PT Family Medicine, PC Financial Policy

Welcome to PT Family Medicine, PC and thank you for choosing us as your primary care provider. We would like to take this opportunity to familiarize you with the practice policies. These policies help us to provide quality care in an efficient manner. Please do not hesitate to contact our office manager if you have any questions about these policies.

- You will be asked to present your insurance card at each visit.
- Please notify us of any changes to your address, personal information, or insurance information.
- PT Family Medicine, PC is pleased to process your insurance claim for reimbursement. However, please remember that:
    - Your insurance is a contract between you, your employer, and the insurance company. PT Family Medicine is not a party to your health insurance contract.
    - Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore,are normally covered up to the maximum allowance determined by each carrier.
    - Not all services are covered benefits on all insurance contracts. Some insurance companies have certain services that they will not cover.
    - Most insurance policies have copayment and/or deductible arrangements. This means that you have some payment responsibility.
    - Any charges that are denied or unpaid by your insurance carrier will be billed to you. We expect that these balances will be paid in a timely manner.
- If you do not have health insurance coverage, 50% of the lowest billable cost will be accepted at the time of service; there is a chance that a higher level of service is billed and you may receive an additional fee to cover these costs. If you do not pay at the time of service, you will be billed the full amount.
- We accept payments in the form of cash, personal check, Visa, MasterCard, American Express or Discover.
- Please understand that appointment times are limited. If you are unable to keep your scheduled appointment please notify us at least 24 hours in advance to reschedule.
- If you are scheduled for an appointment and do not notify us within 24 hours and do not appear for the appointment, you will be given a courtesy call on the first offense. Each occurrence following will accrue a $25 fee and we ask this be paid prior to scheduling another appointment. If there are repeated missed appointments and/or cancellations less than 24 hours in advance you may be dismissed as a patient from the practice.

PT Family Medicine, PC HIPAA Policy

Disclosure of Health Information: I wish to allow disclosure to the following family members, friends, or individuals. I understand that I may change this list at any time:

Name:_____

Relationship: _____

Phone Number:_____

Disclosure (circle one, if limited provide details of what we can discuss): Full or Limited

Name:_____

Relationship: _____

Phone Number:_____

Disclosure (circle one, if limited provide details of what we can discuss): Full or Limited

Name:_____

Relationship: _____

Phone Number:_____

Disclosure (circle one, if limited provide details of what we can discuss): Full or Limited

PATIENT ACKNOWLEDGEMENT: I have read and understand my responsibilities as outlined above.

_____	_____	_____
Printed Patient Name	Signature of patient or responsible party, if a Minor	Date

OFFICE USE ONLY

A good faith effort was made to obtain written acknowledgement of the HIPAA policy.

Date _____ Signature of staff member _____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for PT FAMILY MEDICINE, P.C.**

  Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

  Signed_____**Date:**_____

- **I authorize PT Family Medicine, P.C. to release medical information required to process my claim**

  Signed_____**Date:**_____

- **I have read and understand the Financial Policy for PT FAMILY MEDICINE, P.C.**

  Signed_____**Date:**_____

- **I authorize PT FAMILY MEDICINE, P.C. to obtain/have access to my medication history**

  Signed_____**Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

  Signed_____**Date:**_____

PT Family & Sport Medicine
2057 State Route 130
Jeannette, PA 15644
724-527-2700

PT Family & Sport Medicine

Long Term Use of Controlled Substance Agreement

As part of PT Family Medicine (the "Clinical Office Site") is committed to providing patient care consistent with the recommendations of your physician or Advanced Practice Provider, _____ **(name of physician or APP)** (the "Physician"). In your case, your Physician has recommended Controlled Substances as a component of your overall treatment plan. Controlled Substances include medications for pain (such as opioid analgesics), anxiety, sleep and attention deficit disorder.

PATIENT AND PT FAMILY MEDICINE EXPECTATIONS:

- **Purpose of Treatment:** I understand that the goals of my treatment with Controlled Substances are to decrease my pain and increase my ability to participate in activities of daily living, and/or to participate in my Physician's recommended treatment plan.
- **Comprehensive Treatment Plan:** I understand that taking Controlled Substances is only one part of my overall treatment. The renewal of my Controlled Substance prescriptions depend on both my medical needs and my consistent participation with the overall recommended treatment plan set forth by my Physician.
- **Disclosure of Medications:** I have disclosed to my Physician **ALL** medications, including, but not limited to, Controlled Substances I take for any reason. I must update the Physician named above of **ANY** changes. ***I understand that this list will become part of my permanent medical record.*** Moreover, I give my physician or his/her designee, my express permission to discuss my medication history and current medication practice with any physician, APP, or pharmacy.
- **This Clinical Office Site is Your Exclusive Provider of Controlled Substances:** I will not attempt to obtain prescriptions for Controlled Substances from any source other than my above-named Physician or APP. If I require treatment with Controlled Substances because of an emergency medical or dental situation, I will notify my Physician within seventy-two (72) hours of beginning the treatment.
- **Use of Medications:** I will take **ALL** Controlled Substances exactly as prescribed to me. This means I will not change the dose, frequency, or alter the form of drugs themselves (such as opening capsules, cutting in half, crushing, or chewing medications). I understand that increasing the dose or frequency of any medication, including Controlled Substances, or altering its form, may result in harmful effects including overdose.
- **Pharmacy Identification:** I agree to fill all of my Controlled Substances exclusively at the Pharmacy named below:

  Pharmacy Address:

  Telephone:

- **PT Family Medicine Policy Dictates Refills:** My Physician will only refill my prescriptions consistent with PT Family Medicine policies and procedures. 1) My Physician will not fill any prescriptions early if I run out of Controlled Substances before my scheduled refill or appointment. 2) My Physician or APP will only renew my Controlled Substances prescriptions during a scheduled office visit during the Clinical Office Site's regular office hours. No refills of any Controlled Substance will be written or called in after regular clinic hours or on the weekends. 3) My Physician or APP will not replace lost, stolen, damaged, or otherwise rendered useless Controlled Substances or Controlled Substance prescriptions.
- **Appointment Responsibilities:** I will bring **ALL** medications, including Controlled Substances, in their prescription bottles to **EVERY** appointment.
- **Compliance with Appointment Schedule:** I agree to attend **ALL** scheduled appointments. My physician or APP may determine if I will attend my scheduled appointment in person at the office of PT Family Medicine or if I will attend the appointment via Telemedicine (video). If I choose to partake in telemedicine, I agree that after two consecutive appointments via telemedicine, I will attend the third appointment in person at the office of PT Family Medicine.
- **Drug Testing/Pill Counts:** I agree that my Physician or his/her designee may order me to be tested for drug use at any time in his/her sole discretion. I agree to comply with any and all drug tests, instructions, and pill counts that may be

PT Family & Sport Medicine
2057 State Route 130
Jeannette, PA 15644
724-527-2700

ordered by my Physician or his/her designee, including, but not limited to, urine or blood samples even if requested on days when I have no scheduled appointment. **Patient Initials:** _____

- **Risks of Birth Defects (Female Patients):**
  1) **I am not pregnant:** My Physician or his/her designee, has explained the risks to my unborn child if I become pregnant while taking Controlled Substances. I have also been informed of the importance of using safe and effective birth control while taking Controlled Substances. If I become pregnant, I will notify my physician immediately.
  2) **I am pregnant:** I have informed my Physician or APP of my pregnancy. I acknowledge that I have a complete understanding of the risks of taking Controlled Substances, including opioids, while pregnant. I have chosen to take Controlled Substances despite these risks.
- **Illegal Drug Use and/or Activity:** I will not use any illegal substances/drugs or prescription drugs obtained through illicit means and I will not share, sell, or trade any of my medications, including Controlled Substances prescribed by my Physician with anyone.
- **Use of Alcohol:** Controlled Substances should not be taken with alcohol. I acknowledge that I have a complete understanding of the risks of consuming alcohol while taking Controlled Substances. Should I consume alcohol while taking the Controlled Substances prescribed to me, I do so despite these risks.
- **Notification of Change in Mental Status:** Controlled Substances may impair mental and/or physical ability required for the performance of potentially hazardous tasks. I agree to inform my Physician of **ALL** effects from **ALL** of my medications, including Controlled Substances, as they arise, including, but not limited to, feelings of over sedation (fatigue), nausea, vomiting, constipation, confusion, euphoria, (high feelings), and dysphoria (down feelings). If my level of consciousness is altered, I will not drive or operate heavy machinery.
- **Authorization to Share Protected Health Information:** I agree to waive my right to privacy and authorize the above named Physician or his/her designee, to discuss my medical care and to disclose my use of medications or possible misuse with any health care Provider, Pharmacy, legal authority, or regulatory agency in his/her sole discretion. I further authorize the above named Physician to cooperate fully with any city, state, or federal law enforcement agency (including the DEA), in the investigation about my care or actions.
- **Termination of Treatment at PT Family Medicine:** I understand that my Physician may stop treating me as a patient in his/her sole discretion. Moreover, I acknowledge that my Physician may in his/her sole discretion stop treating me with Controlled Substances, refer me to a substance abuse specialist, and/or terminate my patient status if I break any portion of this Agreement or am arrested for any unlawful conduct.
- **Physician's Medical Judgement:** Nothing in this Agreement is intended to interfere with Physician's medical judgement.

My signature confirms that I understand and agree to all of the above requirements of the Controlled Substances Agreement.

MY SIGNATURE BELOW ACKNOWLEDGES THAT:

1) I have executed this Controlled Substances Agreement voluntarily after having sufficient time to review it.
2) I agree to all of the above requirements of the Controlled Substances Agreement with full understanding of the risks of being prescribed Controlled Substances.
3) I have read, understand, and agree to the statements set forth above in this document.
4) I have had the opportunity to ask questions about this document to a physician or a physician's designee.

Patient Full Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Date:** _____

I have received a copy of this signed Agreement **Patient Initial:** _____

Witness Signature: _____ **Date:** _____

PT Family Medicine Provider Signature: _____ **Date:** _____

PT medicine

PTFM HEALTH HISTORY QUESTIONNAIRE

ALLERGIES:

List anything that you are allergic to and how it affects you.

ALLERGY	REACTION

MEDICATIONS:

List all medications you are taking, including prescriptions and over-the-counter drugs, such as eye drops, vitamins, inhalers, supplements and birth controls.

MEDICATION NAME	DOSE

PAST SURGICAL HISTORY

1) _____

2) _____

3) _____

4) _____

5) _____

PT medicine

HAVE YOU RECEIVED THE FOLLOWING VACCINES?

	YES	NO	NOT SURE
Pneumonia			
Tetanus			
Shingles			
COVID-19			

PAST MEDICAL HISTORY

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Depression
- ☐ Diabetes- Insulin
- ☐ Diabetes- Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive or Underactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PT medicine

FAMILY HEALTH HISTORY

Please circle any family member with the listed diagnosis:

HEART DISEASE	Mother	Paternal Grandmother	Maternal Uncle
	Father	Paternal Grandfather	Paternal Uncle
	Maternal Grandmother	Maternal Aunt	Sibling
	Maternal Grandfather	Paternal Aunt	
STROKE	Mother	Paternal Grandmother	Maternal Uncle
	Father	Paternal Grandfather	Paternal Uncle
	Maternal Grandmother	Maternal Aunt	Sibling
	Maternal Grandfather	Paternal Aunt	
CANCER	Mother	Paternal Grandmother	Maternal Uncle
	Father	Paternal Grandfather	Paternal Uncle
	Maternal Grandmother	Maternal Aunt	Sibling
	Maternal Grandfather	Paternal Aunt	
DIABETES	Mother	Paternal Grandmother	Maternal Uncle
	Father	Paternal Grandfather	Paternal Uncle
	Maternal Grandmother	Maternal Aunt	Sibling
	Maternal Grandfather	Paternal Aunt	

PT
medicine

Please list any specialist or healthcare provider you see:

1.

2.

3.

4.

5.

Please list any additional information about your health that you would like your provider to know:

PT medicine

OBSETRIC AND GYNECOLOGICAL HISTORY (Please check all that apply):

- ☐ Last PAP Smear Date _____
  - ☐ History of Abnormal Pap
- ☐ Last Mammogram Date _____
  - ☐ History of Abnormal Mammo
- ☐ Age of first menstrual period _____
- ☐ Date of last menstrual period
  of age of menopause _____
- ☐ Number of pregnancies _____
- ☐ Number of births _____
- ☐ Number of miscarriages _____
- ☐ Number of abortions _____
- ☐ Number of Cesarean sections _____

- ☐ Bleeding between periods
- ☐ Heavy Periods
- ☐ Extreme menstrual pain
- ☐ Vaginal itching, burning, or discharge
- ☐ Wake in the night to go to the bathroom
- ☐ Hot flashes
- ☐ Breast lump or nipple discharge
- ☐ Painful intercourse
- ☐ Urinary leakage/incontinence

Date of last colonoscopy _____ Date of last Cologuard _____

FAMILY HISTORY (please identify any family member with the following):

Breast Cancer _____

Ovarian Cancer _____

Endometrial Cancer _____

Vaginal Cancer _____

Date of mother's first menarche (period) _____ and menopause _____

SURGICAL HISTORY (please check all that apply):

- ☐ Hysterectomy Date: _____
- ☐ Lumpectomy Date: _____
- ☐ Mastectomy Date: _____
- ☐ D&C Date: _____

ADDITIONAL INFORMATION

1. Current sexual partner is ☐ Female ☐ Male
2. Do you use condoms? ☐ Yes ☐ No
3. Other birth control method used: _____

☐ Please check the box if you are interested in being screened for STD's