Assignment of Benefit Agreement

I hereby authorize my insurance company, including Medicare if I am a Medicare beneficiary, to make payments to Seven Hills Medical Services PC/Franklin Medical Care PC for medical or surgical services or items rendered to me or my dependent by Seven Hills Medical Services PC/Franklin Medical Care PC. Should my insurance carrier deny Seven Hills Medical Services PC/Franklin Medical Care PC payment, I understand that I am financially responsible for the charges. I authorize Seven Hills Medical Services PC/Franklin Medical Care PC to release any and all of my records to my insurer or any other third party payer, legally responsible for the payment of medical expenses. It is my responsibility to update any and all personal, insurance, and health information.

I also authorize Seven Hills Medical Services PC/Franklin Medical Care PC to use my email/cell phone for any electronic communications about my appointment dates, results, reminders, etc.

Name (print): _____

Signature: _____

Date: _____

Email: _____

Phone Number: (_____)_____

Name: _____ **DOB**: ____/____/____

Allergies to Medications, X-Ray Dyes, or Other Substances: [ ] No [ ] Yes

If yes, please list name of medicine and type of reaction:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History:

1. High Blood Pressure	13. Bronchitis	25. Ulcers	37. Arthritis
2. Diabetes	14. Pneumonia	26. Change in Bowels	38. Lower Back Problems
3. Cancer	15. Persistent Cough	27. Unexpected Weight Gain/Loss	39. Skin Disease
4. Heart Disease	16. T.B.	28. Hemorrhoids	40. Blood Disorder
5. Chest Pain/Chest Tightness	17. Hay Fever	29. Gall Bladder Disease	41. Venereal Disease
6. Shortness of Breath	18. Abdominal Discomfort	30. Colitis	42. Anxiety
7. Swollen Ankles	19. Indigestion	31. Hepatitis/Jaundice	43. Depression
8. Palpitations	20. Nausea	32. Thyroid Disease	44. Anemia
9. Light Headedness	21. Vomitting	33. Headaches	45. Alcohol Abuse
10. Frequent Urination	22. Constipation	34. Head/Neck Radiation	46. Drug Abuse
11. High Cholesterol	23. Diarrhea	35. Kidney Disease/Stones	47. Gout
12. Asthma	24. Blood in Stool	36. Difficulty Uriniation	48. Other: _____

Gynecologic and Obstetric History

Onset Period Age: _____ Frequency: _____ Length of Periods: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged/Abnormal Bleeding: [ ] No [ ] Yes; If yes, please describe: _____

Leakage of Urine: [ ] No [ ] Yes; If yes, please describe: _____

Pelvic Pain: [ ] No [ ] Yes; If yes, please describe: _____

Abnormal Discharge: [ ] No [ ] Yes; If yes, please describe: _____

Please List and Supply Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations (Other than Surgery): _____ _____

_____ _____ _____

Name: _____ **DOB**: ____/____/____

Immunization History

Hepatitis B? [ ] No [ ] Yes If yes, what date? _____

Pneumovax Immunization? [ ] No [ ] Yes If yes, what date? _____

Flu Immunization? [ ] No [ ] Yes If yes, what date? _____

Tetanus Immunization? [ ] No [ ] Yes If yes, what date? _____

When was Your Last:

Pap Smear? _____ Breast Exam? _____ Mammogram? _____

Prostate Check? _____ Check for Bloody Stool? _____ Cholesterol Check? _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	*Family Member*	*Age Approx. Diagnosed*
Cancer (Type)		
Hypertension		
Heart Disease		
Diabetes		
Strokes		
Mental Disease		
Drug/Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other:		

Medications

Drug Name	Dosage	Drug Name	Dosage

Name: _____ **DOB**: ____/____/____

Prevention

Do you wear seatbelts? [ ] No [ ] Yes If no, why not? _____

Do you wear a bike helmet? [ ] No [ ] Yes [ ] N/A

Do you smoke? [ ] No [ ] Yes If yes, how many per day? _____

Do you drink alcoholic beverages? [ ] No [ ] Yes If yes, how many per week? _____

Do you use drugs (marijuana, cocaine, heroin, etc.)? [ ] No [ ] Yes If yes, what kind? _____

Do you drink coffee? [ ] No [ ] Yes If yes, how many cups per day? _____

Do you drink tea? [ ] No [ ] Yes If yes, how many cups per day? _____

If there's a gun in your home, do you keep it unloaded & out of children's reach? [ ] No [ ] Yes [ ] N/A

Have you ever engaged in any activity which has put you at risk of getting AIDS? [ ] No [ ] Yes [ ] N/A

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? [ ] No [ ] Yes

Are you in a relationship in which you have been physically hurt by your partner? [ ] No [ ] Yes

Do you ever feel afraid of your partner? [ ] No [ ] Yes

Do you have a living will? [ ] No [ ] Yes

Do you have a donor card? [ ] No [ ] Yes

Method of birth control? _____

I hereby agree that all the information provided above is accurate to the best of my knowledge.

_____

Print Name

_____ _____

Signature Date

Seven Hills Medical Center

Demographics Sheet

Patient's Name: _____

Address: _____

Town: _____ State: _____ Zip: _____

DOB (MM/DD/YYYY): _____

Social Security Number: _____

Phone Numbers: _____ [ ] Cell [ ] Home [ ] Work

_____ [ ] Cell [ ] Home [ ] Work

_____ [ ] Cell [ ] Home [ ] Work

E-Mail Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Emergency Contact Address: _____

Employer's Name: _____

Employer's Address: _____

Primary Doctor Name: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

Address: _____

Primary Insurance Name: _____

Primary Insured's Name: _____

Primary Insured's DOB (MM/DD/YYYY): _____

Relationship to the Insured: _____

Secondary Insurance Name: _____

Secondary Insured's Name: _____

Secondary Insured's DOB (MM/DD/YYYY): _____

Relationship to the Insured: _____

How did you hear about us? ☺

[ ] Family: _____

[ ] Friend: _____

[ ] Physician: _____

[ ] Other: _____

Seven Hills Medical Center

Medical Information Release Form

Patient HIPAA Awareness
As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practice or in accordance with your wishes as stated below.

This waiver authorizes Seven Hills Medical Center PC to send/give medical information as noted:

Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:
[ ] Spouse: _____
[ ] Child(ren): _____
[ ] Other: _____

[ ] Information is not to be released to anyone. This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: _____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

On this date _____, I received and reviewed Seven Hills Medical Center PC's Notice of Privacy Practices, which describe how my medical information may be used and disclosed and explains how I can get access to this information. The authorizations made above will remain effective until I notify Seven Hills Medical Center in writing of requested change.

_____
Print Name of Patient or Legal Guardian

_____
Signature of Patient or Legal Guardian

_____
Date

Seven Hills Medical Center

Authorization Form – HIPAA

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Seven Hills Medical Center/Dr. Venkatesh, to use and/or disclose certain protected health (PHI) about me to:

This authorization permits Dr. Venkatesh to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service(s), type of service(s), level of detail to be released, origin of information, etc.).

If disclosure is requested by the patient, purpose may be listed as "at the request of the individual". The information will be used or disclosed for the following purpose:

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

The practice will [ ] will not [ ] receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Dr. Venkatesh/Seven Hills Medical Center PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My return revocation must be submitted to the privacy officer, Dr. Venkatesh/Seven Hills Medical Center PC.

_____	_____
Print Name of Patient or Legal Guardian	Date
_____	_____
Signature of Patient or Legal Guardiam	Relationship to Patient

Seven Hills Medical Center

Patient Responsibility Disclosure Statement

Your signature below forms a binding agreement between Seven Hills Medical Center PC (the provider of medical center) and the patient who is receiving medical services or the responsible party for minor patient (those patients under 18 years of age). Responsible party is the individual who is financially responsible for payment of medical bills.

ALL charges for services rendered are due and payable at the time of service.
(*Please initial all below*)

_____ I am responsible and expected to pay Seven Hills Medical Center PC for the following:

1. Any co-payment as set by my insurance carrier.
2. Any unsatisfied deductible or termination of coverage.
3. Any amount my insurance carrier deems my responsibility.
4. Any amount considered not covered by my insurance carrier.

_____ Co-pays: All co-pays are due at the time of service. If your insurance requires any additional co-pays you will be responsible for payment and will be billed for it.

_____ Authorization to pay benefits to the physician: Any and all insurance checks that may go directly to the patient MUST be signed over to Seven Hills Medical Center PC for payment for services rendered. Failure to do this will result in the patient receiving a bill for services. I hereby authorize payment for medical services provided directly to Seven Hills Medical Center PC physician. If I should receive any insurance payments, I am to sign the check over to Seven Hills Medical Center PC.

_____ Returned Check Policy: If a payment is made on an account by check and the check is returned as non-sufficient funds (NSF), account closed (AC), or refer to maker (RTM), the patient or patient's responsible party will be responsible for the original check amount in addition to a $10.00 service charge.

I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance information to Seven Hills Medical Center PC.

_____ _____

Patient Name (Print) Date

_____

Patient Name (Signature)

Seven Hills Medical Center

Appointment No Show/Cancellation Policy

Due to high volume of scheduled appointments and in order to best serve our patients, the following policy is necessary:

We require a 24 hour notice if you are not able to make your scheduled appointment.

Failure to do so will result in an **$85** charge.

Payment in full is necessary prior to any treatments being rendered.
The payment is non-refundable and non-transferable.

By signing below, I agree that I was informed of this office policy.

_____

Patient Name (Print)

_____

Signature

_____

Date

Seven Hills Medical Center

Updated Policies (2016)

Due to current economic conditions, there have been a few changes to some of our policies.

1. Any forms that needs to be filled out, there will be a charge of **$25**.
2. Any letter or report which needs to be mailed to patient's home or office, there will be a charge of **$5 per mailing**.
3. Fee for returned/bounced checks will result in a **$29 fee**.
4. We can always fax any documents ***free of charge***.
5. No more mail prescriptions. All prescriptions are electronically sent even if it is MEDCO/Prescription Solutions. **Please inform us of any changes with your pharmacy**.
6. As per state law, the doctor has to see **ALL** patients who need prescriptions for narcotics/anxiolytics/sleep medications. **NO EXCEPTIONS**!
7. No antibiotics will be prescribed over the phone. Immediate visit is required and you will be accommodated into our schedule.
8. All balance needs to be paid in full on the same day of the visit.

I have read, understood, and will comply with the above mentioned terms and conditions.

_____

Patient Name (Print)

_____

Signature

_____

Date