x-rays, etc.). The staff will try to account for these restrictions, but I suggest that patients verify with their insurance company to avoid receiving any unexpected bill.

Narcotic use is another hot topic in the media and amongst the medical community. In my opinion, these medications should be used primarily for acute (short-term) medical conditions or terminal conditions. In special circumstance in which narcotics are required for chronic (long-term) conditions, this should be managed by a specialist in this field.

Please feel free to speak openly to me or my staff about any concerns you may have. I hope you are happy with your decision to choose NWO Family Medicine to provide your medical care.