

TRAYNHAM MEDICAL, PA

PATIENT INFORMATION / PER STATE THIS INFORMATION IS REQUIRED

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME/PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____ DRIVERS LICENSE#: _____ ST. _____

EMPLOYER: _____ WORK PHONE: _____

MARITAL STATUS: _____ SPOUSES NAME: _____ DOB: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE): _____ PHONE: _____

INSURANCE & BILLING INFORMATION: INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP: _____

DATE OF BIRTH: _____ SUBSCRIBER'S SOCIAL SECURITY # _____

WHICH WOULD YOU PREFER INFORMATION LEFT: HOME: _____ CELL: _____ MAIL: _____

WHAT PHARMACY DO YOU USE?: LOCAL: _____ MAIL ORDER: _____

DOES ANYONE HAVE POWER OF DURABLE AND HEALTH CARE POWER OF ATTORNEY OR DO NOT RESUSCITATE ORDER (DNR) FOR YOU?:
IF SO WHOM: _____

GENERAL CONSENT TO TREAT:

I, knowing that myself or my child is suffering from a condition requiring diagnostic, medical, or surgical treatment, I do hereby voluntarily consent to such procedures and care and to such medical, surgical and/or other services under the general and specific instructions of Dr. Julie Traynham D.O., her assistants, or her designee as is necessary in her judgement. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the results of treatment or examination by Dr. Traynham.

NO CALL NO SHOW, CANCELLED APPOINTMENTS, AFTER HOURS:

Traynham Medical does have an after hours line for medical emergencies only. In the case of an emergency that needs a call back from the staff right away, **please be aware that there is a \$25.00 return call fee**. This is not billed to Insurance, this is patient responsibility. If you are more than 15 minutes late the appointment will be rescheduled, unless sick you will have the option to be seen when we can work you in or at the end of the day. After 3 no call no shows the family will be dismissed from the practice and you will need to find a new physician. There is a **\$25.00 fee for missed appointments or appointments not cancelled within 12 hours**. Please call to cancel or reschedule appointments if you are unable to make your appointment. We do have a voicemail to leave a message on after hours to cancel or reschedule appointments.

I have received a copy of the Privacy Policy for Dr. Traynham.

PATIENT SIGNATURE: _____ DATE: _____

OFFICE POLICIES

OUR OFFICE IS PLEASED TO HAVE THE OPPORTUNITY TO SERVE YOU AND YOUR FAMILY. THE FOLLOWING INFORMATION OUTLINES THE FINANCIAL RESPONSIBILITY, AFTER HOURS, AND MEDICATION REFILLS.

PAYMENT GUIDELINES:

We must collect all Co-pays, Co-insurance, and/or Deductibles at the time of service, unless other arrangements have been made in advance with our office. We accept CASH, MONEY ORDERS, AND CREDIT CARDS (Visa, Master Card, Discover, & American Express). We can accept CHECKS after the first initial visit. We can also keep a credit card or a Health Flexible Spending account card (HSA or FSA) on file for deductibles or other patient responsibilities. There is a \$30.00 fee for all returned checks by the bank. If you have a check returned to our office we will no longer be able to accept checks as payment from you or your family. **Please present your insurance card to our office at each visit. This protects you from paying a bill because we had the wrong insurance information. Please be aware if your Insurance comes back stating coverage terminated the balance will become patient responsibility. There is a narrow window to present an accurate claim to the correct company. Failure to do so could mean the claim may be denied and become patients responsibility. We will bill your insurance as a courtesy to you . We cannot estimate what your insurance company will cover due to the vast amount of insurance companies and different policies, this means labs, any tests or procedures done in office, or if we send you out for X-rays or any other testing due to the vast amount of insurance companies and different policies. If we are not in net-work with your Primary or Secondary Insurance plan and you still choose to be seen the balance will be patient's responsibility. As soon as the Explanation of Benefits (EOB) has been received the EOB will be applied to your account and any remaining balance will be mailed to you in an invoice. For large deductible plans we do require a Debit/Credit card or Health Flex spending card on file.** This remains in your chart and only used if you authorize us to run the card and we do not release this information to anyone. Large outstanding balances must be taken care of with a payment arrangement within 6 months.

CREDIT CARD#: _____ EXP: _____ 3 DIGITS ON BACK OF CARD: _____

STREET NUMBER ATTACHED TO CARD: _____ ZIP CODE ATTACHED TO CARD: _____

MEDICATION REFILLS:

Please notify our office 72 hours in advance or the pharmacy for any medication refills. If you are out of refills and have not been in recently please call the office 7 days prior to running out of medicine, it is possible it's time for an appointment or labs. Please do not wait until you are completely out of medication! All refills are done at the end of the business day. If your request is faxed over after 12 on Friday it will not be refilled until the following Monday evening. If you have any medications that are controlled these are sent into the pharmacy at the end of the business day, regardless if your appointment is that morning or not. We do not write prescriptions for anything over the counter as in mattresses, whirlpools, or anything of that nature. There is an appointment required once a year for a routine physical and labs. Diabetics are required to be seen every 3 months if your A1c is above 6.9. Diabetics whose A1c is below 6.9 are required to be seen every 6 months. If you are requesting a medication change an appointment is required for proper documentation in the chart as to why we are changing medication. If a new medication is started or changed you will need to come in for a follow up on this medication before it can be refilled.

Labs:

If patients would like a copy of their normal labs please provide our office with a self addressed stamped envelope. Abnormal labs will automatically be mailed out. We are implementing this policy due to so many labs being returned for an invalid address or the patient has moved. If you do not hear from our office then your labs are normal. We only call patients if the labs are abnormal. **If you do not hear from us this is a good thing!!!**

Patient Compliance:

Per the new Affordable Care Act we are required to see all patients once a year for a physical and fasting labs. Women must have a well woman exam and mammogram if in age range. Diabetic patients must come in every 3 months if you A1c is >7.0 and every 6 months if <6.9, you also need to bring in your Glucometer with all current readings. Patients should always bring in a list of current medications and specialists. We are required to now report these things along with your BMI, blood pressure, and medication lists. If patients are found to be noncompliant with the new recommendations we will have no choice but to dismiss you from the practice.

Patient Signature: _____ Date: _____

MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

REASON FOR VISIT: _____ DATE OF SERVICE: _____

FAMILY MEDICAL HISTORY: If you or any blood relative have ever suffered from any of the following please circle and indicate relationship.

- | | | | | |
|-------------------|---------------|-------------------|----------------------|-------------------|
| 1. Epilepsy | 6. Thyroid | 11. Osteoporosis | 16. Cancer | 21. HERPES |
| 2. Migraine | 7. Hay fever | 12. Arthritis | 17. Alcoholism | 22. CHLAMYDIA |
| 3. Diabetes | 8. Glaucoma | 13. Asthma | 18. Anemia | 23. GONORRHOEA |
| 4. Mental Illness | 9. Stroke | 14. Heart Disease | 19. Hypertension | 24. GENITAL WARTS |
| 5. Bleeds Easily | 10. Hepatitis | 15. HIV/Aids | 20. High Cholesterol | 25. SYPHILIS |

LIST ALL OF THE MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER MEDS, AND ANY FROM ANOTHER PHYSICIAN.

PLEASE LIST ON THE BACK IF YOU NEED MORE SPACE

MEDICATION NAME: _____ STRENGTH _____ HOW OFTEN TAKEN _____

LIST ALL ALLERGIES YOU MAY HAVE: MEDICATION, FOOD, OR OTHERWISE

PLEASE LIST ANY CONDITIONS OR SURGERIES YOU HAVE HAD AND THE YEAR OR SPECIALIST YOU SEE LIST THEIR NAME AND PHONE NUMBER:

TOBACCO USE: YES / NO IF YES PLEASE SPECIFY: CIGARETTES / DIP HOW OFTEN: _____

ALCOHOL USE: YES / NO IF YES PLEASE SPECIFY: BEER / WINE / HEAVY ALCOHOL HOW OFTEN: _____

DRUG USE: YES / NO IF YES PLEASE SPECIFY: STREET DRUGS / PRESCRIPTION / BOTH HOW OFTEN: _____

FEMALES ONLY PLEASE COMPLETE

Menstrual Flow: Regular / Irregular Pain / Cramps Date of last Cycle: _____ Days of Flow: _____

Length of Cycle: _____ Pain during or after sex: _____ Date of last Pap: _____ Normal / Abnormal

Number of Pregnancies: _____ Miscarriages: _____ Live Births: _____ Abortions: _____

Date of last Mammogram: _____ Normal / Abnormal Where was this done: _____

TRAYNHAM MEDICAL E-MAIL CONSENT FORM

RISK OF USING E-MAIL:

Providers offer patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to the following risks.:

- a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
- b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- c. E-mail senders can easily misaddress and e-mail.
- d. E-mail is easier to falsify than handwritten or signed documents.
- e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
- f. Employer and on-line services have a right to archive and inspect e-mails transmitted through their systems.
- g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- h. E-mail can be used to introduce viruses into computer systems.
- i. E-mail can be used as evidence in court.

CONDITIONS FOR THE USE OF E-MAIL:

Providers will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above. Providers cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes an agreement with the following conditions:

- a. All e-mails to or from the patient concerning the diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.
- b. Provider's may forward e-mails internally to Provider's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Provider's will not however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- c. Although Provider's will endeavor to read and respond promptly to an e-mail from the patient, a Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies.
- d. If the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow-up to determine whether the intended recipient received the e-mail and when the recipient will respond.
- e. The patient should not use e-mail for communication regarding sensitive medical information.
- f. Provider's shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across the state lines.
- g. It is the patient's responsibility. to follow-up and or schedule an appointment if warranted.
- h. Please keep in mind to put the patient name in the subject column so your e-mail does not get mistaken for spam.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and myself, and consent to the conditions outlined herein. In addition, I agree to the instructions that the Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

PATIENT E-MAIL ADDRESS: _____

PRINTED PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____