NORWOOD Clinic

New Patient Intake Form

Please complete the below information, to the best of your knowledge, and bring this form to your appointment.

NAME: _____ **BIRTHDATE**_____

LOCAL PHARMACY

NAME/ADDRESS: _____

PHARMACY PHONE # (____) _____ FAX# (____) _____

MAIL ORDER PHARMACY

NAME/CITY/STATE: _____

PHARMACY PHONE # (____) _____ FAX# (____) _____

PLEASE CIRCLE ANY ILLINESSES YOU HAVE HAD:

Anxiety	Gonorrhea	Jaundice	Osteoporosis
Asthma	Gout	Kidney Disease	Rheumatic Fever
Bleeding Tendency	Heart Disease	Kidney Stones	Rheumatoid Arthritis
High Cholesterol	Heart Failure	Liver Disease	Seizures
Degenerative Arthritis	Hepatitis	Lung Disease	Syphilis
Depression	High Blood Pressure	Migraine Headache	Tuberculosis
Glaucoma	HIV/AIDS	Neuropathy	Vein Trouble

DIABETES (if yes, how long & **TYPE**) _____ CANCER (if yes, where) _____

OTHER ILLINESSES: _____

PREVIOUS SURGERY/INJURIES (and date):_____

Did you have any problems with anesthesia? _____

Did you have any surgical complications? _____

DRUG ALLERGIES □ None: _____

FAMILY HISTORY:

Father: Alive? Y or N Illnesses: _____Age at death_____ Cause_____

Mother: Alive? Y or N Illnesses: _____Age at death_____ Cause_____

Number of Siblings/Health Issues: _____

Number of Children/Health Issues: _____

Other Relatives Health Issues: _____

SOCIAL HISTORY: □ Single □ Married □ Divorced □ Widowed Living with: _____

Smoking: □ No □ Yes Packs a day____ How long ____ Circle Type: (pipe, cigar, cigarettes, chew)
Recently quit _____ Wants to quit_____

Alcohol: □ No □ Yes Drinks/day average_____ Circle Type: (beer, wine, liquor)

Substance abuse: □ Y or □ N; List type of drug(s) used: _____

Occupation: _____

Caffeine: □ Y or □ N Drinks/day average_____ Circle Type: (tea, coffee, sodas, medicine, foods)

Hobbies: _____

Diet: □ Y or □ N If yes, Circle Method of Diet: Low Carb, Low Calorie, Low Fat, Vegetarian, Other: _____

Exercise: □ Y or □ N Frequency _____ Duration _____ Type_____

MEDICATIONS:

NAME/DOSE/HOW IT'S TAKEN	NAME/DOSE/HOW IT'S TAKEN
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

HEALTH MAINTENANCE: (enter date of your last exam/study)

Assisted Device: (Please circle one) None Walker Power Scooter Manual Wheelchair Power Wheelchair

Bone Density: Date_____ Findings: _____ Performed by_____

Colonoscopy: Date_____ Findings: _____ Performed by_____

Eye Exam: Date_____ Findings: _____ Performed by_____

Diabetic Foot Exam: Date_____ Findings: _____ Performed by_____

Mammogram: Date_____ Findings: _____ Performed by_____

OBGYN care (Pap smear) Date: _____ Findings: _____ Performed by_____

PSA (men): Date_____ Findings: _____ Performed by_____

Other Physicians seeing you currently: _____ _____

_____ _____

_____

HOSPITALIZATIONS THIS YEAR (list reason/date):_____

IMMUNIZATIONS AND DATES:

Gardasil_____ Hepatitis B_____ Influenza_____ Pneumovax_____ Measles_____

Meningococcal_____ Rubella_____ Tetanus_____ Shingles_____ Prevnar 13 _____

REVIEW OF SYSTEMS:

CONSTITUTIONAL:	□ fevers/chills, □ night-sweats, □ anorexia, □ weight loss
EYES:	□ Blurry vision
EARS, NOSE, MOUTH & THROAT:	□ decreased hearing, □ runny nose, □ mouth sores, □ sore throat
CARDIOVASCULAR:	□ chest pain, □ palpitations, □ decreased exercise tolerance
RESPIRATORY:	□ cough, □ shortness of breath
GASTROINTESTINAL:	□ nausea/vomiting, □ difficulty swallowing, □ heartburn, □ diarrhea □ Constipation, □ blood in stool, □ hemorrhoid problems, □ abdominal pain
MUSCULOSKELETAL:	□ joint pain/swelling, □ weakness
DERMATOLOGIC:	□ rashes, □ suspicious skin lesions

Patient Signature: _____ Date: ____/____/____

NORWOOD Clinic

Patient Portal Registration and Referral Questionnaire

Norwood Clinic is proud to announce an online tool that will allow you to access your healthcare information easily and securely.

You may access the following:

- Schedule an appointment
- Check lab results
- Pay your bill
- Ask the billing department question(s)
- Update your information

Please complete the below information:

Patient Name: _____ Birthday: _____

Email Address: _____

Would you like to receive electronic billing statements? ☐ Yes ☐ No

Referral Information

How did you hear about Norwood Clinic? (Another patient, friend of the patient, relative, dental office, yellow pages, newspaper, school, work, mail out, billboard, radio commercial, etc.)

_____

Signature: _____ Date: _____

FOR STAFF USE ONLY-MUST BE COMPLETED

☐ **Linked** ☐ **Not linked**

Enrollment Completed by: _____

Date: _____

NORWOOD Clinic

Acknowledgement of Receipt of Notice of Privacy Practices with Restrictions

Patient Name: _____ Patient Date of Birth: _____

I have been presented with a copy of Norwood Clinic, Inc.'s ("Norwood") Notice of Privacy Practices, detailing how the above-named patient's information may be used and disclosed as permitted under federal and state law.

In the event of a medical emergency or if I am otherwise unavailable, I hereby allow Norwood to discuss billing, appointments, treatment, diagnosis, test results, and other protected health information regarding the above-named patient with the following persons who are involved with the patient's health care and/or payment related to the patient's health care:

Name	Relationship	Contact #

Contact Methods:

May we leave information on your answering machine at home?	Yes	No
May we leave information on your voicemail at work?	Yes	No
May we leave information on your cell phone?	Yes	No

I understand the contents of the Notice of Privacy Practices, and I request the following restriction(s) concerning the use and/or disclosure of my personal medical information (*include type of information covered and the parties who should not receive the information*):

_____

_____

_____

I understand that Norwood will carefully consider my request, but is not obligated to accept the request unless the request is to restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations and the information pertains solely to a health care item or service for which Norwood has been paid in full other than by the health plan.

The request stated herein □ **does or** □ **does not** restrict the disclosure of information to a health plan for purposes of carrying out payment or other health care operations with the information pertaining solely to a health care item or service for which Norwood has been paid in full other than by the health plan.

My signature below is acknowledgement that I have received a copy of Norwood's Notice of Privacy Practices and that I agree to the conditions stated in the Notice of Privacy Practices and contained in this form.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient

_____

Printed Name of Parent/Patient's Representative (If Applicable)

_____

Signature of Parent/Patient's Representative (If Applicable)

NORWOOD Clinic

E-PRESCRIBE CONSENT FORM

E-Prescribe is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications that the patient is already taking to minimize the number of adverse drug interactions.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled. It also allows the physician to be notified when the patient needs a refill of their medications.

☐ **I DO want to participate.**

By signing this consent, you are agreeing to allow Norwood Clinic, Inc. to request and use your prescription medication history from other healthcare providers and/or third party benefit payers for treatment purposes. Understanding all of the above, I hereby give informed consent to Norwood Clinic, Inc. to enroll me in the **E-Prescribe program**.

_____

Pharmacy Name City Phone Number

☐ **I do NOT want to participate.**

I do hereby decline enrollment in the E-Prescribe program. If I decide at a later time that I want to participate, then it is my responsibility to inform my physician and his/her staff.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature of Patient or Guardian Date Signed

Patient Name: _____ DOB: _____ Pt. ID#: _____

STATEMENT/ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY:

We appreciate you choosing us as your healthcare provider. Payment for services rendered is considered part of your overall treatment. Thus, your understanding of the following financial policies is important to our professional relationship.

Private Insurance Benefits and Coverage Disclosures

As a courtesy, Norwood Clinic, Inc. ("Norwood") will assist in filing insurance claims as appropriate, but this in no way guarantees that any benefits will be paid by the patient's insurance company. Your insurance benefit is a contract between you and your insurance company. You are responsible for notifying Norwood of any insurance coverage and any changes in your insurance coverage. Norwood will assist with, but is not responsible for, obtaining any needed insurance referral(s) or prior authorization(s). Required insurance referral(s) or prior authorization(s) are ultimately the responsibility of the patient. All efforts relating to the collection of the patient's insurance benefits are for the patient's convenience and do not represent a guarantee of collection or a credit to the patient's account until such time as payment is received by Norwood.

The patient's insurance plan's eligible charges or maximum allowed amount(s) are the most the patient's insurance company is required to pay under the terms of the patient's insurance plan. These eligible charges or maximum allowed amounts are determined by the patient's specific insurance plan. Under many insurance plans, Norwood is a non-contracted provider and may not have information about the patient's insurance plan's eligible charges or maximum allowed amount(s) until after a claim has been processed. As a non-contracted provider, Norwood may bill the patient or his or her parent, guardian, or personal representative for any fees relating to care received at Norwood that are not paid by the patient's insurance company even when the patient's insurance carrier has paid the plan's eligible charges or maximum amount(s) for those services.

If the patient no longer meets the plan's qualifications or if the criteria of the plan's benefit guidelines are not met (including but not limited to, referral or prior authorization procedures, benefit exclusion and/or eligibility, etc.), the patient or his or her parent, guardian, or personal representative will be responsible for payment of all non-covered claim charges relating to the care provided by Norwood. If the patient is not able to provide proof of insurance at the time of appointment or if insurance is not able to be verified, the patient or his or her parent, guardian, or personal representative will be responsible for payment.

All services provided must be paid for, regardless of whether the patient's insurance company covers those services. The patient or his or her parent, guardian, or personal representative is ultimately financially responsible for all charges not covered by insurance payments.

Private Pay/Self-Pay Patients

If the patient does not have insurance coverage of any kind, the patient or his or her parent, guardian, or personal representative will solely be responsible for payment of all charges relating to the care provided by Norwood.

Payment Due Dates and Policies

Regardless of whether or not the patient has insurance coverage, the patient or his or her parent, guardian, or personal representative is ultimately responsible for payment for services rendered by Norwood. It is the policy of Norwood to collect payment at the time the service is rendered, including co-pays, deductibles, payments for non-covered services, and payments by private pay patients. In addition, for patients having an outstanding balance at the time of an appointment, payment of the outstanding balance is due prior to any additional services being rendered. Payment may be made by cash, check, or credit/debit card.

If the patient or his or her parent, guardian, or personal representative is unable to pay the amount due in full at the time of the appointment, the following procedures shall apply:

- Norwood will accept payment of one-third (1/3) of the amount due at the time of the appointment. An additional one-third (1/3) is due thirty (30) days later, and the final one-third is due thirty (30) days after that.

- If the patient is unable to pay one-third (1/3) of the amount due at the time of the appointment, established patients may be allowed to enter into a payment plan agreed to by Norwood.

- If the patient is unable to pay any of the amount due at the time of the appointment, in non-emergent situations, the patient will be asked to reschedule their appointment for a later date when payment can be made.

In the event a filed insurance claim has not been paid within a reasonable amount of time, the patient or his or her parent, guardian, or personal representative will be billed and responsible for payment. If Norwood later receives payment from the insurance company, the refund procedures discussed below will apply.

Any amounts due that are not paid timely may be turned over to an attorney or collection agency. The patient or his or her parent, guardian, or personal representative is responsible for all collection and attorney fees, as well as finance or interest charges, associated with such accounts.

Norwood reserves the right to impose a charge for all returned checks. Norwood reserves the right to impose finance charges on overdue balances. In the event that a check is returned making an account balance overdue, both a returned check charge and finance charge may apply.

In the event the patient or his or her parent, guardian, or personal representative has overpaid on an account, any credit balance will be applied towards an outstanding balance. In the event the patient does not have an outstanding balance, a refund will be made in accordance with Norwood's refund policies.

Acknowledgement

By signing below, I acknowledge the following:

- I have read and understand the information contained in this Statement/Acknowledgment of Financial Responsibility.

- I was provided with the opportunity to ask questions about the information contained herein. Any questions asked have been answered to my satisfaction.
- I understand that I am financially responsible for all charges for services rendered that are not covered by insurance.
- The decision to receive care from Norwood was voluntary.

Patient Signature	Printed Name	Date
Parent/Guardian/Personal Representative Signature (If applicable)	Printed Name	Date

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Printed Name of Parent/Patient's Representative (If Applicable)

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Signature of Parent/Patient's Representative (If Applicable)