# Mountain Laurel Family Practice

**Please complete all sections in legible print**

Personal Information

Name- Last_____First_____MI_____

Date of Birth_____Gender_____Martial Status_____

Address_____City_____State/Zip_____

Phone-Home_____Work_____Mobile_____

Email_____SS#_____

**Insurance Information** - Please provide your insurance card - the accuracy of information will insure that your claims are filed correctly.

Ethnicity/Race (Please check one)

☐ American Indian or Alaska Native
☐ Asian
☐ Black of African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ I do not wish to specify my race

Preferred Language_____

Preferred Method of Contact_____
(Home, Work, Cell, Email, Other)

**Individual Medical Release** – Please list all individuals that we are authorized to provide information to. This release will authorize us to provide medical information, billing information, etc with all individuals listed below. Any change in the authorization must be made to MLFP staff.
**Please designate at least one of the below as your Emergency Contact (by placing a ✓)**

Name/Relationship/Phone#_____

Name/Relationship/Phone#_____

Name/Relationship/Phone#_____

Name/Relationship/Phone#_____

**I give consent for MLFP to send text and voice reminders for appointments** _____

# Mountain Laurel Family Practice

## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Mountain Laurel Family Practice (MLFP) to use and disclose my Protected Health Information (PHI) to carry out treatment, payment and health care operations. The Notice of Privacy Practices (NOPP) describes such uses and disclosures more completely and is available on request.

I have the right to review the Notice of Privacy Practices prior to signing this consent. MLFP reserves the right to revise it NOPP at any time. A revised NOPP may be obtained by forwarding a written request to Mona McClure at MLFP.

With this consent MLFP may call or text any provided numbers and leave a message on voicemail or in person in reference to any items that assist MLFP in carrying out treatment, payment and health care operations, such as appointment reminders, insurance issues, laboratory/test results, etc. MLFP may also e-mail or mail through postal service any items that assist in treatment, payment and health care operations.

I have the right to request that MLFP restrict how it uses or discloses my PHI. MLFP is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow MLFP to use and disclose my PHI to carry out treatment, payment and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, MLFP may decline to provide treatment to me.

## Medical Benefits Authorization

By signing below I authorize payment of medical benefits to MLFP and/or its provider for all services provided. I authorize the release of any medical or other information necessary to process my claim. I also request payment of government benefits to myself or to the party who accepts assignment.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name of Patient Legal Guardian, if applicable

On the day of your office visit MLFP office policies 8/2015

1- please arrive 15 minutes prior to visit so that you are ready for your appointment time

2- please bring a current medication list or your medication bottles to each visit

3- bring current insurance card and co-payment to every visit

4- for cash paying patients- be prepared to pay on the day of your visit or make arrangements BEFORE you are seen

Between office visits

5- Refills are issued during visits and it is YOUR responsibility to follow up before you are out of medications.

- We will charge a $10 refill fee if you need refills and are overdue for follow up.

6- Controlled medications are only filled at office visits and will not be issued unless seen

7- Antibiotics will not be issued over the phone-unless recently seen for a related issue.

Expectations

8- All patients are allowed ONE no show appointment and if a second occurs we will not be able to see you as a patient in the future

- All patients are charged $25 for this "one time" no show appointment.

9- We request a 24 hour notice on cancellations, so that we may give someone else the opportunity to be seen

These updated policies were created with the intent to improve our time management and to give us more time with our patients face to face

Please let us know if you have any questions

_____ pt sig _____ witness _____ date

*Mountain Laurel Family Practice*
Patient Health History

Name: _____ Date: _____

Date of birth: _____

**Past Medical History**

Previous surgeries (list type and date/year of surgical procedures; approximate dates are acceptable):

_____

_____

_____

_____

Past hospitalizations (list date and reason for hospitalization):

_____

_____

_____

_____

Specialist care in the last 5 years (list provider's name and reason for care):

_____

_____

_____

Diagnostic testing (list previous x-rays, MRI, and CT scans and the reason that they were performed):

_____

_____

_____

Ongoing health issues (conditions for which you have been treated > 3 months):

_____

_____

Medication Allergies (include medication and type of adverse reaction):

_____

_____

Current medications (include all prescription, over-the-counter medications, vitamins, and supplements):

_____

_____

_____

_____

Family History

Limit history to parents, grandparents, siblings, and children; list who had each condition, if relevant.

High blood pressure: _____

Diabetes: _____

Cancer (include type): _____

Stroke: _____

Heart attack/cardiovascular disease: _____

Depression/anxiety/mental illness: _____

Asthma/allergies: _____

Preventative Healthcare

Last wellness exam/physical: _____

Lab work: _____

Eye exam: _____

Dental exam: _____

Mammogram: _____

Pap smear: _____

Bone density (DEXA scan): _____

Colonoscopy: _____

Foot exam (if diabetic): _____

Social History (indicate type, amount, and duration of use)

Tobacco (oral and/or cigarettes/cigars): _____

Alcohol: _____

Street/elicit drugs: _____

Caffeine: _____

Wellness

Exercise (number of days/week and type of exercise): _____

_____

Diet (dietary restrictions or specific diet followed): _____

_____

Flu vaccine: _____

Tetanus (TDAP vaccine): _____

Pneumonia vaccine: _____

Shingles (zoster) vaccine: _____

Other recent vaccinations received: _____

Employment (what do you do for a living?): _____

Who do you live with? _____

Are there any specific health concerns that you would like to address during your office visit today?

_____

_____

_____