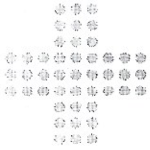


BUTLER MEDICAL PROVIDERS

PHYSICIAN DIVISION

PATIENT REQUEST FOR DISCLOSING VERBAL INFORMATION

PATIENT NAME:____ DATE OF BIRTH:________________

PRACTICE NAME: ***BHS Primary Care – Woody Drive***

I do ☐/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. <u>Be sure to notify all person's listed above of your password</u>.

Secure Password:____

Password Hint:____

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.

____ ________________

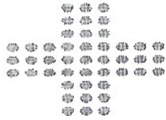
Signature of Patient/Legal Representative: Date/Time:

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__________



BUTLER HEALTH SYSTEM

Dr. Peter Sylves
Dr. Mrunali Luke
Dr. Christania Morganti
Benjamin Edmondson, PA-C

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.

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, ***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 your co-payment 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. **Non-Payment:** 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 ask 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 cancel them.
8. **Form Completions:** Please allow up to two weeks for forms to be completed, however we try to complete them as soon as possible.

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____________________________________ DATE________________

Patient's signature or responsible party

Pediatric Initial Health Assessment Questionnaire

Name: ______________________________ **Today's Date:** ______________

Date of Birth: ______________

Please list **ALL** medications, including routine over the counter medications:

Name	Dose	Times per day
____________________	____________	__________
____________________	____________	__________
____________________	____________	__________
____________________	____________	__________
____________________	____________	__________

Allergies:

None _____ OR ____

Birth History:

Full term or premature: ____________________ If premature, how many weeks: __________

Born: Vaginally C-Section

Did your child require a stay in the NICU? Yes No

If yes, why did they need to stay in the NICU? ______________________________

Birth weight: ______________

Development:

Do you have any concerns about your child's development? Yes No

If yes, what are your concerns?

____

Social History:

Who lives in the household with your child?

____

Please list any pets: ____

Does anyone smoke at home? __________ If so, do they smoke in the house? __________

What does your child like to do? ____

What activities does your child participate in? __________________________________

Medical History: Has your child ever had any of the following:

_____allergies
_____cancer: type______________
_____neurological
_____asthma
_____diabetes
_____headaches
_____ADD/ADHD
_____gastrointestinal/reflux
_____eczema
_____autism
_____learning disability
_____depression
_____anxiety
_____thyroid disease
_____broken bone
_____other: ____

Surgical History: (include dates if known)

_____none or ____

Past Hospitalization:

_____none or ____

Pediatric Family History

Patient Name: ____________________ Patient DOB: ____________________

Does the PATIENT have anyone in the family with any of the following conditions:

	Mom	Dad	Sibling	Aunt	Uncle	Grandparent
ADD/ADHD						
Allergies						
Anxiety						
Asthma						
Autism						
Cancer (please indicate which type)						
Depression						
Diabetes						
Gastrointestinal						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Learning Disability						
Neurological						
Stroke						
Substance Abuse						
Thyroid Disorder						
Other: __________						

__________ **No, no one has any medical problems**