Patient Intake Form

NARBERTH FAMILY MEDICINE

Today's Date

Patient's FullName:

If the words "**PERSONAL CHOICE**" or "**INDEPENDENCE BLUE CROSS**" appear anywhere on your insurance ID card **YOU MUST** pay in full for your visit in the office at the time of service.

Primary Insurance Name
Primary Card Holder: ☐ Self ☐ Spouse ☐ Parent

Subscriber ID #

Group #_____

Name of Policy Holder

Date of Birth of Policy Holder

Copay amount: $_____

Secondary Insurance Name
Primary Card Holder: ☐ Self ☐ Spouse ☐ Parent

Copay amount: $_____

Subscriber ID #

Group #_____

Does this visit pertain to a worker's compensation injury or an MVA claim?

☐ **Yes** ☐ **No** **if you answered yes,**

Date of injury:_____

Claim #: _____

Adjuster Name:_____

Phone Number: _____

822 Montgomery Avenue Suite 315
Narberth, PA 19072

Phone: 610-667-4601
Fax: 610-667-6416

frontdesk@drandrewlipton.com

Demographic Information

Home Phone

Cell Phone

Address

City

State

ZIP Code

DOB

Email Address

Gender

Race

Are you currently under medical care? ☐ Yes ☐ No

Primary Care Physician

How did you hear about us?(family, friend, website, etc.)

How would you classify your problem? ☐ minor ☐ involved ☐ serious

What is your main complaint? _____

_____

_____

What would make today's visit successful? _____

_____

Please Note: We are an osteopathic based integrative medicine practice. Your evaluation will routinely include a complete structural evaluation and osteopathic manipulative therapy which is billed to your insurance as a separate procedure from the office visit.

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Financial Policy, Assignment & Agreement

I, the undersigned, understand claims for services rendered will be submitted to my insurance company for payment. I understand that my health insurance is considered a method of reimbursing me for fees paid to Narberth Family Medicine and Acupuncture Center and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. Therefore, as my insurer may not cover all the services necessary for my treatment, I will be responsible to pay for and be financially liable for all applicable deductibles, co-pays and non-covered items as determined by my insurance carrier. Furthermore, if it is determined by the staff at Narberth Family Medicine that there is a patient copay(s) associated with any of the services provided to me. I understand that these copay(s) are expected at the time services are rendered and will be paid by me at that time.

Although Narberth Family Medicine and Acupuncture Center may **as a courtesy** convey to me information that it receives from my insurance company regarding the scope of my coverage, I understand that Narberth Family Medicine and Acupuncture Center is not responsible to confirm or verify the scope of my coverage and cannot guarantee the accuracy of the information that it receives from my insurer. **I understand that both before and during the course of treatment, I am responsible for understanding the scope of my insurance coverage, given that it does belong to me.** I am also aware that I should personally verify the scope of my insurance coverage with my insurer if I wish to have confirmation regarding the extent of insurance available for my treatment.

1. **I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize and assign Narberth Family Medicine and Acupuncture Center to release to Medicare and/or my insurance carrier and their agents any information needed to determine these benefits or the benefits for related services.**

2. **This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether paid or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.**

SIGNED (Patient or Parent if minor) _____

PRINT NAME_____

DATE_____

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HIPPA -Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NFMAC is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.

Worker's Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about our medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to, preventing, or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

Change of Ownership.

In the even that **NFMAC** is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that **NFMAC** is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that **NFMAC** amend your protected health information. Please be advised, however, that **NFMAC** is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by **NFMAC.**
- You have a right to a paper copy of this Notice of Privacy at any time upon request.

Changes to this Notice of Privacy Practices

NFMAC reserves the right to amend this Notice of Privacy Practices at any time in the future and will make.
the new provisions effective for all information that it maintains. Until such amendment is made, NFMAC is required by law to comply with this Notice.

NFMAC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

This notice is effective as of _____ / _____ / _____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide NFMAC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ Date _____

Patient's Name (print)

Signature _____

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Past Medical History (mark all that apply)

☐ Anxiety ☐ Breast Cancer ☐ Diabetes ☐ Hypertension ☐ Leukemia
☐ Arthritis ☐ Colon Cancer ☐ End Stage Renal Disease ☐ HIV / AIDS ☐ Lung Cancer
☐ Asthma ☐ COPD ☐GERD ☐ Hypercholesterolemia ☐ Lymphoma
☐ Atrial fibrillation ☐ Coronary Artery Disease ☐Hearing Loss ☐ Hyperthyroidism ☐ Prostate Cancer
☐ Bone Marrow ☐ Depression ☐ Hepatitis ☐ Hypothyroidism ☐ Seizures

☐ other (specify)_____

_____

Past Surgical History

Type of Surgery	Date of Surgery

Hospitalizations (not including surgeries listed above)

_____

_____

Family History

please list all medical conditions/problems for the following family members:

Relative	Condition	If deceased, at what age?
Mother		
Father		
Sister(s)		
Brother(s)		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

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Social History

Do you or have you ever smoked tobacco? ☐ Yes ☐ No

Do you or have you ever used any other forms of tobacco or nicotine? ☐ Yes ☐ No

Do you or have you ever used e-cigarettes or vape? ☐ Yes ☐ No

Do you or have you ever used smokeless tobacco? ☐ Yes ☐ No

How many years have you used smokeless tobacco? _____

What is your level of alcohol consumption? ☐ none ☐ occasional ☐ moderate

Do you use any illicit or Recreational drugs? ☐ Yes ☐ No

What is your level of caffeine? consumption? ☐ none ☐ occasional ☐ moderate

What is your relationship status? ☐ married ☐ single ☐ divorced ☐ separated ☐widowed ☐ domestic partner.

Are you sexually active? ☐ Yes ☐ No

How many children do you have? _____

Current Medications (prescribed and/or over the counter) ☐None

Name of medication	Dose

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Supplements

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies (please list medication and the reaction it causes.) ☐ No Known Drug Allergies

_____ _____

_____ _____

Review of Systems

Constitutional
☐ Weight Loss
☐ Fatigue
☐ Fever
☐ Dizziness

Cardiovascular
☐ Murmur
☐ Chest Pain
☐ Palpitations
☐ Edema (swelling)
☐ Shortness of Breath

Gastrointestinal
☐ Heartburn/Reflux
☐Nausea/Vomiting
☐Constipation
☐ Change in Bowel Movements
☐ Abdominal Pain.
☐ Diarrhea
☐Black or Bloody Stools

Psychiatric
☐ Anxiety/Depression
☐ Mood Swings
☐ Difficulty Sleeping.

Musculoskeletal
☐ Joint Pain/Swelling
☐ Stiffness
☐ Muscle Pain
☐Back Pain

Eyes
☐Glasses/Contacts
☐ Eye pain
☐ Cataracts
☐ Double Vision

Endocrin
☐ Loss of Hair
☐ Heat/Cold Intolerance
☐ Fatigue
☐ Weight Gain/Loss

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Genitourinary
- ☐ Burning/Frequency
- ☐ Bladder Leakage
- ☐ Blood in Urine
- ☐ Erectile Dysfunction
- ☐ Abnormal Discharge

Skin
- ☐ Rash/Sores
- ☐ Chills
- ☐ Itching/Burning

Ear/Nose/Throat
- ☐ Difficulty Hearing
- ☐ Ringing in Ears
- ☐ Vertigo
- ☐ Sinus Pressure
- ☐ Nasal Congestion
- ☐ Frequent Sore Throat

Respiratory
- ☐ Cough
- ☐Wheezing

FEMALES ONLY
- ☐ Age of onset period_____
- ☐ Age of onset menopause_____
- ☐ Number of Pregnancies
- ☐ Periods Regular? __Yes ____No
- ☐ Date of last menstrual period_____

Allergic/ Immunologic
- ☐ Hives/Eczema
- ☐ Hay Fever

Neurological
- ☐ Weakness
- ☐ Numbness
- ☐ Headaches
- ☐ Tremors
- ☐ Memory Loss

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