7368 Co. Rd. 623 Unit B Millersburg, OH 44654
PH: 330-473-6314 FX: 330-473-6321
gracefamilypractice@gmail.com

Patient Information

Patient Name:_____ Date Of Birth_____

Address:_____ SS #: _____

City:_____ State:_____ Zip:_____ Gender: Male_____ Female _____

Please mark the boxes below if GFP has permission to leave a Voice Mail Message with personal medical information.

☐ Phone:_____ ☐ Cell: _____

Marital Status: (Circle One) Married Partnered Divorced Single

Email:_____ Spouse Name:_____

Emergency Contact Name & Relationship: _____

Parents Name (if a minor):_____ Siblings (if a minor):_____

Emergency Contact Phone Number: _____

Desired Pharmacy:_____

Parental Consent/Release - (minors only)

I, _____, do hereby give my permission for Grace Family Practice, LLC to assess, diagnose and treat my child, _____ . I hereby authorize the release of any medical information necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities.

As legal parent/guardian for the child named above, I authorize the following people access to bring my child to Grace Family Practice, LLC to be assessed and treated if necessary. In the event that I am unable to bring my child to the office myself that day. I allow them access to personal health information from this date until the child is of legal age, or until further notice.

NAME, RELATIONSHIP: _____

NAME, RELATIONSHIP: _____

NAME, RELATIONSHIP: _____

PAST MEDICAL HISTORY

Family History—

Has anyone in your family experienced any of the following problems? If yes, state relationship.

Asthma Y N _____

Bleeding Tendency Y N _____

Cancer Y N _____

Diabetes Y N _____

Heart Problems Y N _____

Kidney Disease Y N _____

High Blood Pressure Y N _____

Other Y N _____

Social History—

Do you exercise? Y N If yes, how often? _____

How much water do you drink per day? _____

Do you smoke Y N If yes, how much? _____

Do you consume alcoholic beverages Y N If yes, how much/often? _____

Do you use recreational drugs? Y N Past If yes, kind and amount _____

Surgeries and/or Hospitalization History—

Please list any surgeries or hospitalization below, including the year and the reason.

_____

_____

_____

_____

Current Medication/Herbal Supplements

Please list below dose, frequency and reason for taking them.

_____

_____

_____

_____

_____

Allergies—

Allergies to medication? _____

Does the patient have any other allergies or sensitivities? (food, soap, plants, seasonal, latex, etc?)_____

_____

Please circle if you have a history of any of the following:

ADD/ADHD	AIDS/HIV	Abuse/Domestic Violence
Anemia	Anesthesia Complications	Anxiety Disorder
Arthritis	Asthma	Autism Spectrum Disorder (ASD)
Bedwetting	Birth Defects/Inherited Disease	Bladder/Kidney Problems
Blood Diseases	Blood Transfusion	Breast Cancer
Breast Problem	COPD	Cancer
Chicken Pox	Chronic Ear Infections	Congestive Heart Failure
Constipation	Coronary Artery Disease	Depression
Developmental/Behavioral Disorders		Diabetes
Difficulty Swallowing	Diverticulitis	Ear/Hearing Problems
Eating Disorder	Eczema	Endometriosis
Fibromyalgia	GI Problems	Gout
Headaches	Heart Problems	Hepatitis
High Cholesterol	Hypertension	Hyperthyroidism
Hypothyroidism	Infertility	Kidney Disease
Kidney Stones	Liver Disease	Lung Disease
MRSA Exposure	Meniere's Disease	Mental Disorder
Mental Illness	Muscle, Joint/Bone Problems	Obesity
Osteoporosis	Ovarian Cancer	Polyps
Pre-Eclampsia	Pulmonary Embolism	Reflux/GERD
Seizures/Epilepsy	Skin Problems	Stroke
Thrombophilia's	Thyroid Problems	Tuberculosis
Varicosities	Vision/Eye Problems	OTHER _____

_____

_____

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Patient Financial Policy

Patient Name:_____ DOB:_____/_____/_____

Thank you for entrusting us with your healthcare. Our goal is to provide exceptional medical care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (such as address, name, and insurance information). We accept cash, personal check, Visa, Master Card and Discover. We will not accept post-dated checks.

Co-pays, Deductibles and Balances Due

Each patient is expected to have an up-to-date insurance card on file with us at all times. All co-payments and past due balances are due at the time of check-in unless previous arrangements have been made with a billing coordinator. Any patient with a past due balance of over $100 will not be allowed to make an appointment or receive refills on non-essential medications until the balance is paid.

Non-covered services

Occasionally, insurers may decide not to cover a service that your provider considers necessary to diagnose and/or treat your condition. We will not under any circumstances falsify or change a diagnosis or symptom in order to convince an insurer to pay for care that is not covered. If you receive non-covered services, you must agree to pay for these services in the event that your insurance company does not. You must pay for these services in full at the time of visit.

Self-pay Accounts

Self-pay accounts include patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card

on file with us. We do not accept contingency payments. It is always the patient's responsibility to know if our office is participating with his or her insurance plan. *We do give a self-pay discount of 10% when your balance is paid in full the day of your visit..*

Appointments

Patient are seen by appointment only; we are unable to accommodate walk-ins. For health problems that require same day attention, our office should be called early in the day. Separate appointments are needed for each patient, including family members, siblings, etc of the patient.. Please give us the courtesy of 24 hours notice for all cancellations. Appointments missed but not cancelled with enough notice can not be filled by someone who may need it. Any missed appointment without a 24 hour notice is considered a no-show. Therefore, more than 3 no-show appointment within a 6 month period may result in dismissal as a patient.

Privacy (HIPPA)

My medical information may be used by the person I authorize (Grace Family Practice) to receive information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct. This authorization shall be in force and effect until I decided to leave this practice, at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Consent and Release

By signing below you hereby authorize the release of any medical information necessary to process insurance claims or any medical information that is needed for any review or quality assurance activities. I understand that I am responsible for any amount not covered by insurance. I agree to pay any balance due in full no later than 30 days of statement, unless other arrangements have been made in advance.

Patient/Guardian Signature _____Date_____

Printed name _____

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Authorization to Release Records

Patient Name: _____ DOB: _____

Patient Social: _____

I authorize my previous physician's office, _____,
to release the following to Grace Family Practice.

- ☐ ER / Hospital Reports
- ☐ Labs
- ☐ Visit Notes
- ☐ Other (specify) _____

Patient Signature: _____ Date: _____

Printed Name: _____