BHS PRIMARY CARE/DR. LILLY

TIMOTHY J. LILLY, DO, FACOI
GRACE DIEHL, PAC
432 HILLCREST AVE. SUITE 3
GROVE CITY, PA 16127
PHONE: 833-906-0107
FAX: 724-458-6689

Thank you for choosing our practice for your healthcare needs. We are confident that you will be very satisfied with the medical care.

We will schedule your first appointment once you complete your paperwork and return it to our office. You must bring your insurance card or send a copy of it with this paperwork! Enclosed, you will find important office policy information.

Please bring the following to your appointment:

- **Your insurance card(s)**
- **A Photo ID**
- **All medications that you are currently taking**

If you have any questions prior to your appointment date, please call us at 833-906-0107.

Sincerely,

Timothy J. Lilly DO FACOI

BHS Primary Care
Timothy J. Lilly, DO, FACOI

432 Hillcrest Avenue, Suite 3
Grove City, PA 16127
Phone: 833-906-0107
Fax: 724-458-6689

OFFICE POLICIES

- Dr. Lilly prefers that every patient have an annual physical exam.
- Please be aware: If you give us an email address we will send you a link to set up a patient portal. With that set up, you can send non-urgent messages directly to Dr. Lilly or Grace. They will respond to your message without being relayed through staff.
- We try to alternate patient visits between both providers so that both become familiar with your health and your care.
- Please do not wear perfumes or colognes to your appointment.
- We draw blood, check blood pressure and perform ear lavages here in the office on Thursdays between
- 1:00 – 4:00 PM.
- We ask that all patients arrive 30 minutes prior to their schedule appointment. This will give the office staff the time needed to register and room you. Our providers' goal is to enter your exam room at the actual appointment time.
- Please be aware that if you are not here at least 20 minutes prior to your scheduled appointment, you may be asked to re-schedule your appointment.
- Please be aware that if you fail to show for your appointment, you may be charged $20 fee. If you fail to show more than twice within a year without canceling appointment, you may possibly be dismissed from practice.
- We ask that you bring all the medications that you are currently taking to each appointment.
- Prescription refills will be filled within 24-48 hours. Please have the name of the requested medication, the dosage and frequency of the medication. You will also need to supply the pharmacy name, phone number and zip code where you want to receive your prescription. We request 24-48 hour notice on all prescription refills. This includes Sample Medications. Due to prescription regulations, all patients taking controlled medications will need to sign our Controlled Substance contract which will be kept in your chart.

I have reviewed and understand the above Office Policies.

Printed Name	Signature	Date

BHS Medical Providers

Notice to our Patients

Thank you for choosing us as your health care provider. We are committed to providing you with quality and affordable healthcare. The following financial policies have been established to avert payment and insurance miscommunication. Please read it carefully and feel free to ask us any questions you may have. **Please sign in the space provided that you agree and will comply with the policy**. A copy will be provided to you.

1. **Information:** We ask that you present your insurance card to us at every visit as proof of insurance coverage. We will also ask you to verify your current home address and phone number. If we do not have accurate information to bill for the services you receive during your visit with us, ***you may be responsible for payment for all services provided.***

2. **Co-Payments:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services:** You should be aware that some, or perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by your insurance provider. You will be responsible for these services in full. ***If you schedule an appointment for a Physical, and other problems are addressed during that same visit, you may be charged an additional co-pay.***

4. **Payment Arrangements:** We offer monthly payment plans to assist you in paying unexpected balances. Please contact our Patient Account Representative for details at (724)284-4022.

5. **Financial Assistance**: You may be eligible for Financial Assistance based on your income. Please call the Patient Financial Representative at (724)284-4022 for an application and information.

6. **Nonpayment:** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice.

7. **Missed Appointments:** If you are unable to keep your appointment, we asked that you call our office 24 hours prior to your scheduled time. ***You may be charged a $20.00 fee if you miss your appointment without notifying our office.*** These charges will be your responsibility and billed directly to you. After three such missed appointments you may be discharged from this practice. Please help us to serve you better by keeping your regularly scheduled appointments or timely canceling them.

8. **Form Completions:** Please allow up to two weeks for forms to be completed but we try to complete them as soon as possible. Fees may apply.

Our practice is committed to providing the best care to our patients. Thank you for understanding our payment policies. Please let us know if you have any questions or concerns.

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

NAME_____DOB_____PCP_____

X Patients signature or responsible party _____ Date _____

BHS Primary Care

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Notice and Acknowledgment

I acknowledge that the office has a new Notice of Privacy Practices and the notice has been made available to me at the Front Desk of the office.

Patient Name_____
(Print Name)

Date of Birth_____

_____ _____
Patient or Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

BHS Primary Care

Timothy J. Lally DO FACOI

MEDICAL HISTORY

LAST NAME	FIRST NAME	MIDDLE NAME	MALE FEMALE	DATE OF BIRTH
HOME ADDRESS (Number and Street)/Length of Time lived there:			HOME PHONE NUMBER	SOCIAL SECURITY #
CITY		STATE	ZIPCODE	MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED
EMAIL		CELL PHONE NUMBER	WORK NUMBER	
EMPLOYER		OCCUPATION		

Insurance: _____ Member ID: _____

Previous PCP: _____

Date of Last Annual Wellness and/or Physical: _____ (If needed, call previous PCP to get date(s)

Reason for Transfer: _____

Previous Address (if reason for transfer was a recent move): _____

Ever Been Dismissed by a practice (Check one): _____ YES _____ NO

MEDICARE:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

MEDIGAP:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by that the provider of service and (or) supplier. I authorize any holder of Medicare information about about me to release to _____
(Name of Medigap Insurer) any information needed to determine these benefits payable for related services.

MEDICAL ASSISTANCE:

My signature below certifies that I have or will be receiving services. I understand that payment for these services will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws. I have read and agree with the above statement.

GENERAL ASSIGNMENT & RELEASE:

I hereby authorize and assign payment to Butler Medical Providers of insurance benefits otherwise payable to me. I understand I am financially responsible for charges not covered by the authorization and unpaid balance on the service date. I hereby authorize release of billing information by Butler Medical Providers or their billing agent.

As applicable to the above, I am providing my consent with my signature:

Patient Name (please print) _____ Witness _____

Patient Signature _____ Date _____

BHS Primary Care
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MEDICAL HISTORY

NAME:_____ DOB_____ DATE:_____

PERSONAL HISTORY - PLEASE ANSWER ALL QUESTIONS (comment on all positive answers). Check "current" If it is a present condition. PLEASE PRINT

Have you ever had:	Yes	No	Current	Age	Description	Have you ever had:	Yes	No	Current	Age	Description
Rheumatic Fever						Irregular Heart Beat					
Measles						Enlarged Heart					
Mumps						Heart Attack					
Chicken Pox						Heart Valve Problem					
Scarlet Fever						Atrial Fibrillation					
Diphtheria						Endocarditis					
Polio						Arrhythmia					
Post Polio Syndrome						Hypertension					
Tonsillitis						GERD					
Whooping Cough						Hiatal Hernia					
Mononucleosis						Gastritis					
Strep Throat						Stomach Ulcer					
Ear Infections						Esophagitis					
Migraine Headaches						Barrett's Esophagus					
Tension Headaches						Stomach Cancer					
Seizures						H. Pylori Infection					
Epilepsy						Duodenal Ulcer					
Brain Aneurysm						Hepatitis A, B, C					
Stroke						Enlarged Liver					
TIA						Enlarged Spleen					
Concussion						Liver Cancer					
Brain Tumor						Gallstones					
Diabetes I or II, specify						Pancreatitis					
Non Insulin Dependent						Bowel Obstruction					
Insulin Dependent						Crohn's Disease					
Diabetic Retinopathy						Ulcerative Colitis					
Glaucoma						Diverticulosis					
Cataracts						Diverticulitis					
Pink Eye						Colon Polyps					
Subconjunctival Hemorrhage						Colon Cancer					
Macular Degeneration						Hemorrhoids					
Detached Retina						Giardiasis					
Fractured Nose						C. Difficile Infection					
Frequent Nose Bleeds						Prostatitis					
Sinusitis						Prostate Cancer					
Deviated Nasal Septum						Low Testosterone					
Nasal Polyps						Enlarged Prostate					
Deafness						Testicular Cancer					
Vertigo						Fibrocystic Breast					
Thrush						Mastitis					
Cancer of Mouth/Tongue						Breast Cancer					
Cancer of Larynx						Vaginal Yeast Infec.					
Lung Cancer						Kidney Stones					
Pneumonia						Bladder Infection					
Asthma						Bladder Cancer					
COPD						Kidney Failure					
Bronchitis						Varicose Veins					
Tuberculosis						Phlebitis					
Congestive Heart Failure						Osteoarthritis					

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MEDICAL HISTORY

NAME:_____ DOB: _____ DATE:_____

Have you ever had:	Yes	No	Cur-rent	Age	Description	Have you ever had:	Yes	No	Cur-rent	Age	Description
Broken Ribs						Rheumatoid Arthritis					
Collapsed Lung						Gout					
Coronary Artery Disease						Bunion					
Blood clot in Lung						Broken Bones					
Hyperthyroidism						Psoriasis					
Hypothyroidism						Eczema					
Hyperparathyroidism						Warts					
Graves Disease						Nail Fungus					
Thyroid Cancer						Shingles					
High Calcium						Iron Deficiency Anemia					
Poor Circulation in legs (PAD)						Blood Loss Anemia					
Osteoporosis						Blood Transfusions					
Scoliosis						Leukemia					
Multiple Sclerosis						Malaria					
Muscular Dystrophy						Hodgkins Lymphoma					
Other Neurological Disease						NonHodgkins Lymphoma					
Depression						Sickle Cell					
Anxiety						Polycythemia Vera					
Schizophrenia											
Scleroderma						High Cholesterol					
Melanoma						Obesity					
Other Skin Cancers (Squamous Cell or Basal Cell)						Cancer (Other)					
Sunburn						Other					
Burns											

SURGICAL HISTORY-ANSWER ALL QUESTIONS (mark date and age for all positive answers).

Type of Surgery:	Yes	No	Date	Age	Type of Surgery:	Yes	No	Date	Age
Tonsils/Adenoids					Gastric Bypass				
Cataracts with Implants					Splenectomy				
Detached Retina					Liver Biopsy				
Laser Eye Surgery/Lasik Surgery					Abdominal Aneurysm Repair				
Tubes in the Ears					Thyroid Removal				
Sinus Surgery					Parathyroid Surgery				
Teeth Extraction (wisdom, etc.)					Carpal Tunnel Surgery				
Cardiac Catheterization					Leg Bypass				
Heart Bypass					Vein Stripping				
Heart Valve Repair/Replacement					Skin Cancer				
Pacemaker Insertion/Defibrillator Insertion					Moles Removed				
Arthroscopic Surgery Specify Joint?					Repair of Cystocele				
Vertebroplasty					Repair of Rectocele				
Back Surgery					Cystoscopy				
Joint Replacement					Urethral Dilation				
Bunionectomy					Breast Biopsy				
Amputation/Specify Type					Mastectomy				
Lung Surgery/Bronchoscopy					Breast Reduction				
Upper Endoscopy/Esophagus Dilated					Breast Implant				
Colonoscopy/with or without Polypectomy					Breast Surgery				
Appendix Removed					Partial Hysterectomy				

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MEDICAL HISTORY

NAME:_____ DOB: _____ DATE:_____

SURGICAL HISTORY CONT.	YES	NO	DATE	AGE		YES	NO	DATE	AGE
Colostomy & or Colectomy					Complete Hysterectomy				
Ileostomy					D& C				
Inguinal Hernia repair					C-Section				
Umbilical Hernia repair					Tubal Ligation				
Gall Bladder					Circumcision				
Vasectomy					Greenfield Filter				
Penile Implant					Other? Please Specify				

SOCIAL HISTORY-Answer All Questions

Marital Status: SINGLE MARRIED DIVORCED WIDOWED	Hobbies and leisure activities:
Birth Place: Highest Level Education:	Hand Dominance:
Foreign Travel: What Country:	Occupations:
Armed Forces: Branch:	Currently Employed: Full Part time Volunteer
Children: How many:	DIET: Regular Diabetic Low Fat Low Salt Gluten free Vegan Vegetarian Other:
Type of Pets: How many:	Exercise & Frequency

CONSUMES COFFEE (How much)	YES	NO	Do you have a Power of Attorney (POA)	YES	NO
CONSUMES TEA	YES	NO	Have you created advance directives (Living Will)	YES	NO
CONSUMES SODA (How much)	YES	NO	Do you have life alert	YES	NO
CONSUMES MARIJUANA	YES	NO	Do you have fire arms in the home	YES	NO
IV DRUG USE	YES	NO	SMOKE DETECTORS IN HOME	YES	NO
HAVE HISTORY OF SUBSTANCE ABUSE	YES	NO	Do you have fire extinguishers in the home	YES	NO
ANY FAMILY HISTORY SUBSTANCE ABUSE	YES	NO	Carbon Monoxide detectors in your home	YES	NO
TOBACCO USE: what, how much, for how long	YES	NO	What type of heat does your home have? ELECTRIC WOOD GAS FUEL OTHER		
CONSUME ALCOHOL: what, how much, how often	YES	NO	What type of water does your home have? CITY WELL SPRING OTHER		
CAN YOU OPERATE A VEHICLE	YES	NO	Does your home have a basement	YES	NO
WEAR A SEAT BELT	YES	NO	Do you have air conditioning	YES	NO
WEAR A HELMET	YES	NO	Do you use a dehumidifier	YES	NO

IMMUNIZATION HISTORY: (if known)	Yes	No	Date
Hepatitis B Vaccine, if so Children or Adult series?			
Influenza (Do you get yearly flu shots)			
Pneumococcal			
PPD (TB)			
Tetanus (TDAP, TD)			
Zostavax (Shingles)			
Other:			

Last Eye Exam: _____ **Where**_____
Last Dental Exam:_____ **Where**_____
List Other Providers:_____
_____
_____

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MEDICAL HISTORY

NAME:_____ DOB: _____ DATE:_____

WOMEN ONLY:

		Please Circle	
Age First Menstrual Cycle Started	_____	Normal	Abnormal
Date of Last Menstrual Cycle	_____	Normal	Abnormal
Date of Last Pap Test	_____	Normal	Abnormal
Date of Last Mammogram	_____	Normal	Abnormal
Self Breast Exam Frequency	_____	Yes	No

Number of Children:_____ Abortions:_____ Miscarriages:_____

History of Sexually Transmitted Disease_____

MEN ONLY:

		Please Circle	
Date of Last Prostate Exam	_____	Normal	Abnormal
Date of Last PSA	_____	Normal	Abnormal
Self Testicular Exam Frequency	_____	Yes	No
Erectile Dysfunction		Yes	No

History of Sexually Transmitted Disease_____

ALLERGIES: **WHAT TYPE OF REACTION:**

BEE STINGS	YES	NO
ENVIRONMENTAL	YES	NO
IODINE	YES	NO
I.V. CONTRAST	YES	NO
LACTOSE	YES	NO
LATEX	YES	NO
POISON IVY/POISON OAK (Specify)	YES	NO
MEDICINES:	YES	NO

CURRENT PHARMACY: _____

CURRENT MEDICINES--Include over the counter medications, Vitamins, and Herbal medicines. May use the back if necessary.

Medication, Vitamin, Herb	Dose	Frequency	Duration of Therapy
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Any medications discontinued in last 6 months?_____ If so, Why?_____

BHS Primary Care

Timothy J. Lilly, DO, FACO

Name:_____ DOB:_____ Date:_____

Biological Family History - CHECK ALL THAT APPLY

	MOM	DAD	SON	SON	SON	Daughter	Daughter	Daughter	Brother	Brother	Brother	Sister	Sister	Sister	MGM	MGF	PGM	PGF
Age																		
Age of Death																		
Hypertension																		
Stroke																		
Heart disease																		
Heart Attack																		
High Cholesterol																		
Diabetes																		
Asthma																		
Thyroid Disease																		
Kidney Disease																		
Epilepsy																		
Cancer																		

Clarify/Additional Information_____

_____

_____

MGM=Maternal Grandmother MGF=Maternal Grandfather PGM=Paternal Grandmother PGF=Paternal Grandfather

BHS Primary Care
Timothy J. Lilly, DO, FACOI

MEDICAL HISTORY

NAME:_____ DOB: _____ DATE:_____

REVIEW OF SYSTEMS- Please circle any of the following <u>if true of the past 3 months or currently.</u>

<u>A. General Symptoms:</u> fever chills sweats blurry vision double vision nose bleeds
post nasal drip mouth sores pain in teeth bleeding gums weight gain weight loss change in taste
change in smell itchy eyes hearing loss hearing aids wear glasses dentures

<u>B. Cardiac</u>: passing out chest pain angina palpitations near faint leg cramps skipped
heart beats pacemaker shock from defibrillator pain in legs when walking

<u>C. Respiratory</u>: cough sputum blood in sputum leg swelling runny nose sneezing
sinus congestion itchy nose itchy throat ankle swelling lips turning blue nail beds turning blue
shortness of breath with exertion sleep on more than one pillow nocturnal shortness of breath

<u>D. Gastrointestinal</u>: black tarry stool nausea vomiting abdominal pain bloating indigestion
painful swallowing vomiting blood diarrhea constipation rectal bleeding choking burping
painful hemorrhoids loss of appetite acid reflux yellow skin

<u>E. Genitourinary:</u> blood in urine frequency burning urgency dribbling painful urination
urinating at night difficulty urinating incontinence if coughing or sneezing vaginal itching/sores vaginal discharge
abnormal vaginal bleeding erectile dysfunction blood in semen penile discharge

<u>F. Neurologic:</u> sudden visual loss numbness tingling headache lightheaded dizziness/vertigo
loss of consciousness memory loss weakness snoring sleep apnea paralysis tremors

<u>G. Musculoskeletal</u>: back pain/sciatica neck pain swollen joints joint pain muscle pain stiffness

<u>H. Endocrine:</u> increased hat size change in voice excessive thirst bruising oily skin dry skin/hair
excessive hunger excessive hair growth hair loss cold intolerance heat intolerance excessive urination

<u>I. Psychiatric</u>: attempted suicide depression tearfulness insomnia hear voices schizophrenia

<u>J. Skin:</u> rash/redness itching non-healing sores cracking birth marks scars

BUTLER MEDICAL PROVIDERS

PHYSICIAN DIVISION

PATIENT REQUEST FOR DISCLOSING VERBAL INFORMATION

PATIENT NAME:_____ DATE OF BIRTH:_____

PRACTICE NAME: **BHS PRIMARY CARE/DR. LILLY**

I do X/do not☐ consent for detailed messages to be left on my voicemail.
Phone:_____

Please list any person(s) whom you allow this office to discuss your medical care with (such as parents/spouse/ children, etc.)

Name:_____Relationship:_____ Phone _____

Name:_____Relationship:_____ Phone _____

Name:_____Relationship:_____ Phone _____

Name:_____Relationship:_____ Phone _____

Special Instructions or Limitations:_____

_____

As an extra measure of security, before any member of our office staff will discuss any aspect of your care or information, including but not limited to, appointment dates and times, test results, medication lists, etc., with you or any person listed above, you or that person must know the unique password that you create with this office. Please choose any word that is easy to remember for you and the listed members. For example: pet's name, favorite vacation, favorite food, favorite color, etc. Be sure to notify all person's listed above of your password.

Secure Password (middle name):_____

We will continue to rely on the information on this form when communicating with you, family members, or others involved in your care unless you request changes. Please promptly notify our office in writing if you wish to alter the designations above. With my signature, I am aware that BMP Physician Division encompasses many different Physician Specialties within Butler Health System. Any of those offices may have access to my medical records.

_____ _____

Signature of Patient/Legal Representative: Date/Time:

Relationship to Patient:_____

This authorization hereby revokes any previous authorizations.
To revoke this authorization, please send a written request to our office.

Reviewed. No changes.

Initials_____ Date_____ Initials_____ Date_____
Initials_____ Date_____ Initials_____ Date_____

BHS Primary Care

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

1. CREATION OF A DURABLE POWER OF ATTORNEY FOR HEALTHCARE

To my family, doctors and all those concerned with my care: Date of Birth _____

I_____(name), residing at_____

_____(street address) in_____(city or county),_____(state), being of sound mind, intend by this document to create a durable power of attorney for healthcare. My executing this durable power of attorney for healthcare is voluntary. I expect, despite the creation of this durable power of attorney for healthcare, to be fully informed about and to make any healthcare decision for myself whenever I am able to do so. For purposes of this document, "healthcare decision" means an informed decision in the exercise of my right to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain, diagnose or treat my physical or mental condition.

2. DESIGNATION OF HEALTHCARE AGENTS

If I am unable to make healthcare decisions for myself, due to my incapacity, I hereby designate:

Name:_____
Address:_____
Home Phone:_____Work Phone:_____

They are to be my healthcare agent for the purpose of making healthcare decisions on my behalf.
If she/he is ever unable or unwilling to do so, I hereby designate:

Name:_____
Address:_____
Home Phone:_____Work Phone:_____

They are to be my first alternate healthcare agent for the purpose of making healthcare decisions on my behalf.
In the event that neither the person named to be my healthcare agent nor the person named as first alternate healthcare agent is able or willing to be my healthcare agent, I then designate:

Name:_____
Address:_____
Home Phone:_____Work Phone:_____

They are to be my second alternate healthcare agent for the purposes of making healthcare decisions on my behalf.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack capacity to manage my healthcare decisions, I instruct my healthcare provider to obtain the healthcare decision of my healthcare agent for all my healthcare. I have discussed my desires thoroughly with my healthcare agent as well as those named as alternates and believe that they understand my philosophy regarding the healthcare decisions I would make if I were able to do so. I desire that my wishes be carried out through the authority given to my healthcare agent under this document.

My healthcare agent is instructed that if I am unable, due to my incapacity to make a healthcare decision she/he shall make a healthcare decision for me. My healthcare agent shall base her/his healthcare decision on any healthcare choices that I have expressed prior to the time of the decision. If I have not expressed a healthcare choice about the healthcare in question, my healthcare agent shall base her/his healthcare decision on what she/he believes to be in my best interest.

4. ADMISSION TO NURSING HOMES OR LONG TERM CARE FACILITIES My healthcare agent may admit me to a nursing home or other long term care facility as she/he may deem appropriate.

5. LIVING WILL DECLARATION

If it should be determined in the course of my care that I am in a terminal condition or am permanently unconscious with no reasonable expectation of recovery, I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying. I further direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I ◯ do ◯ do not want cardiac resuscitation.
I ◯ do ◯ do not want mechanical respiration.
I ◯ do ◯ do not want tube feedings or any other artificial or invasive form of nutrition or hydration.
I ◯ do ◯ do not want blood or blood products.
I ◯ do ◯ do not want any form of surgery or invasive diagnostic tests.
I ◯ do ◯ do not want kidney dialysis.
I ◯ do ◯ do not want antibiotics.
I ◯ do ◯ do not wish to donate my tissues or organs. Subject to these limitations , if any _____

_____

6. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations included in the document, my healthcare agent has the authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health including medical and hospital records.
(b) Execute, on my behalf, any documents that may be required to obtain this information.
(c) Consent to the disclosure of this information.

7. SIGNING DOCUMENTS, WAIVERS AND RELEASES

Where necessary to implement the healthcare decisions that my healthcare agent is authorized by this document to make, my healthcare agent has the authority to execute on my behalf any of the following:

(a) Documents titled or purported to be a "consent to permit treatment", "refusal to permit treatment" or "leaving hospital against medical advice".
(b) A waiver or release from liability required by a hospital or physician.

Signature_____Date_____

8. STATEMENT OF WITNESSES

The foregoing document was declared by _____(name) to be her/his grant of Durable Power of Attorney for Healthcare and was signed in our presence, all being present at the same time, and we, at her/his request and in her/his presence and in the presence of each other, have subscribed our names as witnesses on the date above written.

Signature_____ Signature_____

Address_____ Address_____

_____ _____

RECORD RELEASE

432 Hillcrest Avenue, Suite 3, Grove City, PA 16127 Phone: 833-906-0107 Fax: 724-458-6689

AUHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

This authorization gives BHS Primary Care permission to use and/or disclose health information about you.
Patient Name: (Please print)_____
BirthDate:_____
Address:_____

____ **Furnish Records To:** DR. TIMOTHY LILLY, 432 HILLCREST AVE, SUITE 3, GROVE CITY, PA 16127

____**Obtain Records From: Name and Address**

_____

_____

_____

Specific description of information to be used or disclosed:_____

_____

Purpose of disclosure:_____
If you are transferring please indicate reason for transfer: _____

_____

Right not to sign. You may refuse to sign this authorization. Refusal to sign this authorization will not affect your ability to obtain treatment by BHS Primary Care, except in the case of health care that is solely for the purpose of creating health care information for disclosure to a third party (pre-employment physical, life insurance physical, research related care).

Right to revoke. You may revoke this authorization, in writing, at any time by sending written notification to:
BHS Primary Care/Timothy J. Lilly DO & Associates
Attention: Office Manager
432 Hillcrest Ave. Suite 3
Grove City, PA 16127

I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information.

Re-disclosure. **Health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by the federal privacy rule or another privacy law.**

Inspect/Copy. **You have the right to inspect or copy the protected health information to be used or disclosed.**

RECORD RELEASE

This authorization shall remain in effect from the date signed below for 90 days.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Name of Personal Representative:

_____

Relationship to Patient

_____

Witness

Patient given a copy of the release _____

SPECIAL AUTHORIZATION

SPECIAL AUTHORIZATION IS REQUESTED FOR RELEASE OF HIV INFORMATION

YOUR SIGNATURE IS REQUIRED IN THE SPECIAL AUTHORIZATION AREA FOR THESE RECORDS

HIV RECORDS RELEASE AUTHORIZATION

My HIV records information may be released to the recipient noted on this form.

PATIENT SIGNATURE:_____ **Date:**_____

The patient above named is unable to provide a signature due to:_____

PARENT/LEGAL GUARDIAN SIGNATURE_____ **Date:**_____

Relationship to Patient:_____

Address:_____

This consent will be valid beginning on_____/_____/_____**and will expire after 30 (thirty) days, if not revoked earlier or** _____ **(list any specific events or conditions) any may be revoked at any time unless relied upon.**

I understand that my consent is subject to my revocation at any time, except to the extent that the person to whom this disclosure has been made has already acted in reliance on it.

The following statement will be attached to the record requested: This information has been disclosed to you from records protected by Pennsylvania Law. Pennsylvania Law prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for release of medical or other information is not sufficient for this purpose.