BEWELLMY*FRIEND*, LLC

Integrative Health Center

12 Shuman Ave Ste 6 Augusta, ME 04330

Phone: (207) 307-0958 Fax: (207) 512-5909

Michael D. Dufresne, D.O.
Samuel Moss, D.O.
Jennifer Marlowe, MS. LCPC.CCS

Kevin R. Kenerson, D.O.
Brett Adell, LCSW
Elena Nechepurenko, PMH NP

Patient Information

Patient Name: Date of birth: Address: City:
State: Zip:

SSN: _____Sex:

Marital Status: _____ Home Phone:( ) _____ Cell Phone: **( ) _____**

Email Address: _____

If you **DO NOT** wish to receive text or email correspondence, please check. Cell _____ Email _____

Primary Care Physician: _____Referred by: _____

****PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE FRONT DESK****

Insurance Carrier: _____ Member ID: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Secondary Insurance: _____Member ID: _____

Is this a Worker's Compensation Case? Yes _____ No _____

If yes, please see the receptionist for additional documents.

Emergency Contact

Name: _____ Contact number: _____ Relationship: _____

Name: _____ Contact number: _____ Relationship: _____

Authorized People: (You give permission to discuss medical advice and call on your behalf)

Name: _____ Contact number: _____ Relationship: _____

Name: _____ Contact number: _____ Relationship: _____

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Insurance Referral Waiver

If you are here today to see someone other than Dr. Dufresne or Dr. Kenerson for primary care then your insurance will consider us specialists. Many insurance plans require a referral from your primary care physician to see specialists. It is your responsibility to check with your insurance company to see if a referral is needed. If a referral is needed, you are required to call your primary care physician with the date of your appointment in order to start the referral process. Failure to obtain a referral may result in denial of payment / claim by your insurance company.

Guarantee of Payment

The guarantor of each account is ultimately responsible for payment in full of the account. Current, accurate information regarding guarantor and insurance coverage must be provided to Be Well My Friend, LLC. I understand that I am responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities I have been advised that if my health insurance carrier HMO/Medicaid/Medicare plain claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services. I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize services I received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services. I authorize payment of benefits from my insurance carriers directly to Be Well My Friend, LLC. (If I have not checked this item, the benefit payments will be paid to me and I will be responsible for paying Be Well My Friend, LLC. I understand that it is at the judgment of Be Well My Friend, LLC to discontinue services if I repeatedly miss or cancel my appointments (with less than 24-hour notice).

Payment is required at the time of service. A $30.00 fee will be applied for returned checks. For your convenience we accept ALL credit cards.

Minor Patients Only: The parent, guardian or accompanying adult of the minor being treated is responsible for payment at the time of service.

FINANCIAL INFORMATION AUTHORIZATION AND RELEASE

The purpose of this Authorization and Release form is for your privacy and protection. This form gives permission for our practice to speak to selected individuals about your financial information, such as your account, bill and / or paying your bill.

If you DO NOT wish to authorize another individual, please sign the bottom of the form.

I authorize the staff of Be Well My Friend, LLC to release any FINANCIAL INFORMATION to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have read and understand my insurance & financial responsibilities as outline above.

Patient Signature: _____**Date**: _____

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Patient Health History

General Health Review

Medical History: (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, psychiatric illnesses, etc.) _____

_____

Surgical History & dates: _____

_____

Allergies: (include medications & food allergies) _____

_____

Intolerances: (include side effects from previous medications, such as gastritis, nausea, constipation, etc.) _____

_____

Current Medications List: (include vitamins & birth control pills if applicable) _____

_____

Do you have any of the following? (Circle all that apply)

Headaches Stomach Pain Chest Pain Nausea Vomiting Constipation Vision Problems

Shortness of Breath Urinary Problems Diarrhea Dizziness Chronic Fatigue Rashes

Difficulty Swallowing Swollen Joints Hearing Problems

Domestic Situation

Are there any substance abuse issues in your home? YES _____ NO _____ If yes, please explain:

_____

Are you able to take care of yourself? YES _____ NO _____ If not, please explain:

_____

With whom do you live? _____

Substance Use

Are you presently taking any drugs or using any substances listed below? (Circle all that apply)

Alcohol Barbiturates Cocaine Heroin Amphetamines Marijuana Other (specify)_____

Do you presently smoke cigarettes or use any tobacco? YES_____ NO _____ How many packs daily? _____

If no, did you ever smoke cigarettes or use any tobacco? YES ___NO _____For how many years _____

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Privacy Notice, Patient Rights & Consent to Treat

This notice describes how medical information about you may be used and disclosed, and how you can access this information. Please review it carefully.

Patient Consent to Treat

I consent to diagnostic procedures and medical care as necessary in the judgment of Be Well My Friend, LLC and their staff with regards to my overall health. I understand that my doctor will explain to me the purpose of the benefits, and the usual risks and hazards involved in the diagnosis and treatment of an illness or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests, or treatment. I acknowledge that no guarantees have been made to me as to the result of treatment or examination.

Practice Privacy Policy

At Be Well My Friend, LLC we are required by law to maintain the privacy of protected health information and your privacy is one of our top priorities. Our doctors and staff are bound to honor and respect the patient information entrusted to us. We must commit to protecting your privacy by abiding by the policies we have established.

Patient Health Care Information Use and Disclosure

Your protected health information will be used to treat you, to work with your insurance company for payment purposes, and to carry out healthcare operations. Healthcare operations may include uses and disclosures necessary to manage our practice and assure quality health care. I authorize Be Well My Friend, LLC Center and their staff to call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others). Such items may also be mailed to my home or other designated location. I also consent to allowing Be Well My Friend, LLC to use and disclose protected health information about me to carry out treatment, payment and healthcare operations as noted below.

Practice Duties- Regarding your Health Care Information

Be Well My Friend, LLC is required to provide patients with notice of its legal duties and privacy practices with respect to protected health information. Be Well My Friend, LLC is required to abide by the terms of the notice in effect. We reserve the right to change these policies and we must inform you of these changes. We will inform you of these changes when you arrive at our practice for treatment. If you have a concern about how your protected health information has been handled by our practice, the managing partner will review your complaint. There will be no retaliation against a patient for filing a complaint. You will receive written notification informing you of the action taken in response to your concern. If you feel your complaint is not resolved, you may file a complaint to the Secretary of Health and Human Services.

Patient Rights- Regarding your Health Care Information

The patient has the right to request that the practice restrict the use and disclosure of protected health information. Be Well My Friend, LLC is not required to agree to the requested restrictions. The patient has the right to receive confidential communications of protected health information. Generally, the patient has the right to inspect and request a copy of their protected health information (additional fees may apply). The patient has the right to request an amendment to the protected health information in the practice medical record. The patient has the right to receive a paper copy of this notice. By signing this notice, I am consenting Be Well My Friend, LLC to use and disclosure my protected health information to carry out treatment, payment and healthcare 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, Be Well My Friend, LLC may decline to provide treatment to me.

I have reviewed all the paperwork that has been handed to me (front and back), filled in the blanks and acknowledge that everything on each form is correct. If patient is under the age of 18, please have legal guardian/parent sign.

Signature_____ Date_____

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Authorization for Release of Protected Health Information (PHI)

Patient Name: _____ **Date of Birth:** _____ **Patient Address:** _____
_____

I hereby authorize (name of facility/provider **releasing** information) **to disclose the above-named individual's health information:**

Facility Name (releasing information): _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Facility Telephone Number: _____ **Facility Fax Number:** _____

Date(s) of Service Requested (if known) or Provider: _____

Description of Information to be released: (check all that apply)

___Progress notes ___Consultations ___Most recent history and physical

___Prescriptions List ___Laboratory reports ___Radiology films

___Radiology/Imaging reports ___Immunization record

___Two-way verbal exchange of communication ___Other_____

_X_ Entire medical record (to include all previous provider's records)

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This information may be disclosed <u>to</u> and used by the following individual or organization (receiving the information)

Facility Name (facility receiving information): BE WELL MY FRIEND LLC

Address: 12 Shuman Ave. Ste 6 City: Augusta State: ME Zip: 04330

Facility Telephone Number: (207) 307-0958 Facility Fax Number: (207) 512-5909

Description of the purpose of the use and/or disclosure: (check one)

___Continuing Care ___Second Opinion ___Emergency/acute care

___Consultation ___Legal purposes ___ Personal Use

_X__ Other: Transfer of medical care

I understand that this authorization is voluntary and I may refuse to sign this authorization. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. This authorization will expire by 12 months from the date of this authorization unless I otherwise specify.

I further understand that I may revoke this authorization at any time. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
(Printed name of Patient or Patient's Representative) (Relationship to Patient or Legal Authority)