Welcome to Ingleside Medical Associates

OFFICE POLICIES

Please get to know us:

1. We are a Family Practice with four board certified physicians and three certified physician assistants.
2. We **enjoy treating patients of all ages**; from infants through maturity.
3. Our **convenient office hours** are: Mon., Tues, and Thurs. 9 am to 9 pm: Wed. 9 am to 8 pm: Fri. 9 am to 5 pm. We also have appointments available Saturday mornings for your convenience.
4. We have **two locations** to better serve your family's medical needs
5. We provide **a wide scope of services**, including our in-office laboratory, x-rays, minor surgeries, laceration repair, allergy shots, cosmetic procedures, osteopathic manual therapies, routine gynecologic care, as well as nursing home and hospital care.
6. We do all we can to stay on schedule, but medical emergencies may come up and require urgent attention. Therefore, we may be behind schedule at times. We appreciate your understanding.
7. Likewise, we would appreciate your timely arrival for appointments. We will attempt to accommodate you if you arrive late, but there may be times when we will need to reschedule your appointment.
8. We ask you to please give us **48 hours'** notice for your prescription refills, and **72 hours** for any forms or documents you may need filled out by the doctor. The physician responsible for prescribing your medication or completing your forms may be out of the office or doing his/her hospital rotation at the time of your request.

*I understand Ingleside Medical may view my external prescription history via electronic medical record. I understand this history may come from other medical providers, insurance companies, and pharmacy benefit managers.

Out of fairness to all of our patients, we do use all available appointments. Therefore, we do track all missed or canceled appointments. We require 24-hour notice if you are not able to make your scheduled appointments. After the first occurrence, a $75.00 charge will be applied per instance. My signature certifies I have read and understand the above policies.

_____ _____ _____

Signature of Patient or Legal Representative Print Name Date

Ingleside Medical Associates

Patient Information Form

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Secondary Phone #: _____

Date of Birth: _____/_____/_____ Social Security #: _____

Race: Caucasian: ____ African American: ____ Hispanic: _____ Other: _____

E Mail Address (Please Print): _____

Web Portal privileges are standard for all patients. Please check here to Decline: _____

Your Local Pharmacy: _____Mail Order: _____

Person to Contact in the Event of an Emergency:

Name: _____ Relationship: _____

Phone #: _____ Alternate Phone #: _____

Note: Please give all of your medical insurance, Motor vehicle or Workman's Comp insurance information to the front desk with this form after completion. We must have this information at the time of your visit or you may be asked to reschedule your appointment.

I authorize payment directly to the physician or supplier for the services described and further authorizes the release of information to my insurance carriers to process claim. If you do not have insurance or we do not have your current insurance information, you have to pay for today's visit in full. If you have a balance on your account, you will be asked for payment today.

Patient Signature: _____ Today's Date: _____

Parent or Guardian: _____ Today's Date: _____

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your Doctor and members of our Medical Staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contract is made by phone and you are not at home, a message will be left on your answering machine. By signing this, form you are giving us authorization to contact you with theses reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocations must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive you your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact us to provide appointment reminders, information about treatment alternative, or other health related information at any time.

This notice is effective as of April 14,2003. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient Name Printed Date

Patient Signature

Personal Representative Printed Personal Rep. Signature

Description of personal representative's authority to act for the patient**:** _____

PATIENT'S COPY: PLEASE KEEP FOR YOUR RECORDS

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and How you can get access to this information. Please review it carefully.

This notice takes effect on April 14,2003 and remains in effect until we replace it.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide o with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

The Law Requires us to:

- Keep your medical information private
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

We have the Right to:

Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.

Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to Privacy Practices:

Before we make an important change in our privacy practices, we will change this notice and make the new notice available up request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMAITON

The following section describe different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed some of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For treatment: We may use medical information about to provide you with medical treatment or services. We may disclose medical information about to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment: we may use and disclose your medical information for payment purposes, such as insurance carrier, employer, motor vehicle insurance carrier, workers' compensation carrier if they are potentially responsible for the payment of your services.

Notification: Medical information to notify or help notify a family member, your personal representative, or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-rays, or medical information for you.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director and Organ Procurement Organization: To help them carry out their duties, we may share the medical information of a person who has died with the funeral director or an organ procurement organization.

Court Orders: we may disclose medical information in response to a court or administrative order, subpoena, or other lawful process, under certain circumstances.

Workers' Compensation and Motor Vehicle Accidents: We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation, motor vehicle accidents, or other authorized activities.

YOUR INDIVIDUAL RIGHTS

- Look at or get copies of your medical information. You must make your request in writing.
- Receive a list of all the time we shared your medical information for purposes other than treatment, payment, and other specified exceptions.
- Request that we place additional restrictions on our use or disclosure of your medical information. We are not requested to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
- Request that we communicate with you about your medical information at different locations. Your request that we communicate your medical information. We may deny tour request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

Questions and Complaints

If you have any questions about this notice or if you think that we may have violated your privacy right, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services Regional Manager; 150 S Independence Mall W., Suite 372, Public Ledger Bldg., Philadelphia, Pa 19106-9111. We will not retaliate in any way if you choose to file a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the NOTICE OF PRIVACY PRACTICES for

Ingleside Medical Associates

Name of Patient: _____ D.O.B _____

Date of Receipt: _____ Signature of Patient: _____

(or patient's personal representative, parent or guardian)

Personal representative, parent or guardian information (if applicable):

Name: _____

Relationship to Patient (or authority): _____

AUTHORIZATION TO DISCUSS MEDICAL HISTORY

I hereby authorize you to discuss or release any of my information to the following:

(such as spouse, parent, family member)

Name **Relationship**

_____ _____

_____ _____

_____ _____

Signature of Patient or Personal Representative:

_____ Date: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDs, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records release (please initial):

_____ Drug/Alcohol Abuse/Treatment & Diagnosis

_____ Sexually Transmitted Disease

_____ HIV/AIDS Diagnosis/Treatment/Testing

_____ Mental Illness or Psychiatric Diagnosis/Treatment

AUTHORIZATION TO OBTAIN/RELEASE HEALTHCARE INFORMATION

INGLESIDE MEDICAL ASSOCIATES

200 Municipal Drive, Thorndale, PA, 19372 Phone: 610-383-6300 Fax: 610-383-0114

Patient Name: _____ Date of Birth: ____/____/_____

Social Security #: _____ Phone: _____

I give permission to Ingleside Medical Associates to: (Please check one)

☐ OBTAIN ☐ RELEASE

My personal healthcare information from/to current Physician:

Dr.: _____

Address: _____ City: _____State: ____ Zip Code: _____

Phone: _____ Fax: _____

Information to be released (please check one):

Entire Patient Chart ☐

Most recent 2 years of patient information (chart notes, labs, x-rays, and special tests) ☐

Specific Information (please specify) ☐ _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDs, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records release (please initial):

_____ Drug/Alcohol Abuse/Treatment & Diagnosis

_____ Sexually Transmitted Disease

_____ HIV/AIDS Diagnosis/Treatment/Testing

_____ Mental Illness or Psychiatric Diagnosis/Treatment

_____ _____

Signature of Patient/Legal Guardian Date

ADULT PATIENT QUESTIONNAIRE

(For Patients 18yrs & older)

Patient's Name: _____ Date of Birth: _____

Instructions: Circle the Yes or No. If lines are provided write in your answer.

PERSONAL HISTORY

~~Have You Ever Had:~~

Scarlet Fever	Y or N	Jaundice	Y or N	Broken Bones or Cracked Bones	Y or N
Migraine Headaches	Y or N	Concussion or Head Injury	Y or N	Pneumonia	Y or N
Tuberculosis	Y or N	Diabetes	Y or N	Rheumatic Fever or Heart Disease	Y or N
Cancer	Y or N	Arthritis or Rheumatism	Y or N	Colonoscopy/Sigmoidoscopy	Y or N
Bone Disease or Joint Disease	Y or N	High Blood Pressure	Y or N	Neuritis or Neuralgia	Y or N
Nervous Breakdown	Y or N	Bursitis/ Sciatica/ Lumbago	Y or N	Hay Fever or Asthma	Y or N
Polio or Meningitis	Y or N	Hives or Eczema	Y or N	Gonorrhea/ Syphilis/HIV	Y or N
Anemia	Y or N				

Are you Allergic To:

Penicillin or Sulfa Drugs	Y or N	Any other drugs	Y or N	Any Foods	Y or N
Aspirin/ Codeine/Morphine	Y or N	Explain _____		Explain _____	
Mycins or Other Antibiotics	Y or N	Iodine or Radiologic Dye	Y or N	Latex	Y or N
Tetanus or Antitoxin	Y or N	Adhesive Tape	Y or N		

Have You Had Removed:

Tonsils	Y or N	Ovary or Ovaries	Y or N	Had Hernia Repaired	Y or N
Appendix	Y or N	Had Any Other Operations	Y or N	Explain _____	
Gall Bladder	Y or N	Ever Have A Transfusion	Y or N	Been Hospitalized for Any Illness	Y or N
Uterus	Y or N	Blood or Plasma	Y or N	Explain _____	

ADULT PATIENT QUESTIONNAIRE

(Continued)

Patient's Name: _____ Date of Birth: _____

Review of Symptoms

Do You Now Have or Have You Ever Had :

Eye Disease/ Injury/ Impaired Sight	Y or N	Kidney Disease or Stones	Y or N
Ear Disease/ Injury/Impaired Hearing	Y or N	Bladder Disease	Y or N
Trouble With:		Blood/Protein/Sugar in Urine	Y or N
Nose/Sinuses/Mouth	Y or N		
Fainting Spells	Y or N	Difficulty in Urination	Y or N
Convulsions	Y or N	Narrowed Stream	Y or N
Paralysis	Y or N		
Dizziness	Y or N	Prostate Trouble	Y or N
Headaches:	Y or N	Stomach Trouble or Ulcer	Y or N
Frequent or Severe	Y or N	Indigestion	Y or N
Thyroid: Overactive or Underactive/Enlarged	Y or N		
Skin Disease	Y or N	Liver Disease or Gall Bladder Disease	Y or N
Cough	Y or N	Colitis or Other Bowel Disease	Y or N
Frequent or Chronic	Y or N		
Chest Pain or Angina Pectoris	Y or N	Hemorrhoids or Rectal Bleeding	Y or N
Spitting up Blood	Y or N	Black/ Tarry Stools	Y or N
Night Sweats	Y or N	Constipation or Diarrhea	Y or N
Shortness of Breath	Y or N		
Exertion or at Night	Y or N	Palpitation or Fluttering Heart	Y or N
Palpitation or Fluttering Heart	Y or N	Any Change in Appetite or Eating Habits	Y or N
Swelling of: Hands/Feet/Ankles	Y or N	Any Change in Bowel Action or Stools	Y or N
Varicose Veins	Y or N	Explain: _____	
Extreme: Tiredness or Weakness	Y or N		