James A. Gottfried, MD. Inc. / Northern Ohio Family Practice
257 Benedict Ave. Bldg C. Ste 1
Norwalk, OH 44857
PH: (419) 668-1101 Fax: (419) 668-1191
www.northernohiofamilypractice.com

PLEASE NOTE: ALL LINES MUST BE COMPLETED

Date: ______________________

Patients Name: ______________________ Date Of Birth: ______________

Address: ______________________ City ______________ Zip ______________

Home Phone: ______________________ Cell Phone: ______________

Soc. Sec. # ______________________ Sex: M ☐ F ☐ Marital Status ______________

Patients Employer ______________________

Employer Address ______________________ City ______________ Zip ______________

Spouse or Next of Kin ______________________ Relationship ______________

Address ______________________ City ______________ Zip ______________

Phone Number ______________________ Work Number ______________

In Case of Emergency ______________________ Phone Number ______________

Referring Physician ______________________ Phone Number ______________

Preferred Pharmacy ______________________ City of Pharmacy ______________ Phone Number ______________

PLEASE NOTE: IF YOUR INSURANCE IS IN YOUR HUSBAND OR WIFES NAME, THIS SECTION MUST BE FILLED OUT.
BRING ALL INSURANCE CARDS TO VISITS

Primary Insurance ______________________ Telephone Number ______________

Address of Insurance ______________________

Soc. Sec. Number of Insured ______________________ Insured DOB ______________ Relationship to Insured ______________

Insured's Employer ______________________ Address of Employer ______________

Secondary (if applicable) ______________________ Telephone Number ______________

Address of Insurance ______________________

Soc. Sec. Number of Insured ______________________ Insured DOB ______________ Relationship to Insured ______________

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Name ______________________________ **DOB:** ____________________

Soc. Sec. # ______________________________ ____________________

Please fill out both pages of this form completely. This information is a confidential record.

PERSONAL HISTORY

Have you ever had any of the following? ***CIRCLE any that apply***

Abnormal Pap	Bronchitis	Gout		Psychiatric Disorder
AIDS	Cancer - What Kind?	Hearing Loss	Irritable Bowel Syndrome	
Alcoholism		Heart Attack	Kidney Disease	Rheumatic Fever
Anemia	Chickenpox	Heart Disease	Kidney Infection	Scarlet Fever
Anorexia	Depression	Hemorrhoids	Liver Disease	Sexually transmitted disease - what kind?
Anxiety	Diabetes Type I		Measles	
	Diabetes Type II	Hepatitis - what kind?	Migraine	
Irregular Heart Beat	Drug Addiction	Hernia	Headaches	Stroke
Arthritis	Eczema	HIV		FenPhen / Redux
Asthma	Emphysema	High Cholesterol	Mitral Valve Prolapse	Thyroid Disease
Back Pain	Epilepsy		Mono	Tuberculosis
Bladder Infections	Gastric Ulcer	High Blood Pressure	Mumps	Whooping Cough
Legally Blind	GERD	Impotence / Sexual dysfunction	Osteoporosis	Other:
Blood Disorder	Glaucoma		Pneumonia	
Blood Transfusion	Goiter			

If you have had any of the following - when was the LAST TIME?

TEST	Never	1 - 2 years ago	3 - 4 years ago	> 5 years ago
Eye Exam				
Dental Exam				
Tetanus Shot				
Immunizations				
Chest X-Ray				
Cholesterol Check				
Colonoscopy				
Pap Smear				
Bone Mineral Density				
Mammogram				
Preventative Exam				
PSA				

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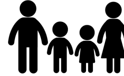
Name ______________________ DOB: ______________

FAMILY HISTORY

Are you Adopted? YES ◯ NO ◯

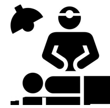
Has any BLOOD RELATIVE had any of the following?



*If so - CIRCLE the problem the your relative had and list how the relative was related. Ex: *maternal grandmother**

Problem	Family Member	Problem	Family Member	
Alcohol Abuse		Gastric Ulcer		
Allergies		Glaucoma		
Anemia		Gout		
Asthma		Heart Disease		
Blood Disorder		High Cholesterol		
Cancer - What kind?		High Blood Pressure		
		Kidney Disease		
Depression		Migraines		
Diabetes Type I		Obesity		
Diabetes Type II		Psychiatric Disorder		
Drug Abuse		Stroke		
Epilepsy		Tuberculosis		

SURGICAL HISTORY



List all Surgeries and Procedures you have had **(List additional on back if necessary or use another sheet)**

Surgery / Procedure	When was this done?

MEDICATION HISTORY

List all MEDICATIONS and SUPPLEMENTS you take regularly. (List additional on back or on another sheet if necessary)

Medication	Dose	Frequency	Prescribing Physician

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ALLERGY HISTORY

Please list all medications ALLERGIES and the REACTION you have if you take them.

Medication Allergy		Reaction		

List ANY OTHER ALLERGIES that you have (ex: food, dye, etc…)

Allergen	Reaction

SOCIAL HISTORY

Highest Level in School →	Some High School, GED, High School, Some College, AD, BA, BS, MA, PHD, Other
Marital Status →	Single Married Divorced Widowed Seperated
Do you smoke? →	Yes No If yes, how many packs per day?
Did you quit smoking? →	How long ago? How many packs per day when you quit?
Do you use smokeless tobacco? →	Never Quit (when) Yes -How much?
Do you use illegal drugs? →	Never Former Yes - what kind and how often?
Do you drink alchohol? →	Never Former Yes - How much and how often?
Do you drink caffeine? →	No Yes - what kind and how often?
How much exercise do you get? →	Sedentary 1-2 times /month 1-2 times / week 3-4 times/ week daily
Do you have a living will/advance directive? →	Yes No

NO SHOW POLICY

Patients who fail to show for their appointments and who do not notify the practice in advance is costly to the practice and may prevent a sick individual who needs to be seen from getting a preferred appointment time.

For the purposes of this policy, a no-show appointment is defined as an appointment, which is missed by the patient without any advance notice, or an appointment at which the patient showed up for late.

PLEASE BE SURE TO CANCEL APPOINTMENT AT LEAST 4 HOURS PRIOR TO YOUR APPOINTMENT SO THAT THE SLOT MAY BE AVAILABLE FOR ANOTHER PATIENT!
(*The only exception to this will be for an emergency that will be documented).*

All patients will be reminded of their appointment via a telephone call from the office / call service **at least one day prior to their appointment UNLESS their appointment was made the same day or previous day**. If the patient is unavailable, a message will be left indicating the date and time of the appointment.

If a confirmation call was documented and the patient fails to appear for his or her appointment, the patient will be documented as a *no show* appointment and the policy below implemented.

1. 1st NO-SHOW – A friendly letter will be mailed to remind you of your appointment.

2. 2nd NO-SHOW – A second letter will be mailed warning that you could be dismissed from the practice and a $10 NO SHOW FEE assessed for the missed appointment. Payment of the NO-SHOW fee must be made in cash, valid credit card, or verified check before further appointments are allowed.

3. 3rd N0-SHOW – A letter of dismissal may be mailed to the patient because of the pattern of no – shows to the practice.

It is also our policy that any NEW PATIENT that makes an appointment and does not show for their appointment will not be rescheduled.

Our follow-up protocols are based on years of experience and provide you with the highest standard of care. Keeping follow-up appointments are an important part of the legal contract that forms between you and our office when you agree to become a patient.

If there is a 20% no-show rate, we must "overbook" by 20%. If everyone shows, the lobby becomes crowded and waiting times and stress levels increase**. Please comply with our appointment policy so that we can stay on schedule.**

Our office will make every effort to remind you of your appointment. Please update your home, work, and cellular telephone numbers, and your e-mail address each time you visit, or at any time on our website through your "Patient Portal".

James A Gottfried MD, Inc. Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan, we do business with but do not have an up-to-date insurance card; payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments - All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. 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. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed appointments. Our policy is to charge for no-show appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

- We accept cash, personal checks, money orders, Mastercard, Visa and Discover cards for you convenience.
- We are NOT providers for work related claims and do NOT accept letters of protection from attorneys for personal injuries / auto accidents.

Refunds. Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances or toward future family members balances, unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded every 6 months once all outstanding insurance claims are paid. All refunds will be mailed to the patient/guarantor. Patient/ Guarantor may also request that credit amounts in excess of $20 be retained on account to be used for future services.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.
I have read and understand the payment policy and agree to abide by its guidelines:

____ ________________________

Signature of patient or responsible party Date

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<u>HIPPA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT</u>

The Health Insurance Portability and Accountability Act (HIPPA) require James A Gottfried MD, Inc. / Northern Ohio Family practice to make available to me a Notice of Privacy Practices that explains my rights regarding the privacy and confidentiality of my patient health information. I have received this Notice and am aware that any questions regarding this notice should to:

James A Gottfried, MD Inc. / Northern Ohio Family Practice

257 Benedict Ave Ste C1

Norwalk, OH 44857

(419-668-1101)

Signature____ Date__________

Print Name____ DOB_________

……………………………………………………………………………………………………

With understanding the new HIPPA laws, **<u>I DO REALIZE THAT MY HEALTH INFORMATION CANNOT BE SHARED WITH FAMILY MEMBERS AND OR FRIENDS WITHOUT MY WRITTEN CONSENT</u>**. In understanding this, I would like my information to be shared with the following people.

LIST EVERYONE THAT YOU WOULD LIKE TO HAVE INFORMATION SHARED WITH:

___________________________________ ____

___________________________________ ____

Signature ____ Date_____________

<u>CONSENT FOR RELEASE OF INFORMATION (by phone)</u>

Where are we allowed to attempt to contact you? ____________________________________

Are we permitted to give lab, diagnostic and/or any other test results to family members? __________

This is not a release for your medical records