Infinity Family Clinic

ALWAYS BY YOUR SIDE

Patient General Information (please print)

Name_____ DOB _____ Sex: __M __F

Social sec # _____ Status: Single____ Married____ Divorced ____Widowed ____

Primary address _____

City_____State_____Zip_____

Home phone _____Work phone _____ Cell phone_____

Emergency contact _____ Relationship _____ Phone_____

E-mail _____ Authorize E-mail?: ____Y ____N

Pharmacy _____ Phone _____ Fax _____

Employment status: ____employed ____not employed ____retired ____student

Employer _____ Occupation_____

Patient Phone Message Consent:

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

Leave a detailed message on voice mail/machine/cell YES _____ NO _____ (initial yes or no)

Leave a detailed message with individual answering the phone YES _____ NO _____(initial yes or no)

Sharing of Medical Information

I give the physician and office staff of Infinity Family Clinic permission to discuss my medical condition with the following individuals:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

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Primary Insurance

Insurance Name _____ Subscriber's Name _____

Insurance ID# _____Group # _____

SSN _____ DOB _____ Relationship to Insured _____

Secondary Insurance

Insurance name _____ Subscriber's Name _____

Insurance ID# _____Group # _____

SSN _____ DOB _____ Relationship to insured_____

Patient Authorization for ePRESCRIBE

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of Infinity Family Clinic to enroll me in the ePrescribe Program.

Patient signature _____ Date _____

Patient Authorization for PHARMACY BENEFITS

I authorize the physician and/or staff of Infinity Family Clinic to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third party pharmacy payors for treatment purposes.

Patient signature _____ Date _____

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Patient Authorization for MEDICARE PATIENTS

I authorize the physician and/or staff of Infinity Family Clinic to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.

Patient signature _____ Date _____

Patient Authorization for PPO and HMO PATIENTS

I authorize the physician and/or staff of Infinity Family Clinic to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above named insurance company to pay directly to Infinity Family Clinic the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature _____ Date _____

Patient Authorization for ALL PATIENTS

I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and Infinity Family Clinic to photograph me for medically related documentation purposes.

Patient signature _____ Date _____

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Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify Infinity Family Clinic of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week's notice. Under the American with Disabilities Act, "Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company." If a patient who has requested accommodations does not provide a minimum of 24 hours' notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by Infinity Family Clinic is the patient's responsibilities.

Patient signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement if you wish.
I acknowledge that I have received a copy of the Infinity Family Clinic Notice of Privacy Practices.

Patient signature _____ Date _____

ACKNOWLEDGEMENT OF INFINITY FAMILY CLINIC POLICY

Infinity Family Clinic requires 5 business days to receive most lab and imaging results. 5 business days will allow the doctor and the staff of Infinity Family Clinic to review, complete, and when possible, post results into the Patient Portal.
Infinity Family Clinic will submit outgoing referrals within 5 business days of your visit. This will allow the staff of our office to get proper authorization and fax referrals with documentation as needed.
I acknowledge that I have read and understand Infinity Family Clinic Policy.

Patient signature _____ Date _____

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PATIENT CONSENT TO TREAT

I hereby give my consent to Infinity Family Clinic and authorize him or her to provide my medical treatment. I understand that Infinity Family Clinic will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Infinity Family Clinic to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read, and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient signature _____ Date _____

Cancellation and No Show Policy

Our Policy is as follows:
Non-Cancellation/No Shows within 24 hours notification: $30.00

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as a **NO SHOW**. Patients who No-Show three (3) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Office Manager.

I acknowledge that I have read and understand Infinity Family Clinic Cancellation Policy.

Patient signature _____Date _____

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Dear patient,

In an effort to meet the increasing demands of insurance companies and keeping in compliance with Medicare, we at Infinity Family Clinic, PLLC are asking that our patients follow the protocol necessary to meet their guidelines. We are requesting from all patients:

a) ID and Insurance- Please provide us with your current ID and if you have insurance, we need your insurance card to ensure efficient billing.
b) Patients with insurance- We draw labs in the office as a courtesy to patients and send those labs to Quest Diagnostics. Make sure your insurance is always up to date with Infinity Family Clinic, PLLC. The insurance provided is what will be sent to Quest whom then will bill the insurance. Should you encounter an issue with billing, please refer to your insurance company for lab coverage. All patients with no insurance will be charged directly from the office.
c) Medications- We need a list of all your medications. Please provide us with a list of all medications you are taking including from any specialists.
d) Refills- We are not able to refill medications prior to you being seen at Infinity Family Clinic, PLLC. Medication refills are based on the NP discretion and varies with each individual.
e) Annual Visit- Our patients are required to have an annual/ physical/ wellness visit every year. This is usually mandated by your insurance company. Any patient that does not comply with this very important visit will be subject to not being seen by our practice or penalties by your insurance company. This is separate and different from a follow up appointment.
f) Specialist- We need to know if you have seen a specialist, if so, we need your records. Please provide us with their names and information.

We hope you understand that these guidelines were set to help our providers and the office to coordinate the best possible healthcare for our patients.

Thank you for choosing Infinity Family Clinic, PLLC.

Patient:_____DOB_____Signature_____Date_____

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PATIENT QUESTIONNAIRE

Fall Risk Screening Questions

1. Have you had two or more falls within the past 12 months with or without injury? ☐ Yes ☐No
2. Do you feel unsteady walking or standing? ☐ Yes ☐No
3. Do you worry about falling? ☐ Yes ☐No
4. Do you use a cane or a walker? ☐ Yes ☐No

Physical Health

1. Does physical health interfere with your daily activities? ☐ Almost Never ☐Occasionally ☐Frequently
2. How many days per week are you physically active? ☐ 0-1 Days ☐ 2-3 Days ☐ 4 or more Days
3. Are you as active as other persons your age? ☐ Yes ☐No
4. Do you choose stairs over escalators / elevators? ☐ Almost Never ☐Occasionally ☐Frequently

Emotional Health

1. How would you describe your emotional health? ☐ Calm ☐ Energetic ☐ Downhearted
2. In the last month, has your emotional health interfered with your daily activities? ☐ Yes ☐No
3. How many hours of sleep do you typically get at night? ☐5 or less ☐6-7 hours ☐8 or more hours
4. In the last month, have you accomplished less than you would like or been more careless at work or while performing daily activities? ☐ Yes ☐No

Bladder Control

1. Is bladder control a problem for you? ☐ Yes ☐No
2. In the past 60 days, has urine leakage changed your daily activities or interfered with sleep? ☐ Yes ☐No
3. If urine leakage is a problem, would you be willing to try:
   - Medication ☐ Yes ☐No
   - Exercise ☐ Yes ☐No
   - Surgery ☐ Yes ☐No

Medications

1. In the last 2 weeks have you forgotten to take your medications? ☐ Yes ☐No
2. Do you have any questions on prescribed medications and how and when to take them? ☐ Yes ☐No
3. Do you have any medications that are unaffordable even with help from copays? ☐ Yes ☐No
4. Do you have any worries or questions related to your medication or side effects? ☐ Yes ☐No

Patient Name_____ DOB_____ Signature_____ Date_____