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COMMUNICATION CONSENT FORM

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PHONE #

HOME _____
 WORK _____
 CELL _____
 OTHER _____
 EMAIL _____

<u>ORDER TO CALL</u>					<u>MESSAGE?</u>	
1 ST	2 ND	3 RD	4 TH	NEVER	YES	NO

In the event that we are unable to reach you, may we give your results to anyone except yourself?

If so, who: _____ Relationship Spouse Child Friend _____

I understand that it is my responsibility to notify the office of any changes to this list, or if at any time I wish to have this consent revoked.

Signed _____ Date _____

This authorization is valid for **1 year** from date of signature.



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January, 2007

To the Patients of the Lakewood Family Medicine:

As our practice continues to grow, it is necessary for us to inform new patients and remind existing patients of our business policies. Listed below are our guidelines which represent the philosophy of the practice. Please read and familiarize yourself with them. We believe that they help us take better care of you.

Appointments:

We require that all visits to our office be scheduled in advance. Patients may not be seen without a scheduled appointment. Whenever possible, please schedule your next appointment prior to leaving our office. This will secure an appointment time that is both convenient for you and will also coordinate with any medication refill schedule.

Please notify the office at least 24 hours in advance if you must cancel or reschedule your appointment. Otherwise, there will be a service charge for all missed appointments not cancelled in advance. This charge is not reimbursable by any insurance company and must be paid prior to seeing the Doctor again.

Phone Calls:

Except in the case of a truly urgent medical problem, we ask that you contact the office during business hours 8:00am-6:00pm Monday thru Friday. Only Urgent medically necessary request should be directed to the answering service after hours.

Your office visit is the best time to ask all the questions you have. We suggest you write these down so you don't forget to ask them during the visit. *If you utilize your visit wisely, you need not call the office unless:*

1. The Doctor or Nurse Practitioner told you to call;
2. You have a problem with a prescription prescribed by the Doctor or Nurse;
3. You have an urgent medical problem;
(Please note that running out of your medication(s) early does not constitute an emergency);
4. You need to schedule a routine appointment.

Please understand that unscheduled visits and frequent phone calls can be very disruptive to taking care of patients. Minimizing such calls will allow us to concentrate better on our daily tasks, and in turn, better serve you during your visit to our office.

Medications:

Please bring a list of all your medications to each visit. This list should include the name of the medication, dose and frequency and should be presented at the beginning of your visit. Better yet, place all your pill bottles in one bag and just bring the bag.

All refill requests for medication should be made during your office visit. Please check the amount of each of your medications before your visit so refills can be written to meet your needs. This will ensure that you have sufficient supply to last until your next appointment.

Refills between visits must be *called in by your Pharmacist* to our refill line (call them FIRST!): 303-985-1597 or *faxed by your Pharmacist* to 303-985-2108. Please allow a minimum of 72 hours to process refill requests.

Medicare Patients:

If your primary insurance is traditional Medicare, please note that you will be asked to fill out an Advanced Beneficiary Notice for those charges that we believe to be medically necessary, but that Medicare may not cover.

Finance and Insurance:

We provide quality medical care at a reasonable cost. We participate with most insurance plans. Please help us serve you well by being a responsible consumer. By knowing and following your insurance policy we can work together effectively in this time of managed care.

You will be asked to provide a copy of your insurance card at each visit. Patients are responsible for the terms of their insurance policies. If you have questions regarding your coverage, referrals, exclusions, etc., call your member services office-the phone number should be listed on your insurance card. *There are thousands of plan variations, please do not ask our staff questions regarding your insurance policy*-each policy is so different, it would only be our best guess.

The billing process and mailing of statements is a very expensive process, therefore we ask that you pay any deductibles and patient pay portion of your bill at the time of service. Additionally, Lakewood Family Medicine is obligated to collect co-pay for any and all type visits at the time service is provided. **Your co-payment is due at each visit and should be presented upon your arrival. A \$10.00 service charge will be assessed for any co-payment not paid at the time of your appointment.**

If you are covered by an insurance plan that Dr. Hermann and Dr. Lipson participates with, your insurance will be billed up to 3 times (each visit) as a courtesy to you. Please understand however, that regardless of insurance coverage, *you are responsible for all-charges incurred during your office visit*. Certain medical services may be excluded from your insurance plan and you will be fully responsible for that portion of the bill. Statements will be mailed for any remaining balances owed after insurance has paid their portion of your

If despite our best efforts, we do not receive reimbursement from your insurance company within 90 days, you must pay us in full I take over dealing directly with your insurance company to obtain reimbursement.

Patients without insurance, or who have insurance with which we do not participate, will be required to pay in full for all charges at the time of service. Patient account balances are due and payable within 30 days. Any balances more than 30 days will be assessed monthly \$4.00 re-billing charge.

We contract with a collection agency to secure payment for any outstanding account balances not paid in a timely manner. Any additional costs associated with these actions, ie., collection fees, attorney and court fees, etc., are the responsibility of the account guarantor, patient, parent or guardian. Please be aware that once your account has been referred to a collection agency you will be asked to find another doctor.

Your Privacy:

Lakewood Family Medicine is committed to providing you with quality health care and to forming a relationship with you that is built with trust. We protect your privacy and confidentiality rights by putting into practice policies and procedures that allow access to your personal medical information only for legitimate reasons.

When we provide your health care, we are required to maintain a complete copy of your medical history, current condition, treatment plan and all treatment provided, including test results, procedure and therapies. Physicians and other health care professionals who are involved in your care may need to access to this information in order to provide appropriate treatment. Your medical record is the physical property of our practice. However, you or anyone to whom you give written permission, or your legal representatives, have the right to read and obtain a copy of your medical information.

Lakewood Family Medicine has established detailed policies regarding access to medical records, carefully outlining the circumstances under which your medical information may be released to outside parties. These policies conform with state and federal law and are designed to safeguard your privacy. You will be asked to review our "Privacy Practices" and sign an annual consent indicating your understanding of these policies.

Administrative costs associated with managed care have skyrocketed in recent years. You can help us better serve you, by taking responsibility for your share of the relationship. Only then can we provide you with the excellent, cost-effective health care. Let's work together, shall we?

Signature: I have read and agree to abide by the preceding policies, terms and conditions of Lakewood Family Medicine.

Patient Signature (Parent or Guardian)

Date



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand that, under the Health Information Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers;
- Conduct normal health care operation such as quality assessments and physician certifications.

I have been informed and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Lakewood Family Medicine has the right to change its Notice of Privacy Practices from time to time and that I may contact Lakewood Family Medicine at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

- Relationship to Patient: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	Initials:	Reason:

PATIENT NAME: _____ DATE OF BIRTH: _____

ANNUAL CONSENT FOR TREATMENT

The signer, knowing that the patient is suffering from a condition requiring diagnosis and medical treatment, does hereby voluntarily agree to such diagnostic procedures and services and to such medical treatment, x-ray treatment and injections which may be administrated to or performed on the patient under the general or specific instruction of the attending physician, his or her assistants or his or her designees.

As a patient, you have the right to be treated with respect and dignity. You are entitled to receive information regarding the methods of treatment, the techniques used, and the fees involved in treatment. You may seek a second opinion from another physician or terminate treatment used at any time. Furthermore, you should now that sexual intimacy is never appropriate between a physician and a patient.

I hereby apply for the voluntarily consent to care provided by the staff at the Lakewood Family Medicine medical office. I understand that any surgical procedure will be fully explained to me and my consent will be obtained prior to any such procedure.

Signature: _____ Date: _____

PAYMENT AGREEMENT

I understand that I am responsible for all charges including co-pays except in the case of Medicaid, Medicare, Worker's Compensation, Auto related injuries with PIP will cover charges, and participating insurance plans. I authorize payment of medical benefits to the undersigned physician or supplies for services described below. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits.

Signature: _____ Date: _____

ANNUAL CONSENT/PREAUTHORIZATION TO TREAT MINORS

For families who are ongoing patients of Lakewood Family Medicine it may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you wish to authorize such treatment in advance.

I request and authorize Lakewood Family Medicine and its personnel to deliver medical care to my child listed below:

Name: _____ Date of Birth: _____

Signature: _____ Relationship: _____

In the event of a emergency, please try to contact me regarding health care of my child at the following number:

Parent Name: _____ Office/Home: _____ Office/Home: _____

Parent Name: _____ Office/Home: _____ Office/Home: _____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain on the reverse side of this form with your signature, printed name, and phone number for contact.

Medical History

Date _____

Name _____ Age _____ Birthdate _____

Address _____ Sex Male Female

Home Phone _____

Work Phone _____

Occupation _____ Emergency Contact _____

Phone _____

Single Married Divorced Widowed Separated

If married, spouse's name _____

Children's names and ages _____

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 and Review of Systems

Please check off if you have had any problems with or are presently experiencing any of the following:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Unexplained weight gain/loss	<input type="checkbox"/> Low back problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Skin diseases
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> T.B.	<input type="checkbox"/> Gall Bladder disease	<input type="checkbox"/> Blood disorders
<input type="checkbox"/> Chest pain/chest tightness	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Colitis	<input type="checkbox"/> Venereal diseases
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Hepatitis or jaundice	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Nausea	<input type="checkbox"/> Head or neck radiation	<input type="checkbox"/> Anemia
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Headache	<input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Gout
<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Impotence or Erectile Dysfunction
	<input type="checkbox"/> Ulcers		<input type="checkbox"/> Other

Gynecologic and Obstetric History

Age at onset of periods _____ Frequency _____ Length of period _____

Pregnancies _____ Births _____ Miscarriages _____

Prolonged or abnormal bleeding No Yes (Please describe) _____

Leakage of urine No Yes (Please describe) _____

Pelvic pain No Yes (Please describe) _____

Abnormal discharge No Yes (Please describe) _____

History of abnormal Pap smear No Yes (Please describe) _____

Medical History

Name _____

Date _____

Please List and Supply the Dates of:

Operations _____

Hospitalizations other than for surgery _____

Immunization history—have you had:
 Hepatitis B? No Yes When? _____
 Other? No Yes When? _____
 Pneumovax immunization? No Yes When? _____
 Flu immunization? No Yes When? _____
 Tetanus immunization? No Yes When? _____

When was your last:
 Pap Smear? _____ Breast Exam? _____ Stool check for blood? _____
 Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

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

Illness	Which family members?	Age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc.)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Other _____	_____	_____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Prevention

Do you wear seat belts? Yes No If no, why not? _____
 Do you wear a bike helmet? Yes No N/A
 Do you exercise regularly? Yes No If yes, type, duration and number of times per week? _____
 Do you smoke? Yes No If yes, how many packs per day? _____
 Do you drink alcoholic beverages? Yes No If yes, how much per week? _____
 Do you drink coffee? Yes No If yes, how many cups per day? _____
 Do you drink tea? Yes No If yes, how many cups per day? _____
 If there is a gun in your home, do you keep it unloaded and out of children's reach? Yes No N/A
 Do you use drugs? (marijuana, cocaine, crack, etc.) Yes No If yes, explain: _____
 Have you ever engaged in any activity which has put you at risk of getting AIDS? Yes No If yes, explain: _____
 Do you wish to be tested for AIDS? Yes No
 Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Yes No If yes, explain: _____
 Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Yes No
 Do you ever feel afraid of your partner? Yes No N/A
 Do you have a "living will"? Yes No
 Do you have a donor card? Yes No
 Method of birth control? _____