



Muskogee Family Medicine

Brad McIntosh, M.D.

Jason Dansby, M.D.

Justin Roberts, APRN-CNP

PATIENT INFORMATION

Patient Last Name

Insurance Company Name

First Middle

Cardholder's Name

Mailing Address

Cardholder's Date of Birth SSN

City State Zip

Cardholder's Employer:

Birthdate SSN

Cardholder's Relationship to Patient:

Marital Status Gender

PRIVACY NOTICE

Indicate if we may leave a voice message with medical information at the numbers below by marking yes or no.

I have been provided a copy of Muskogee Family Medicine HIPPA notice of privacy practices

Primary Phone

I authorize the physicians of Muskogee Family Medicine to provide medical care to the patient. Also, to release any medical information necessary to process claims and request payment of benefits from Medicare or other insurance to myself or to this clinic.

Secondary Phone

RELEASE OF MEDICAL RECORDS

Employer:

In addition to the above statements, I also authorize release of my protected health information to the following persons:

Work Phone:

Parent/Guardian or Spouse name:

Birthdate: Phone #

Address if different from patient:

Name Relationship to Patient

City State Zip

Name Relationship to Patient

Please indicate your preferred method(s) of receiving appointment confirmations below

Text Message: Phone #

Name Relationship to Patient

Email:

Name Relationship to Patient

Voice: Phone#

Note: If no individuals are listed above, the patient and/or legal guardian(s) are the ONLY persons who will have access to ANY health information. If you would like your spouse to have access to your health information, you MUST list them here\*\*

I agree to all of the above and attest that the information provided is complete and accurate to the best of my ability.

Patient Signature: (Parent/Guardian signature if patient is a minor)

Date

Printed Name of Signer:

Office use only: Initial of staff:

### PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**1. Insurance.** We participate in many insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit and you will be provided information to submit your own claim. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**2. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service unless you have documentation that your deductible has been met. Failure to collect co-pay and deductibles from our patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**3. Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit if we notify you that a service is not covered by your insurance. If we are not aware the service is not a covered benefit until we receive notification from your insurance company, you will then be asked to pay in full as soon as we notify you.

**4. Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**5. Claims submission.** We will submit your claims if you are insured with a company with which we are currently contracted and we will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**6. Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

**7. Nonpayment.** If your account is over 90 days past due, you will be asked to sign a payment agreement. If you do not meet the obligations of your agreement, the total balance of your account will become due immediately. You will not be allowed to increase your balance during the period of your payment agreement. If you continue to have a delinquent account you will be referred to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physicians will only be able to treat you on an emergency basis.

**8. Missed appointments.** There is a \$25 charge for missed appointments. Kindly call us 24 hours in advance to cancel or reschedule your appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

---

Signature of patient or responsible party

---

Date



---

## Patient Consent for E-Mail Transmission of Protected Health Information

### **1. RISK OF USING E-MAIL**

Transmitting patient results by e-mail has a number of risks that patients should consider before authorizing receipt of e-mail transmissions. These include but are not limited to the following risks:

- a. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) recommends that e-mail that contains protected health information be encrypted. All transmissions from Muskogee Family Medicine will be encrypted and will require the patient to establish an account with a password to view.
- b. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- c. E-mail senders can easily misaddress an e-mail.
- d. Back-up copies of e-mail may exist even after sender has deleted his copy.
- e. Employers and on-line services have a right to inspect e-mail transmitted through their systems.
- f. E-mail can be used to introduce viruses into computer systems.
- g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

### **2. CONDITIONS FOR USE OF E-MAIL**

Muskogee Family Medicine cannot guarantee the security and confidentiality of e-mail but will use reasonable means, including e-mail encryption, to maintain security and confidentiality. The facility and physicians are not liable for improper disclosure of confidential information that is not caused by practice or physician intentional misconduct. Patients must acknowledge and comply with the following:

- a. All e-mails sent from the facility will be one way. Patients will not be allowed to respond since the e-mail address will not be monitored. The e-mails will be sent from [donotreply@muskogeefamilymedicine.com](mailto:donotreply@muskogeefamilymedicine.com)
- b. Provide a valid e-mail address and inform the facility of any future address change.
- c. Establish an account to open encrypted e-mails upon receipt of first encrypted e-mail.
- d. Protect his/her password to the encrypted e-mail.

### **3. PATIENT ACKNOWLEDGE AND AGREEMENT**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail from Muskogee Family Medicine, and I consent to the conditions outlined as well as any other instructions that the practice may impose to communicate with patient by e-mail. If I have questions, I may inquire with the manager.

E-mail address (please print) \_\_\_\_\_

Patient Name Printed \_\_\_\_\_ DOB \_\_\_\_\_

Patient signature \_\_\_\_\_ Date \_\_\_\_\_



## PATIENT QUESTIONNAIRE

Information contained in this questionnaire is confidential and will not be released except when you authorize us to do so by signing a "Release of Information" form.

A Medical history provides us with essential information about you. Your current problems will be discussed at length with your doctor.

Please answer the following questions as completely as possible.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Reason for Consulting Physician: \_\_\_\_\_

OPERATIONS:	YES	NO	AGE or DATE
Appendectomy	_____	_____	_____
Tonsillectomy	_____	_____	_____
Adenoidectomy	_____	_____	_____
Hysterectomy	_____	_____	_____
Hemorrhoidectomy	_____	_____	_____
Cholecystectomy (gallbladder surgery)	_____	_____	_____
Other _____	_____	_____	_____

HOSPITALIZATIONS:		
Date	Location	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INJURIES: \_\_\_\_\_

ILLNESSES: Please list approximate year or age you had the following:

_____ Epilepsy	_____ High Blood Pressure	_____ Tuberculosis	_____ Stomach Ulcer	_____ Thyroid Disease
_____ Heart Attack	_____ Blood Disorder (anemia)	_____ Malaria	_____ Stroke	_____ Kidney Disease
_____ Diabetes	_____ Migraine Headaches	_____ Hepatitis	_____ Allergies	_____ Kidney Stones
_____ Gallstones	_____ Pneumonia			

ALLERGIES: Please list all medication and/or food allergies \_\_\_\_\_

MEDICATIONS: Please list any prescription or non-prescription medications you are currently taking and the approximate dates they were started.

Drug Name	Reason	Date	Prescribed by Dr.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HABITS:

	YES	NO	
Do you exercise regularly?	_____	_____	If so, Please describe: _____
Do you smoke?	_____	_____	If so, how much per day? _____
Do you use alcohol?	_____	_____	If so, how much per day? _____
Do you drink coffee?	_____	_____	If so, how much per day? _____
Do you follow a special diet?	_____	_____	If so, what type? _____

SOCIAL HISTORY: Where were you born? \_\_\_\_\_

Where were you raised? \_\_\_\_\_

Education: High School – Year \_\_\_\_\_ Where: \_\_\_\_\_

College -- Year \_\_\_\_\_ Where: \_\_\_\_\_

Degrees -- \_\_\_\_\_

Occupation: \_\_\_\_\_

Military: \_\_\_\_\_

Marital Status: \_\_\_\_\_ State age and health status of spouse: \_\_\_\_\_ / \_\_\_\_\_

Foreign countries you have visited: \_\_\_\_\_

Recent exposure to insect or animal bites: \_\_\_\_\_

List pets or domestic animals: \_\_\_\_\_

FAMILY HISTORY: Father – Living \_\_\_\_\_ Age: \_\_\_\_\_ Health Status: \_\_\_\_\_

Dead \_\_\_\_\_ Age: \_\_\_\_\_ Cause of Death: \_\_\_\_\_

Mother – Living \_\_\_\_\_ Age: \_\_\_\_\_ Health Status: \_\_\_\_\_

Dead \_\_\_\_\_ Age: \_\_\_\_\_ Cause of Death: \_\_\_\_\_

Brothers & Sisters:	Age	Living/Dead	State of Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children: Name	Age	Living/Dead	State of Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have any of your blood relatives (aunts, uncles, grandparents, cousins, nephews, etc.) died before the age of 60 with heart disease? \_\_\_YES \_\_\_NO  
 If so, please list: \_\_\_\_\_

REVIEW OF SYSTEMS

GENERAL:	HEENT (Head):	YES	NO	COMMENTS
Height: _____ Weight: _____ If recent loss, how much _____ If recent gain, how much _____	Frequent headaches	_____	_____	_____
Is your appetite good? ___Yes ___No	Neck lumps, or swelling	_____	_____	_____
How many hours do you sleep? _____	(Eyes): Glasses	_____	_____	_____
SKIN:	See double	_____	_____	_____
Change in body hair	Glaucoma	_____	_____	_____
Rash	Cataracts	_____	_____	_____
Wart or moles	(Ears): Hearing difficulty	_____	_____	_____
Removed	Buzzing/roaring	_____	_____	_____
RESPIRATORY:	Infections	_____	_____	_____
Wheezes, asthma	(Nose): Bleeding	_____	_____	_____
Daily cough	Sinusitis	_____	_____	_____
Cough up phlegm	Allergies	_____	_____	_____
Cough up blood	(Throat): Last dental check	_____	_____	_____
Shortness of breath	Hoarse voice	_____	_____	_____
With rest?	GASTROINTESTINAL (Stomach):	_____	_____	_____
At night?	Difficulty swallowing	_____	_____	_____
With exertion?	Indigestion (heartburn)	_____	_____	_____
MUSCULOSKELETAL:	Nausea	_____	_____	_____
Arthritis	Vomiting	_____	_____	_____
Swollen joints	Constipation	_____	_____	_____
Back pain	Blood in stools	_____	_____	_____
Bursitis/tendonitis	Black, tarry stools	_____	_____	_____
Neck pain	Change in stool color	_____	_____	_____
Muscle weakness	Or size	_____	_____	_____

	YES	NO	COMMENTS
<b>GENITOURINARY (Kidneys):</b>			
Burning on urination	_____	_____	_____
Difficulty with urination	_____	_____	_____
Frequent urination	_____	_____	_____
Brown, Black, bloody urine	_____	_____	_____
Testicles – painful or Lumps	_____	_____	_____
Kidney Stones	_____	_____	_____

<b>NEUROLOGICAL (Brain, Nerves):</b>			
Fainting	_____	_____	_____
Seizures	_____	_____	_____
Dizziness	_____	_____	_____
Numbness	_____	_____	_____
Tremors	_____	_____	_____
Depression	_____	_____	_____
Anxiety	_____	_____	_____
Work or family problems	_____	_____	_____
Considered suicide	_____	_____	_____
Considered or desired Psychiatric help	_____	_____	_____

	YES	NO	COMMENTS
<b>WOMEN (Gynecological History):</b>			
Date of last menstrual period	_____	_____	_____
Date of last pap smear	_____	_____	_____
Menstrual trouble	_____	_____	_____
Lumps in breast	_____	_____	_____
Vaginal discharge	_____	_____	_____
Number of pregnancies	_____	_____	_____
Number of deliveries	_____	_____	_____
Number of miscarriages	_____	_____	_____
Complications of Pregnancy	_____	_____	_____
Have you had an Abortion	_____	_____	_____
<b>CARDIOVASCULAR (Heart): Have you ever been told that you have any of the following illnesses?</b>			
Heart disease	_____	_____	_____
Heart attack	_____	_____	_____
Angina	_____	_____	_____
Heart failure	_____	_____	_____
Aneurysm	_____	_____	_____
High blood pressure	_____	_____	_____
High cholesterol	_____	_____	_____
Leg cramps while walking	_____	_____	_____
Palpitations	_____	_____	_____
Leg or ankle swelling	_____	_____	_____