

NAME: _____ DATE: _____ DOB: _____

FEMALE

Have you recently experienced any of the following?

GENERAL	YES	NO	RESPIRATORY	YES	NO	MUSCULAR/SKELETAL	YES	NO
Change in Activity	<input type="checkbox"/>	<input type="checkbox"/>	Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Appetite Change	<input type="checkbox"/>	<input type="checkbox"/>	(<i>Stop Breathing</i>)	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Chest Tightness	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Walking	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Sweating	<input type="checkbox"/>	<input type="checkbox"/>	Choking Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Aches	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Other_____		
Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>			
Other_____			Frequent Snoring	<input type="checkbox"/>	<input type="checkbox"/>	SKIN	YES	NO
			Other_____			Color Change	<input type="checkbox"/>	<input type="checkbox"/>
HEAD, EARS, NOSE & THROAT	YES	NO	CARDIOVASCULAR	YES	NO	Paleness	<input type="checkbox"/>	<input type="checkbox"/>
Facial Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Leg Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Wound	<input type="checkbox"/>	<input type="checkbox"/>
Neck Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Other_____		
Ear Drainage	<input type="checkbox"/>	<input type="checkbox"/>	Other_____			NEUROLOGICAL	YES	NO
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>				Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL	YES	NO	Facial Asymmetry	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Distension	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
(<i>Ringing in the Ears</i>)			Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Light Headedness	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Anal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Rhinorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
(<i>Runny Nose</i>)			Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Postnasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Other_____		
Dental Problem	<input type="checkbox"/>	<input type="checkbox"/>	Other_____			HEMATOLOGIC	YES	NO
Drooling	<input type="checkbox"/>	<input type="checkbox"/>				Swollen Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Mouth Sores	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY	YES	NO	Bruises/Bleeds Easily	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Other_____		
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>			
Voice Change	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC		
Other_____			Flank/Side Pain	<input type="checkbox"/>	<input type="checkbox"/>	Agitation	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency	<input type="checkbox"/>	<input type="checkbox"/>	Behavior Problem	<input type="checkbox"/>	<input type="checkbox"/>
EYES	YES	NO	Genital Sore	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>
Eye Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Concentratio	<input type="checkbox"/>	<input type="checkbox"/>
Eye Itching	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problem	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of Unhappiness	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Eye Redness	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactive	<input type="checkbox"/>	<input type="checkbox"/>
Photophobia	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Urine	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Anxious	<input type="checkbox"/>	<input type="checkbox"/>
(<i>Sensitivity to Light</i>)	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Self-Injury	<input type="checkbox"/>	<input type="checkbox"/>
Visual Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>
(<i>Blurred Vision</i>)			Vaginal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts/Ideas	<input type="checkbox"/>	<input type="checkbox"/>
Other_____			Other_____			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 CITY 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 CITY 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



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