# ESPOSITO MEDICAL ASSOCIATES

**New Patient Health Questionnaire**

599 N. Church Street Suite 200 and 505 N. Pittsburgh St
Mount Pleasant, PA 15666 Connellsville, PA 15425
(724) 542-5349 phone (724) 603-6200 phone
(724) 542-4658 fax (724) 626-4480 fax

Name: _____ DOB: _____
Address: _____ Home Phone: _____
Cell Phone: _____ Email: _____
Emergency Contact: (Name & Number) _____
Insurance: _____ ID# _____ Gr# _____

PREVIOUS PRIMARY CARE PHYSICIAN: _____ Date last seen: _____

What medical concerns bring you to our office? _____

Marital Status: _____ Who lives in your home with you? _____

Occupation: _____

Do you exercise routinely? _____ How often and what type? _____

Do you smoke? _____ Which type? Cigar, Pipe, Cigarettes, Vape, Chewing tobacco
How many a day? ____ # Years? _____ Have you quit? _____ When? _____

Do you drink alcohol? _____ How much? _____

Do you drink caffeine? _____ Specify coffee, soda, tea? _____ How many per day? ____

Do you have a Living Will or an Advanced Directive/Power of Attorney? _____

Any ALLERGIES? _____ Please list type of reaction: _____

**Medications**: Please list all prescription and over the counter medicines including herbal/natural including dose, and how often you take it

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Medical Illnesses or Conditions**: any chronic conditions you have been diagnosed to have

_____ _____ _____
_____ _____ _____
_____ _____ _____

**Operations:**

| Year: | Surgery: |
|---|---|
| ____ | _____ |
| ____ | _____ |
| ____ | _____ |
| ____ | _____ |

**Hospitalizations:**

| Year: | Reason Hospitalization |
|---|---|
| ____ | _____ |
| ____ | _____ |
| ____ | _____ |
| ____ | _____ |

Have **YOU** been diagnosed with any of the following? Yes or No

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Cataracts | | Heart Disease | | Ulcers | | Anemia | | Depression | |
| Glaucoma | | Heart Murmur | | Digestive | | Frequent Infection | | Cancer Type: | |
| Asthma | | High Blood Pressure | | TB/Lung Disease | | Jaundice | | Bleeding Disorder | |
| Stroke | | Pneumonia | | Bone or Joint Disease | | Prostate Enlargement | | High Cholesterol | |
| Seizure | | Pleurisy | | Jaundice | | Hemorrhoids | | Prostate Enlargement | |
| Heart Attack | | Syphilis | | Rheumatic Fever | | German Measles | | Kidney Stone | |
| Allergies | | Chicken Pox | | Diabetes | | Thyroid | | Covid-19 | |

**Family History**:

| | Age | Health / Illness | Age at Death | Cause of Death | Comments |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brothers/Sisters | | | | | |
| | | | | | |
| | | | | | |
| Spouse | | | | | |
| Children | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Has any **BLOOD RELATIVES** ever had? (If Yes, please indicate relationship)

| Y/N | | Relation | Y/N | | Relation | Y/N | | Relation |
|---|---|---|---|---|---|---|---|---|
| | Alzheimer's | | | Stroke | | | Alcoholism | |
| | Tuberculosis | | | Seizures | | | Allergies | |
| | Diabetes | | | Bleeding | | | Asthma | |
| | High Blood Pressure | | | Heart Attack before 55 | | | Mental Disorder | |
| | Heart Disease | | | Depression | | | Cancer/type? | |

Comments: _____

_____

_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

# Authorization and Consent to Treatment

## Assignment of Benefits and Authorization to Release Medical Information

I understand and agree that payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers will be made to me or on my behalf to the provider or supplier of any services furnished to me by that provider or supplier. I authorize any holder of my medical information to release it to Esposito Medical Associates (EMA), the Centers for Medicare & Medicaid Services (CMS), the listed insurer and/or agents of the company and/or the listed responsible person(s), and any information necessary to determine my benefits or the benefit for the related services. If my insurance plan does not participate in network, or if I am a self-pay patient, assignment of benefits may not apply.

## Guarantee of Payment & Pre-Certification

In consideration of services provided to me by EMA, I agree to be financially responsible and to pay charges for all services ordered by my provider(s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain consistent payments, my account will be referred to a collection agent and/or attorney and I agree to pay all collection related charges.

I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services rendered according to the plan's provisions. I understand that my failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

## Consent to Treatment

As an EMA patient, I voluntarily consent to the rendering of such care and treatment as the EMA providers and personnel, in their professional judgment, deem necessary for my health and well-being.

My consent shall include medical examination and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/removals and vaccine administration. My consent shall also include the carrying out of the orders of my treating provider by EMA staff. I acknowledge that neither my EMA provider nor any EMA staff has made any guarantee or promise as to the results that may be obtained.

## Consent to Call

I understand and agree that EMA may contact me using automated calls, emails, and text messaging sent to my landline and mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from EMA.

I understand that I may voluntarily "opt-in" to receive automated text message communications from EMA and its partners by informing my provider's staff or visiting "My Profile" on my Patient Portal, and agreeing to any additional Terms and Conditions established by my mobile carrier.

**I hereby acknowledge that I have received EMA's Financial Policy and Notice of Privacy Practices. I agree to the terms of EMA's Financial Policy, the sharing of my information via HIE, and consent to my treatment by EMA providers.**

Printed Name of Patient: _____ Date: _____

Signature: _____

*To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent*

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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE

I acknowledge that I received the Notice of Privacy for Esposito Medical Associates.

Please indicate each method of communication Esposito Medical Associates may use to contact you in regards to your health information and upcoming appointments.

- ☐ Messages may be left on my home answering machine
- ☐ Messages may be left on my work voicemail
- ☐ Messages may be left on my cellphone
- ☐ Information may be released only to me and not to be left by any electronic method.

Name of Patient: _____

Signature of Patient: _____ Date : _____

Personal representative information if applicable:

Name of personal representative _____

Relationship to patient _____

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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE of Privacy Practices

Esposito Medical Associates has a notice of Privacy Practices, which describes how we may use and disclose your protected health information. You may review our current notice prior to signing this acknowledgment.
I acknowledge that I have received the Notice of Privacy Practices for Esposito Medical Associates.

Name of Patient: _____ DOB: _____

Signature of Patient: _____ Date : _____

Please specify to whom other than yourself, we may release your protected health information (PHI)"

Spouse/Significant other: If yes/Name: _____

Children (over 18): If yes/Name: _____
If yes/Name: _____

Other: If yes/Name: _____

Are we permitted to leave normal test results on answering machine/voicemail?

□ Yes □ No

Below is for practice use only:
I have provided the above named patient/representative with the Notice of Privacy Practices for Esposito Medical Associates.

Staff Signature: _____ Date: _____

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# AGREEMENT TO PARTICIPATE
# SURESCRIPTS PHARMACY SERVICES

I, _____ DOB _____agree to the participation with Surescripts pharmacy services in providing and coordinating electronic prescription transmittal services between Esposito Medical Associates LTD and the pharmacy I select.

I understand the purpose of this agreement is to allow my physician to access my medication history through Surescripts. I understand this agreement will remain in effect for as long as I seek medical care with Esposito Medical Associates LTD, and it will terminate should I transfer my care, request termination of this agreement or after a period of three years without activity with this practice.

Signature of Patient: _____ Date : _____

Witness Signature: _____ Date: _____

# MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to ESPOSITO MEDICAL ASSOCIATES, LTD. When you schedule an appointment with us we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

*Effective January 1, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a NO SHOW and charged a $30.00 fee.

*Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice **a second time** will be charged a $55.00 fee.

*If a **third NO SHOW** or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from ESPOSITO MEDICAL ASSOCIATES, LTD.

*Any NEW PATIENT who fails to show for their initial appointment will not be rescheduled.

* The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**

*As a courtesy, when time allows, we make reminder phone calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office manager, who may waive the **NO SHOW FEE.** You may contact Esposito Medical Associates, LTD 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Saturday, or a weekend, you may leave a message.

**ESPOSITO MEDICAL ASSOCIATES, LTD 724-542-5349 or 724-603-6200**

**I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.**

**Signature(Parent/Legal Guardian)**_____

**Relationship to patient**_____

**Printed name**_____ **Date**_____

ESPOSITO MEDICAL ASSOCIATES
CORONA VIRUS SCREENING QUESTIONNAIRE

PATIENT NAME _____ DOB _____

Patient Temperature _____

1. In the last 14 days, have you traveled to any foreign country or outside our state? Or been exposed to anyone who has traveled? Or is under investigation by any health department for illness? If yes, which locations?_____

   □ YES □ NO

2. Do you have a fever or any respiratory illness (severe productive cough, shortness of breath, chest tightness, wheezing)?

   □ YES □ NO

3. Have you been diagnosed with Covid-19? □ YES □ NO
   If yes, when_____?

4. Have you been in contact with anybody who has been diagnosed with Covid-19 within the last 14 days?

   □ YES □ NO If yes, when_____?

Performed by: _____ Date: _____
Staff Signature

Revised 1/28/2021