NAME:________________________________ DATE:________________ DOB:____________

MALE

Have you recently experienced any of the following?

GENERAL	YES	NO
Change in Activity	☐	☐
Appetite Change	☐	☐
Chills	☐	☐
Excessive Sweating	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Weight Change	☐	☐
Other_______________		

HEAD, EARS, NOSE & THROAT	YES	NO
Facial Swelling	☐	☐
Neck Pain	☐	☐
Neck Stiffness	☐	☐
Ear Drainage	☐	☐
Hearing Loss	☐	☐
Ear Pain	☐	☐
Tinnitus *(Ringing in the Ears)*	☐	☐
Nosebleeds	☐	☐
Congestion	☐	☐
Rhinorrhea *(Runny Nose)*	☐	☐
Postnasal Drip	☐	☐
Frequent Sneezing	☐	☐
Sinus Pressure	☐	☐
Dental Problem	☐	☐
Drooling	☐	☐
Mouth Sores	☐	☐
Sore Throat	☐	☐
Trouble Swallowing	☐	☐
Voice Change	☐	☐
Other_______________		

EYES	YES	NO
Eye Discharge	☐	☐
Eye Itching	☐	☐
Eye Pain	☐	☐
Eye Redness	☐	☐
Photophobia		
(Sensitivity to Light)	☐	☐
Visual Disturbance *(Blurred Vision)*	☐	☐
Other_______________		

RESPIRATORY	YES	NO
Apnea	☐	☐
(Stop Breathing)	☐	☐
Chest Tightness	☐	☐
Choking Sensation	☐	☐
Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Frequent Snoring	☐	☐
Other_______________		

CARDIOVASCULAR	YES	NO
Chest Pain	☐	☐
Leg Swelling	☐	☐
Palpitations	☐	☐
Other_______________		

GASTROINTESTINAL	YES	NO
Abdominal Distension	☐	☐
Abdominal Pain	☐	☐
Anal Bleeding	☐	☐
Blood in Stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Nausea	☐	☐
Rectal Pain	☐	☐
Vomiting	☐	☐
Other_______________		

GENITOURINARY	YES	NO
Difficulty Urinating	☐	☐
Painful Urination	☐	☐
Urinary Incontinence	☐	☐
Flank/Side Pain	☐	☐
Frequency	☐	☐
Genital Sore	☐	☐
Blood in Urine	☐	☐
Penile Discharge	☐	☐
Penile Pain	☐	☐
Penile Swelling	☐	☐
Scrotal Swelling	☐	☐
Testicular Pain	☐	☐
Urgency	☐	☐
Decreased Urine	☐	☐
Other_______________		

MUSCULAR/SKELETA	YES	NO
Joint Pain	☐	☐
Back Pain	☐	☐
Trouble Walking	☐	☐
Joint Swelling	☐	☐
Muscle Aches	☐	☐
Other_______________		

SKIN	YES	NO
Color Change	☐	☐
Paleness	☐	☐
Rash	☐	☐
Wound	☐	☐
Other_______________		

NEUROLOGICAL	YES	NO
Dizziness	☐	☐
Facial Asymmetry	☐	☐
Headaches	☐	☐
Light Headedness	☐	☐
Numbness	☐	☐
Seizures	☐	☐
Speech Difficulty	☐	☐
Loss of Consciousness	☐	☐
Tremors	☐	☐
Weakness	☐	☐
Other_______________		

HEMATOLOGIC	YES	NO
Swollen Lymph Nodes	☐	☐
Bruises/Bleeds Easily	☐	☐
Other_______________		

PSYCHIATRIC		
Agitation	☐	☐
Behavior Problem	☐	☐
Confusion	☐	☐
Decreased Concentratic	☐	☐
Feelings of Unhappines	☐	☐
Hallucinations	☐	☐
Hyperactive	☐	☐
Nervous/Anxious	☐	☐
Self-Injury	☐	☐
Sleep Disturbance	☐	☐
Suicidal Thoughts/Ideas	☐	☐
Other_______________		

REGISTRATION FORM Today's Date________________

JOHN M. STAFFORD, M.D. & ASSOCIATES, P.C.

PATIENT NAME____ MARITAL STATUS: S M D W (circle)

LAST FIRST Middle Initial

ADDRESS____

STREET APT# CITY STATE ZIP

BIRTHDATE________________HOME PHONE__________________ WORK________________ Ext_____

MO. DAY YEAR Area Code

CELL PHONE______________________ Email Address____

Area Code

RACE______________________ Ethnicity_______________________ Religion______________________

White/Black/Asian/Native Amer.,Hawaiian, or Alaska Hispanic/Non-Hispanic Faith or Denomination

Preferred Language___________________________ Do You Need an Interpreter?_______________

SOCIAL SECURITY #___________________________ SEX M F (circle)

EMPLOYER____

NAME ADDRESS C ITY STATE ZIP

Job Status (circle) Full Time Part Time Self Employed Retired Other

Company Size-# of Employees(circle) 1-19 20-99 100+

RESPONSIBLE FOR BILL (Guarantor or Subscriber) IF OTHER THAN SELF:

Must have Subscriber's SS# and Date of Birth

____

NAME ADDRESS CITY STATE ZIP

BIRTHDATE ________________________ **SOC SECURITY #**______________________________ PHONE #_____________________________

EFFECTIVE DATE__________________

EMPLOYER____

NAME ADDRESS C ITY STATE ZIP

Job Status (circle) Full Time Part Time Self Employed Retired Other

Company Size # of Employees(circle) 1-19 20-99 100+

I have had a chance to read & receive a copy of Dr. Stafford's "Notice of Privacy Practices & Blood Exposure Policy"

____ ____________________

Signature of patient or representative **Date**

WE NEED TO COPY YOUR INSURANCE CARDS & DRIVER'S LICENSE

John M. Stafford, MD & Associates PC

HIPAA Policy Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to the restrictions.
- The patient acknowledges that he/she has received a copy of our HIPAA practices brochure.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

1. What is your preferred phone number that you would like us to reach you on?

   (__ __ __) __ __ __ - __ __ __ __

2. Please **circle** your preferred method to confirm appointments. CALL TEXT

3. **Circle** if we may leave a message on your answering machine?

   Home Phone YES NO
   Cell Phone YES NO

4. **May we discuss your medical condition with any member of your family?** YES NO

   If yes, list the **name, relationship, & phone** number of the members allowed below:

____

____

____

____

5. ______________________ ______________________ ______________

   Printed Name **Signature** **Date**

Relationship to Patient (If other than patient) ______________________

John M. Stafford, MD & Associates PC
Consent for Treatment
Blood Exposure Policy
Photo Consent
Financial Policy

CONSENT for TREATMENT: I consent to treatment by John M. Stafford, MD and Associates.
BLOOD EXPOSURE POLICY: Understand that your (your child's) blood will be tested, at no charge to you, for Hepatitis B or HIV (Aids Virus) if a healthcare worker has an accidental exposure to your (your child's) blood and/or body fluids. These results will be noted on your (your child's) chart. You will be informed of any positive results and offered counseling.

PHOTO CONSENT: In addition to requiring a copy of your Driver's License or Photo ID, the Practice may require a more current photo of you for identification purposes. The patient gives permission to have their photo taken if or when it is deemed necessary by the Practice.

FINANCIAL POLICY:

1. I understand that I am ultimately responsible to know what my insurance benefits are and therefore accept responsibility to pay for uncovered services.

2. Overdue accounts which are over 120 days past due may be sent to collections.

3. Checks returned for NSF (Non-Sufficient Funds) will be charged a fee of $36.00.

4. If our practice participates with your insurance, the deductible and co-pay are due at the time service is rendered.

5. Patients who do not have insurance, will be expected to pay in full at time of service. (Payment plans may be available.)

6. Our office will now accept “assignment” for Medicare patients. Patients who are covered by Medicare only will have an annual deductible and co-pays. Patients who have regular Medicare along with a supplemental medigap policy usually do not have co-pays nor deductibles. Patients who have Medicare Advantage plans will usually owe a co-pay. If you do not know what your co-pay is, we will charge a minimum of $25.00.

7. We must have current copies of your insurance information on file as well as the social security number for the owner of the policy. **If you are not the owner of the policy, please inform the front desk staff.**

8. Patients must request refunds if desired. If not requested, the amount will be credited to your account.

9. There may be fees for document preparation such as letters, employer forms, disability or insurance company requests, and medical records. This fee will depend on the number of pages copied and/or the length of time needed to fill out the forms. We request 7 to 10 business days to complete.

10. Forms of Payment: We accept CASH, CHECKS, MONEY ORDERS, MASTERCARD, and VISA.

11. Cancellation/No-Show Policy: We ask if you need to cancel or reschedule an appointment that you give us 24 hours notice prior to your scheduled time.

I understand and agree that I will be financially responsible for services provided to me and all costs of collection incurred by the practice should my account become delinquent. I have provided the Practice with all of my insurance coverage information and will keep the office informed of any coverage changes. I have read and understand the policies and how they affect me and my financial obligations to the Practice.

Release of Authorization: I authorize the release of any medical information necessary to process my insurance claims. I understand and agree that I am responsible for all charges not authorized by my insurance carrier.

PATIENT CONSENT FORM

John M. Stafford MD & Associates, PC

Please sign below acknowledging:

- Your understanding of and consent to our Blood Exposure Policy.
- Your permission to be photographed for identification purposes if necessary.
- Your understanding of our Financial Policy and your authorization and consent for release of Medical Record information that may be required for claims processing and coordination of your care.
- The patient may revoke this Consent in writing at any time.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by:______________________________/___________________/_______
Printed Name--Patient or Patient Rep. Signature Date

Relationship to Patient (If other than patient)____

Witness:____/___________________/________
Printed Name--Practice Representative Signature Date

Patient Centered Medical Home Model of Care

Physician and Patient Letter of Understanding

Your care team will provide:

- Respect and privacy for you as an individual.
- Access to care 24 hours a day, seven days per week.
- Coordinated, comprehensive care, including:
  - Services by specialists and hospitals.
  - Community-based services.
- Office-based services, including:
  - Disease prevention and self-management.
  - Health coaching and wellness education.
- High quality and safe care using evidence-based practices.
- Team-based care
  - With a Doctor-led care team.
- Greater access to medical information and communication using:
  - Electronic medical records.
  - Computer-based, secure access to your medical information.

We ask you to:

- Share your concerns. Be sure to ask questions. Take part in your care.
- Be honest about your medical history, symptoms and other information about your health.
  - Set personal goals. Follow through with treatment plans as set up by your doctor and care team.
- Prepare for and keep planned appointments with all care team members.
- Participate with your care managers and health educators.
  - If you have a medical problem, always call this office or your provider. If you have a medical emergency, call 9-1-1.
  - Make sure at the end of every visit that you fully understand your provider's expectations, treatment goals and future plans.

By signing below, you state your wish to be a part of our patient-centered medical home model of care. You agree to do your best to follow the statements above. This is not a legally binding contract. It is a framework for building a relationship to improve your health in a comfortable and welcoming setting. This Letter of Understanding may be ended at any time by either party. It is not required to receive care at our practice.

Physician/NP/PA Name____

____ ____________________

Patient Name (PRINT) Date of Birth

____ ____________________

Patient Signature Date

______________________________________ ________________________________

Parent/Guardian for patient listed above (Please Print) Parent or Guardian Signature

For Office Use Only

☐ **Consent Form Scanned** ☐ **Patient Declines PCMH Program**

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered insurance fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge $50 for missed appointments not canceled within 24 hours prior to the appointment time. These charges will be your responsibility and billed directly to you. The third missed appointment is reason for us to no longer provide you medical care. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____ ____________________

Signature of patient or responsible party/ **Date**