

**OFFICE POLICIES**

**MAINTENANCE MEDICATIONS:** Any maintenance medications for Diabetes, Hypertension, Cholesterol, Thyroid, or Depression/Anxiety, once your dosage has been set, you will need to be seen every 6 months for a follow up and fasting blood work. Please schedule your appointment at least 1 week before you run out of your medication to allow time for lab-work to return. Refills will not be given without a 6-month re-check. If you were just started on a medication you will need to follow up every 3 months until dosage is established then every 6 months.

\*\*\*Please allow 24 to 48 hours for a call back on any messages.\*\*\*

**ANY WEIGHT MANAGEMENT MEDICATIONS:** To get a medication refill you must be seen every month. This is to verify that the medication is working and that you are losing weight. Refills will not be called in without a re-check visit. Please verify with your insurance if weight management is covered, some policies do NOT cover weight loss visits.

**ADD/ADHD MEDICATIONS:** Patients must be seen every 3 months after establishing medication and dosage. Refills will not be given without a follow-up visit. If you are on a schedule 2 medication and it was to get lost or stolen these are also not replaced without a follow-up visit and proper documentation. Drug screen monitoring is required for new patients and at provider discretion. Please verify coverage with your insurance, these visits are often denied to behavior health.

**PAIN MEDICATION:** Refills are not given on any pain medications. You must be seen each time a pain medication is needed. Our providers will not do long-term pain management.

**PRIOR AUTHORIZATIONS:** Contact your insurance and find out if there are alternative medications that are covered/preferred. After contacting your insurance and getting the alternative medications call the office and let them know if you have previously taken any of these medications and if there were any side effects. If the office has to do a PA for your medication there will be a \$25 charge.

**FORMS:** Any forms or paperwork completed by the office will be charged an administrative fee for completing. Turn around time for completion is 3-5 business days. FMLA \$25, Immunization forms \$10, Patient letters \$10

**CANCELLATION POLICY:** A cancellation fee will be charged for any “no show” or cancellations that are less than 24 hours from appointment. Cancellation fee is \$25 for regular appointment, \$50 for physical or procedure.

**INSURANCE POLICY:** Current insurance card must be provided at every visit along with all necessary information needed to file and verify. A picture ID is required to file insurance. It is the patients responsibility to know plan limitations and benefits, as well as to verify network eligibility.

**PAYMENT POLICY:** Payment is due at time of service. All co-pays/deductibles and out of pocket are collected at your visit.

I, \_\_\_\_\_, acknowledge that I have received a copy of Physicians Pointe office policy.  
Patient Name

\_\_\_\_\_  
Patient Signature

**Insurance Waiver for Behavioral Health**

In order to accommodate the needs and requests of our patients, we have enrolled in numerous insurance plans. While we are please to be able to provide this service, it is extremely difficult for us to keep track of the many individual requirements from each company, as each one has different stipulations regarding how, when, and where services may be performed.

It is the responsibility of the patient/policy holder to make sure your particular policy covers any services that you are being seen for.

In the event that your insurance company denies a service as Behavioral Health, since we are a Primary Care Office and are unable to file services under Behavioral Health, we will have no choice but to bill you directly and expect payment for all charges related to your visit.

I have read and understand the office policy stated above and agree to accept responsibility as described above.

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Signature of Patient/Guardian \_\_\_\_\_

Date \_\_\_\_\_

**Behavioral Health Services could include any of the following:**

ADD/ADHD

DEPRESSION

ANXIETY

OBESITY/WEIGHT MANAGEMENT

EATING DISORDER

INSOMNIA

# Physicians Pointe

Family Medicine, Minor Emergencies, Aesthetics

Norvin Ona, D.O.

## PATIENT INFORMATION

(Please Print)

Today's Date \_\_\_/\_\_\_/\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Email address: \_\_\_\_\_ Can we contact you by email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

## PARENT/GUARDIAN (for minors)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_

## INSURANCE

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Policy Holder name: (if different from patient) \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Policy Holder SS#: \_\_\_\_\_

Relationship of patient to the Insured \_\_\_\_\_

**\*\*In case of Emergency** \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

I authorize the release of medical information to referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

**\*\*Patient/Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event that your account must be turned over to collections, a \$50.00 collection fee (or 35% whichever is greater) will be added to your Account, as well as you will be responsible for any and all attorney fees and court costs. Your signature below signifies your understanding and willingness to comply with this policy.

**\*\*Patient/Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_

**PHYSICIANS POINTE  
RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_ have been informed that a copy of PHYSICIANS POINTE Notice of  
Patient's Name

Privacy Practices is available in the office. A copy will be furnished to me upon my request.

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

It is our policy not to leave confidential and/or unauthorized information on answering machines, work voicemail and/or cell phone voicemail. ***However with your permission we will leave a message for a normal test result.*** Whenever returning phone calls and the answering machine picks up, we will leave a message asking you to call our office back. Information will also not be left with an unauthorized person who may answer the telephone.

**I authorize PHYSICIANS POINTE to contact me at the following places:**

Home telephone: Yes \_\_\_\_\_ No \_\_\_\_\_ Answering Machine: Yes \_\_\_\_\_ No \_\_\_\_\_

Cell phone/voice mail: Yes \_\_\_\_\_ No \_\_\_\_\_ Cell phone # \_\_\_\_\_

Work telephone: Yes \_\_\_\_\_ No \_\_\_\_\_ Work #: \_\_\_\_\_

E-Mail: yes \_\_\_\_\_ No \_\_\_\_\_ Email Address: \_\_\_\_\_

**Please list names of people with whom we may discuss your medical care:**

Name/Relation: \_\_\_\_\_ Phone # \_\_\_\_\_

Name/Relation: \_\_\_\_\_ Phone # \_\_\_\_\_

Name/Relation: \_\_\_\_\_ Phone # \_\_\_\_\_

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## PATIENT'S SOCIAL HISTORY

Date: \_\_\_/\_\_\_/\_\_\_

Name: \_\_\_\_\_ D.O.B \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ OK to e-mail: Yes No

Ethnicity (Circle One) Non-Hispanic or Latino Hispanic or Latino: Specify \_\_\_\_\_

Race (Circle One) White American Indian Asian African American Other

Primary Language: \_\_\_\_\_ Additional Languages: \_\_\_\_\_

Yes No- - - -Current smoker Pack per day: \_\_\_\_\_ # Years smoked: \_\_\_\_\_

Yes No- - - -Former smoker Pack per day: \_\_\_\_\_ # Years smoked: \_\_\_\_\_ Quit Date/Year: \_\_\_\_\_

Yes No- - - -Never smoked

Yes No- - - -Alcohol use

## IN YOUR (THE PATIENT'S) PAST MEDICAL HISTORY HAS THERE BEEN:

Yes No- - - -Cancer, if yes, please specify: \_\_\_\_\_

Yes No- - - -Colonoscopy, Month \_\_\_/\_\_\_ Yr, Normal \_\_\_ Abnormal \_\_\_ Facility \_\_\_\_\_

Yes No- - - -Cologuard; Month \_\_\_/\_\_\_ Yr, Normal \_\_\_ Abnormal \_\_\_

Yes No- - - -COPD

Yes No- - - -Depression

Yes No- - - -Diabetes, How many times a day do you check your blood sugar? \_\_\_\_\_

Date of diabetic Foot Exam: \_\_\_\_\_ Date of diabetic Eye Exam: \_\_\_\_\_

Yes No- - - -Heart attack

Yes No- - - -Heart disease (CAD)

Yes No- - - -Heart murmur

Yes No- - - -High blood pressure

Yes No- - - -High cholesterol

Yes No- - - -Mammography, Month \_\_\_/\_\_\_ Yr, Normal \_\_\_ Abnormal \_\_\_ Facility \_\_\_\_\_

Yes No- - - -PAP Smear, Month \_\_\_/\_\_\_ Yr, Normal \_\_\_ Abnormal \_\_\_ Facility \_\_\_\_\_

Yes No- - - -Pneumonia Vaccine, Date/Year: \_\_\_\_\_

Yes No- - - -Prostate exam

Yes No- - - -Sexually transmitted disease, type: \_\_\_\_\_

Yes No- - - -LAST Bone Density: Month \_\_\_/\_\_\_ Yr., Normal \_\_\_ Abnormal \_\_\_ Facility \_\_\_\_\_

Yes No- - - -Surgeries-Date/Year: \_\_\_\_\_

Other past medical history not listed above: \_\_\_\_\_

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Name: \_\_\_\_\_ D.O.B \_\_\_\_\_

## HAS THERE EVER BEEN A **FAMILY HISTORY** OF:

- Cancer of the breast      Family member: \_\_\_\_\_
- Cancer of the colon      Family member: \_\_\_\_\_
- Cancer of the ovaries      Family member: \_\_\_\_\_
- Cancer of the prostate      Family member: \_\_\_\_\_
- Cancer of the uterus      Family member: \_\_\_\_\_
- Cancer, other unspecified      Family member: \_\_\_\_\_
- Colon polyps      Family member: \_\_\_\_\_
- Depression      Family member: \_\_\_\_\_

Other past medical history not listed above: \_\_\_\_\_

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## WOMEN ONLY-Menstrual History

Age at onset \_\_\_\_\_

Regular?      Yes      No      Varies

Number of days of cycle \_\_\_\_\_

Flow:    Heavy      Medium      Light

Date of last period \_\_\_\_\_

Do you take birth control pills?    Yes      No

If so, how long have you taken them? \_\_\_\_\_

## Pregnancies:

How many children born alive \_\_\_\_\_

How many stillbirths \_\_\_\_\_

How many premature births \_\_\_\_\_

How many Cesarean Sections \_\_\_\_\_

How many miscarriages \_\_\_\_\_

Any complications with pregnancy?    Yes      No

If so, describe \_\_\_\_\_