



Adult Health History

PATIENT INFORMATION

Full Name: (include middle initial)	Date:
Date of Birth:	Age:
Address 1:	Social Security #:
Address 2:	Sex:
City:	Language:
State: Zip:	Employer:
Home phone:	Emergency Contact:
Work phone:	Emergency Phone:
Cell phone:	Emergency Relationship:

GUARANTOR INFORMATION (Person whom is financially responsible if not the patient.)

Name:	Date of Birth:
Address 1:	Social Security #:
Address 2:	Sex:
City:	Language:
State: Zip:	Employer:
Home phone:	Emergency Contact:
Work phone:	Emergency Phone:
Cell phone:	Emergency Relationship:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate #:	Certificate #:
Group #:	Group #:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Social Security #:	Social Security #:
DOB:	DOB:

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Pine Lake Health, LLC, when he/she accepts assignment.

Authorization to Release Medical Information: I hereby authorize my Provider, Pine Lake Health, LLC, to release any information necessary for my course of treatment.

Signed (patient or parent if minor)

Date

Name: _____ Sex: M F Date: _____

Age: _____ DOB: _____ Marital Status: S M D W Occupation: _____

Spouse's Name: _____ Occupation: _____

Children's Names and Ages: _____

Current Medical Problem: _____

Past or Present (*on going*) Medical Problems: _____

Surgeries & Dates: _____

Immunizations: (*give date of most recent immunization*)
Tetanus _____ Influenza _____ Pneumonia (pneumovax) _____ Shingles(Zostavax) _____

Current Medications:	Dosage:	How Often:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Any Allergies to Medications and/or Other Substances:
_____ Reaction: _____
_____ Reaction: _____

Family History: (*Indicate maternal or paternal relatives with any of the following problems*)
Heart Disease: _____
High Blood Pressure: _____
Diabetes: _____
Cancer: (Include type) _____
Other Inherited Diseases: _____
Emotional Problems: _____

Health Habits: (*Circle most appropriate and fill in blank*)
Tobacco Use: Never In The Past Now
Type of tobacco:: _____ How Much: _____ How Long: _____
Alcohol: Never Rarely Frequently How Much: _____
Street Drugs: Never Rarely Frequently What: _____
Exercise: Never Rarely Frequently How Often: _____
Seatbelt: Never Sometimes Always
Eating: Poorly Meets Needs Excessively
Caffeine: Never Sometimes Frequently How Much: _____

Approximate number of hours of sleep per night?: _____

Colonoscopy Date: _____

Mammogram Date: _____

Name: _____ Todays Date: _____

Have you had any of the following problems: (Include current and past problems) **Mark with X current symptoms, ✓ for past symptoms**

General	Current	Past		Skin	Current	Past
Weight Gain	_____	_____		Excessive Sweating	_____	_____
Weight Loss	_____	_____		Rash	_____	_____
Appetite Loss	_____	_____		Neck	Current	Past
Chills/Fever	_____	_____		Neck Pain	_____	_____
Fatigue	_____	_____		Neck Stiffness	_____	_____
Sleep Difficulties	_____	_____		Breast	Current	Past
Lymph Gland Swelling/Lumps	_____	_____		Breast Pain	_____	_____
HEENT	Current	Past		Nipple Discharge	_____	_____
Frequent Headaches	_____	_____		Breast Lump	_____	_____
Recent Changes in vision	_____	_____		Cardiovascular		
Glaucoma	_____	_____		Chest Pain	_____	_____
Cataract	_____	_____		Severe calf pain when walking	_____	_____
Hearing Loss	_____	_____		Shortness of Breath with exercise	_____	_____
Ringing in the Ears	_____	_____		Irregular Heartbeat	_____	_____
Frequent Nosebleeds	_____	_____		High Blood Pressure	_____	_____
Persistent Hoarseness	_____	_____		Palpitations/Heart Racing	_____	_____
Difficulty Swallowing	_____	_____		Waking at night due to	_____	_____
Sore Throat	_____	_____		Shortness of Breath	_____	_____
Respiratory	Current	Past		Heart Attack	_____	_____
Frequent cough	_____	_____		History of Heart Failure	_____	_____
Snoring	_____	_____		Rheumatic Fever	_____	_____
Asthma	_____	_____		Heart Murmur	_____	_____
Emphysema	_____	_____		Gastrointestinal	Current	Past
Shortness of Breath	_____	_____		Hemorrhoids	_____	_____
Coughing up Blood	_____	_____		Frequent Abdominal Pain	_____	_____
Coughing up Phlegm	_____	_____		Black Tarry Stools	_____	_____
Tuberculosis	_____	_____		Recent Change in Bowel Habits	_____	_____
Recurrent Pneumonia	_____	_____		Constipation	_____	_____
Recurrent Bronchitis	_____	_____		Diarrhea	_____	_____
Genitourinary	Current	Past		Vomiting Blood	_____	_____
Blood in Urine	_____	_____		Indigestion/Heartburn	_____	_____
Difficulty Starting Urine	_____	_____		Nausea	_____	_____
Burning with Urination	_____	_____		Rectal Bleeding/Bloody Stool	_____	_____
Urinary Frequency	_____	_____		Vomiting	_____	_____
Urinary Incontinence	_____	_____		Hepatitis/Liver Problems	_____	_____
Slow Urine Flow	_____	_____		Gallbladder Problems	_____	_____
Bladder Infections	_____	_____		Ulcers	_____	_____
Kidney Infections	_____	_____		Musculoskeletal	Current	Past
Kidney Stones	_____	_____		Painful/Swollen Joints	_____	_____
Venereal Disease	_____	_____		Persistent Back or Neck Pain	_____	_____
<i>Men</i>				Decreased Range of Motion	_____	_____
Prostate Problems	_____	_____		Muscle Pain	_____	_____
Discharge from Penis	_____	_____		Neurological	Current	Past
Lump in Testicles	_____	_____		Numbness in Face, Arms, Legs	_____	_____
<i>Women</i>				Fainting/Loss of Consciousness	_____	_____
Vaginal Discharge	_____	_____		Seizures or Epilepsy	_____	_____
Irregular Periods	_____	_____		Previous Stroke	_____	_____
Painful Periods	_____	_____		Weakness in Face, Arms, Legs	_____	_____
Pain with intercourse	_____	_____		Psychological	Current	Past
Abnormal Vaginal Bleeding	_____	_____		Frequent Anxiety	_____	_____
Abnormal PAP Test	_____	_____		Depression	_____	_____
Date of last PAP _____/_____/_____				Loss of Interest in Usual Activities	_____	_____
Age of Onset of Periods: _____				Recent Thoughts of Suicide	_____	_____
Total # of days in Cycle: _____ Days of Flow: _____				Suicide Attempt	_____	_____
Number of Pregnancies _____ Number of Children _____				Hematology	Current	Past
Method of Birth Control: _____				Abnormal Bleeding	_____	_____
Endocrine	Current	Past		Anemia	_____	_____
Thyroid problems	_____	_____		Blood Clots	_____	_____
Excessive thirst or urination	_____	_____				
Diabetes/High Blood Sugar	_____	_____				

Pine Lake Health, LLC & Waverly Health Care
Patient Information
(Please Print)

Patient Name: _____

DOB: _____

Receipt of Notice of Privacy Practice

_____ I have been offered or received a copy of Pine Lake Health, LLC's Notice of Privacy Practices.
Initial

Message Authorization

Representatives of Pine Lake Health, LLC are allowed to leave any and all information regarding my status as a patient on my voice mail, answering machine, or email. I realize this information may include pertinent health status and/or financial information.

DO NOT leave a message *(Check box if applicable)*

Authorization to Communicate Personal Health Information:

Pine Lake Health, LLC may communicate information to the following people regarding my health status as needed:

Name _____ Phone Number _____ Relationship _____

Name _____ Phone Number _____ Relationship _____

Patient Authorized Signature

Relationship to patient

Date

For MEDICARE Patients ONLY

MEDICARE Authorization

I request that payment of authorized MEDICARE benefits be made either to me, or, on my behalf, to Pine Lake Health, LLC for any services furnished to me by its physician. I authorize my holder of medical information to release to the Centers for MEDICAID and MEDICARE Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Secondary Insurance Benefits Authorization

I hereby authorize payment of my Medigap and/or Secondary Insurance benefits to Pine Lake Health, LLC for all claims filed on my behalf. This authorization applies to all services until my representative or I revoke it.

Patient Authorized Signature

Relationship to patient

Date

Pine Lake Health, LLC & Waverly Health Care Financial Policy and Patient Responsibilities

Thank you for choosing Pine Lake Health, LLC as your primary health care provider. We are committed to assisting you with timely insurance filing and payment of your account. The following is a statement of our Financial Policy, which we require you to read and sign prior to initial visit.

Pine Lake Health, LLC is committed to providing the best treatment possible for our patients. Patients are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Our practice participates with many insurance plans and a current listing is available at each location and on our website www.pinelakehealth.com. If your insurance plan does not cover our services, payment in full is expected at the time of your visit. We accept cash, checks, MasterCard, Visa, Discover, and debit cards.

Updated insurance information must be given to us at the time of service. We will require a copy of your insurance cards before services are performed and these will be scanned into our system. We file all insurance claims in a timely manner. After filing, we allow 30 business days for your insurance company to pay. If your insurance company fails to make payment, you will be responsible for payment in full.

If the patient is a minor, the adult accompanying the child for treatment will ultimately be responsible for payment. We cannot become involved in third party liabilities, personal injury, or custody issues to determine the responsible party for payment. We cannot accept an attorney's letter of payment guarantee. If you have a past due personal balance on your account, you will need to contact the billing office to make payment arrangements prior to receiving most services. Any account that is over 90 days past due will be sent to an independent collection service and may be subject to reporting to the credit bureau and possible termination of the doctor/patient relationship.

Copays, Co-insurance and /or Deductibles – There may be some copay, co-insurance or deductible charges associated with certain medical services and tests. Patient payment of the copay, co-insurance, or deductible is required at the time of service.

Pre-certification – Pre-certification or prior approval may be required by your health plan before certain procedures, tests, or surgeries are performed. We will assist you in the pre-certification process by contacting your insurance company on your behalf. It is your responsibility to confirm that you have been granted approval of certification before your appointment so you do not incur any unnecessary personal charges.

Other physician charges – Our practice is committed to providing the best treatment for our patients which may necessitate the outsourcing of some services to other professionals. When this occurs, you may receive a statement from the provider of ancillary services such as Pathology, Laboratory, and/or Radiology interpretation services, unless Pine Lake Health, LLC purchased these services.

Motor Vehicle Accident – Medical insurance will be filed and any co pay, co-insurance or deductible is required to be paid at the time of service. If no payment is received from the insurance company after 30 business days, it will become the patient's responsibility. Filing claims to the auto insurance is the responsibility of the patient.

Unless contractually prohibited by your insurance carrier, you may be personally charged the following additional fees. These fees will not be filed to your insurance carrier and are the direct responsibility of the patient. Please initial to the left of each category to indicate your acknowledgement.

_____ ***No Show Appointments & Returned Checks*** – Unless canceled at least 24 hours in advance, (INITIAL) depending on the type of appointment, you may be charged a fee of \$25.00 to \$50.00 for each occurrence. After the 2nd no show appointment you will be dismissed from the practice. All returned checks will be charged a fee of \$25.00 for each occurrence.

_____ ***Patient Billing Fee*** – Unless other suitable arrangements are made in advance, patients who fail to pay their co-payment, (INITIAL) co-insurance, deductible, or estimated balance due at the time of service may be billed a fee up to \$25.00 for each occurrence. I agreed to be billed a fee of 35% of a bad debt balance for any extraordinary costs associated with collection of funds owed to Pine Lake Health, including but not limited to, collection agency fees, attorneys' fees and court costs.

_____ ***Forms / Letters / Copy of Medical Records*** – There is a charge for completion of all forms, letters, or copying of medical records. (INITIAL) Payment must be made before the completion or release of any forms, letters, or medical records. Forms for disability, FMLA and etc... will range \$20.00 to \$50.00. Letters may be billed up to a maximum of \$40.00. Copying of medical records is charged of \$5.00 handling fee plus \$.25 per page.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of medical or other information about me to release to any third party payers (including Medicare and Medicaid) information needed for claims for health care benefits. I request that payment of authorized health care benefits be paid and I assign the benefits payable for the physician services to the physician or organization furnishing the services. I authorize such physician or organization to submit a claim to my health insurance carrier or any other third party payer, including Medicare and Medicaid, on my behalf. I request payment of benefits under Title XVIII (Medicare and XIX Medicaid) of the Social Security Act to Pine Lake Health, LLC. I understand that I am financially responsible for charges not covered by the assignment, and I hereby guarantee timely payment in full of any such charges.

By signing below, I acknowledge that I have read and fully understand this Policy and my financial responsibilities as a patient of Pine Lake Health, LLC.

Print Patient Name: _____ Date _____

Signature of Patient or Responsible Party _____