MELISSA D. GRAVES M.D FAMILY MEDICINE P.L.L.C

First Name: _____ Middle: _____ Last Name: _____

DOB: _____/_____/_____ Age: _____ Sex: M / F

S.S# _____-_____-_____ Marital Status: S / M / W / D

Cell #:_____ Home #:_____ Work #: _____

Email: _____

Address: _____ City:_____ St:_____ Zip:_____

Billing Information:

Billing Name:_____ Relationship to Patient:_____

Billing Address: _____

Employer:_____

Insurance Information:

Insurance Name: _____ ID #:_____ Group#:_____

Address: _____

Policy Holder's Name: _____Relationship:_____

Policy Holder's S.S#: ____-____-_____ Policy Holder's DOB: ___/____/____

Policy Holder's Employer: _____

Insurance Information: Secondary

Insurance Name: _____ ID #:_____ Group#:_____

Address: _____

Policy Holder's Name: _____Relationship:_____

Policy Holder's S.S#: ____-____-_____ Policy Holder's DOB: ___/____/____

Policy Holder's Employer: _____

Patient Name: _____

May we leave messages for appointment confirmation and/or for you to call us back at your home phone number? Y / N Patient Initials_____

ER Contact Name: _____ Relationship: _____ Phone#: _____

We must have copies of your insurance cards. It is **your** responsibility to inform us of any changes in your coverage.

Assignment of insurance benefits
I hereby authorize direct payment of surgical/medical benefits to Dr. Graves, for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Authorization to release information
I hereby authorize Dr. Graves, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Medicare/Medicaid
I certify that the information given by me in applying for payment is correct. I authorize release of old records when requested. I request that payment of authorized benefits be made on my behalf.

Patient Responsibility
I understand that my insurance will be billed for services rendered. I understand and I am responsible for any and all of the balance not covered by my insurance.

A photocopy of these assignments shall be valid as the original.

Patient or responsible party Relationship Date

Today's Date: _____/_____/_____

Name: _____ Age: _____ Birth Date: ___/____/_____

Occupation: _____ Sex M / F Marital Status: S M W D

Why are you here to see the doctor today?

_____

_____

_____

_____

Allergies: _____

Hospitalizations/Surgeries: Year

Have you ever had a Transfusion? Yes / No

Childhood illnesses: (please circle)

Chicken Pox	Rheumatic Fever	Scarlet Fever
Recurrent ear infections	recurrent sore throats	Asthma
Measles	Mumps	Other: _____

Family History:

Father	Age now/ Age at Death: Illnesses:
Mother	Age now/ Age at Death: Illnesses:
Brother # _____ Sisters # _____	Ages: Illnesses:
Other:	

Do you have a Family history of:

	YES	NO
Asthma		
Cancer / Type		
Heart problems		
Colitis		
Stroke/ Mini Strokes		
Diabetes / Sugar Problems		
Stomach Ulcers		
Thyroid Problems / Goiter		
High Blood Pressure		
Arthritis		
Alcoholism		
Other:		

Name:_____

Personal Information:

Do you use tobacco products? Yes / No Age use Started :_____ When did you Stop:_____
Cigarettes / Cigars / Pipe / Smokeless Tobacco # per day_____ Are you interested in quitting? Yes / No
How often do you drink Alcohol? Daily / Weekly / Socially / Once per year / Occasionally / Rarely /Never
Beer / Wine / Liquor Do you feel you need to cut back? Yes / No Have you ever felt guilty? Yes / No
Has anyone ever complained about it? Yes / No Do you ever need a drink to get you going in the AM
Yes/No How many caffeinated beverages do you drink per day? ____ Coffee / Tea / Soft Drinks
Do you or have you ever used recreational drugs and/or Marijuana Yes / No
Which one and How often? _____
What types of exercise do you get? _____
How often? _____ How many pets do you have? ___ What types? _____
Have you traveled outside of the Unites States? Yes / No Where and When? _____

Review of Systems: *(check if you have ever had any of these problems Mark C for Current problems)*

	Enlarged Lymph Nodes		Sweating		Hemorrhoids
	Skin Rashes		Shortness of breath at rest		Blood in urine
	Changes in a mole		SOB with activity		Painful urination
	Eczema		Unable to lie flat		Getting up at night to urinate
	Psoriasis		Asthma Attacks		Urinary urgency
	Recurrent Headaches		Dry Cough		Urinary Frequency
	Migraines		Coughing up Blood		Kidney Stones
	Blurred Vision		Coughing up sputum		Urinary Incontinence
	Chronic Sinus Infection		Wheezing		Frequent UTI's
	Nose Bleeds		Abdominal pain		Vaginal/Penile discharge
	Ear pain		Nausea		Decreased muscle strength
	Hay Fever/Seasonal Allergies		Vomiting		Muscle weakness
	Frequent colds		Diarrhea		Joint pain
	Frequent ear infections		Constipation		Muscle pain
	Chest pain at rest		Jaundice		Morning Stiffness
	Chest pain with activity		Change in stool habits		Confusion
	Jaw pain		Change in stool color		Heat or cold intolerance
	Palpitations		Pain with swallowing		Excessive Thirst
	Weakness		Frequent heartburn		Other:
	Dizziness		Fatigue		
	Insomnia		Back pain		
	Leg Swelling		Depression		
	Anxiety				

Immunizations:
Tetanus ___/___/____ Pneumonia Vax ___/___/____ Flu shot ___/___/____
Hepatitis ___/___/____ #1 ___/___/____ #2 ___/___/____#3
Childhood immunizations: Yes / No

Females only:
Age at onset of Menstrual Cycle: ___ # of Pregnancies _____ # of children____ # Miscarriages_____
Age at Menopause: _____ Age at Hysterectomy: ____ First day of Menstrual period ___/___/____
Last Pap Smear: ___/___/____ Have you ever had an abnormal pap? Yes / No

Payment 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 the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do accept partial payment of at least $50 the day of your office visit. This charge is expected at each visit. If you are insured by plan we do not do business with, or don't have an up-to-date insurance card, payment of at least $50 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.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This agreement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles from patients can be considered fraud. Please help us to uphold the law by paying your copayments at each visit.
3. **Non-covered services**. Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **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.
6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance is unpaid, we may refer you her account to a collection agency.

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 understood the payment policy and agreed to abide by its guidelines:

_____

Signature outpatient or responsible party Date

Notice of Privacy Practices

To our patients: This notice describes how health information about you, as the patient for this practice, may be used and disclosed, and how you can get access to your health information. This is required by the privacy regulations created as a result of the health insurance portability and accountability act of 1996 (HIPPA)

Our commitment to your privacy

Our practice is dedicated to maintain the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and disclosure of your health information and certain special circumstances

The following circumstances may require us to use or disclosure health information:

1. To public health authorities and health oversight agencies that are authorized by the law to collect information.
2. Law suits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure as to a person or organization able to help prevent the threat.
5. If you or a member of the U.S. or foreign military forces (including the veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are in inmate or under the custody of a law enforcement officer.
8. For worker's compensation and similar programs.

Your right regarding your health information

1. Communications. You can request that we communicate with you about your health related issues in a particular manner. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request: however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you including patient's medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to:

Melissa Graves
164 Parkview Dr.
Keyser, WV 26726

4. You may ask us to amend your health information if you believe it's incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submit to:

   Melissa Graves
   164 Parkview Dr.
   Keyser, WV 26726
   Phone: 304-597-2494 Fax: 304-597-2497

5. Right to a copy of this notice: You are entitled to receive a copy of this notice of privacy practices. You may ask us to give a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the Department of Health and Human Services. To file a complaint with our practice, contact:

   Melissa Graves
   164 Parkview Dr.
   Keyser, WV 26726
   Phone: 304-597-2494 Fax: 304-597-2497

   All complaints must be submitted in writing. You will not be penalized for filing a complaint
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain you written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

   If you have any questions regarding this notice or health information privacy policies please contact us. I hereby acknowledge that I have been presented with a copy of Dr. Melissa Graves MD notice of privacy practices. (Please sign and date next page)

Signature date

Patient name (please print)

If the patient is a Minot:

Print patient name

Parents were guardian the signature parent or guardian print

Authorization to release Medical Information

I, (Patient's Name_ _____, S.S.# _____,
Born on the _____ day of _____, Year _____. hereby authorized (name and address)
_____
_____
_____

To provide Dr. Melissa Graves 164 Parkview Dr. Keyser, WV 26726, with the following information:

_____ Surgical or Medical Procedures, diagnostic tests and/or summaries thereof

_____ Entire Medical Record

_____ Other (specify) _____

Purpose for Disclosure:
_____
_____

I understand and acknowledge that my medical record may obtain alcohol/drug and/or mental health information that I expressly consent to therea lease of such information contained in the records designated above.

This information has been disclosed to you from records whose confidentiality is protected under federal law. Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without a specific written constant of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose

This authorization for release of information is valid for 6 months from the date of signature unless revoked by written notice for the providing institution; if said notice is received prior to the release of the information.

Signature of patient_____ Date_____
Or
Authorized to representative_____ Relationship_____

Witness_____ Date_____