Patient Communication Request

Name:_______________________________________ Date of Birth: ______________

Address:____ ZIP:_______________

Home Phone: ______________ Work Phone: ______________ Cell Phone:____________

E-mail address: ____

It is the policy of Capstone Family Practice to contact patients for any lab results. If the laboratory evaluation is part of a yearly physical exam, normal results are communicated through the mail. For any abnormal lab results or lab work order for a specific concern, please indicate below how you would like us to contact you.

_____ Mail

_____ Phone

_____ I DO NOT authorize results to be left on my answering machine.

_____ I DO authorize results to be left on my answering machine at the following number(s): ____

_____ Patient Portal (secure web access)

I wish for my test results and medical information to be released to:

_____ Myself only

_____ Myself and ____

(Names and dates of birth of individuals)

Signature: _________________________________ Date: ____________________

Capstone Family Practice
Patient Registration

Patient Information:

Last name: ____________________________ First Name:_________________ Middle name: ________________

Date of birth: ____/____/______ Gender:_____ Social security number: ____-____-_______ Marital status:______

Home phone number: (______) ______-_________ Work phone number: (______) ______-_________

Cell phone number: (______) ______-_________ E-mail address: ____

Claims address: _________________________________ City: _____________ State: _________ Zip: _________

Employer: ____Current occupation: ___________________________

Emergency Contact Information

Name: ____________________________Relationship: _____________ Phone number: (______) ______-_______

Please select your race below:

***Race:** _____ White (Non-Hispanic) _____ Asian _____Black or African American

_____ Hispanic or Latino _____Other Race

***Ethnic Group:** _________________________ **Decline to answer** ______

*** Reporting of race and ethnic group is a new government requirement under the American Recovery and Reinvestment Act.**

Primary Insurance / Guarantor Information:

Insurance Company Name: ____

Claims address: _________________________________ City: _____________ State: _________ Zip: _________

Insurance phone number: (______) ______-_________

ID number: _____________________________________ Group number: _________________________________

Policyholder full name: ____ Date of birth: ____/____/______

Home address: _________________________________ City: _____________ State: _________ Zip: _________

Social security number: _______-_______-___________ Gender: _________

Employer: ____ _____________

Home phone number: (______) ______-_________ Work phone number: (______) ______-_________

Cell phone number: (______) ______-_________ E-mail address: ____

Patient's relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other: ___________________

Secondary Insurance Information (**ONLY** for patients with Medicare primary):

Insurance Company Name: ____

Claims address: ____________________________ City: ______________State: ________ Zip: ____________

Insurance phone number: (______) ______-_________

ID number: ___________________________________ Group number: _______________________________

Policyholder full name: ____ Date of birth: ____/____/______

Home address: _______________________________ City: _____________ State: _________ Zip: _________

Social security number: _______-_______-__________ Gender: _________

Employer: ____ _____________

Home phone number: (______) ______-_________ Work phone number: (______) ______-_________

Cell phone number: (______) ______-_________ E-mail address: ______________________________________

Patient's relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other: ___________________

We love referrals; can you please tell us how you found out about our practice? ______________________

____

Patient Consents- Please initial each line:

_______ **Consent for Treatment**:
Initial here

I give consent for the physicians of Capstone Family Practice to treat and/or test me or the minor listed above. I am the parent or legal guardian of this child.

_______ **Assignment of Insurance Benefits/Release of Information**:
Initial here

I authorize my insurance carrier to pay benefits directly to Drs. Andy Spafford and Tina Corkran at Capstone Family Practice for all services provided. I authorize the release of pertinent information required by my insurance carrier to process insurance claims for payment to the physicians of Capstone Family Practice.

_______ **Clinic Policy**:
Initial here

I acknowledge that I have received, read, understand and accept the policies of Capstone Family Practice. I understand that regardless of my insurance status I am ultimately responsible for the balance on my account for any medical services rendered.

_______ **Payment Policy**:
Initial here

I understand that if any balance is not paid in a timely manner, Capstone Family Practice reserves the right to transfer the balance to a collection agency, and will add a collection fee to my past due balance.

_______ **Notification of HIPAA**:
Initial here

I acknowledge that I have received, read, understand and accept the policies outlining my rights to privacy concerning my health information. I understand that additional information is available upon request to further explain these issues.

______________________	______________________	______________________
Signature	Relationship to patient	Date

Patient Health History

Welcome to Capstone Family Practice!

Please complete as much information as possible so that we can better serve you.

Name: ____ Today's date:________________

Date of birth: _______________Age:_______ Date of last physical exam: ________________

What is your reason(s) for seeing the physician today?________________________________

Symptoms: Circle any symptoms that you currently have or have had within the past year:

GENERAL
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Nervousness
Numbness
Sweats
Weight gain
Weight loss

MUSCLE/JOINT
Arm pain
Leg pain
Back pain
Hand pain
Foot Pain
Knee pain
Neck pain
Shoulder pain
Other _________________

GENITOURINARY
Blood in urine
Frequent urination
Painful urination
Urinary incontinence

GASTROINTESTINAL
Poor appetite
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

CARDIOVASCULAR
Chest pain
High blood pressure
Low blood pressure
Irregular heart rate
Poor circulation
Rapid heartbeat
Swelling of ankle(s)
Varicose veins
Heart murmur
Shortness of breath

EAR/NOSE/THROAT
Bleeding gums
Blurry vision
Coughing up blood
Crossed eyes
Difficulty swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing in ears
Sinus problems
Itchy eyes

SKIN
Bruise easily
Hives
Dry skin
Itching
Yellow skin
Change in moles
Rash
Scars
Sores that won't heal
Hair changes
Other _________________

MEN ONLY
Breast lump
Erection difficulty
Testicular lump
Penis discharge
Sores on penis
Other _________________

WOMEN ONLY
Abnormal PAP smears
Bleeding between cycles
Breast lump
Menstrual Pain
Nipple discharge
Painful intercourse
Vaginal discharge

Other _________________

Last menstrual period?

____

Are you pregnant? ______

Number of births? ______

Miscarriages? __________

Conditions: Circle conditions you have or have had in the past:

HIV / AIDS
Alcoholism
Allergies
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Blood disorders
Breast lump
Bronchitis
Bulimia
Cancer: _______________
Cataracts
Chemical dependency
Chicken pox

Diabetes
Emphysema
Glaucoma
Gout
Heart Disease
Hepatitis
Hernia
Herpes
High cholesterol
Hypertension
Kidney disease
Liver disease
Lupus
Measles
Migraine headaches
Miscarriage

Mononucleosis
Multiple sclerosis
Mumps
Pacemaker
Pneumonia
Polio
Prostate problems
Psychiatric
Rheumatic fever
Scarlet fever
Seizure
Sexually transmitted disease:

____

Skin problems
Stomach problems
Stroke
Suicide attempt
Thyroid problems
Tonsillitis
Tuberculosis
Typhoid fever
Urinary problems
Vaginal infections

Other: ________________

____

____

Medications you currently take:	Allergies to medications:

Preferred Pharmacy

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone: ____

Family History

Are your parents currently healthy? ______________ Please list their current ages and any medical problems.

____

____

Please circle any of the following conditions that have occurred in any of your blood relatives:

Arthritis	**Heart disease**	**Schizophrenia**
Allergies	**High blood pressure**	**Thyroid problems**
Asthma	**High cholesterol**	**Lupus**
Breast cancer	**Kidney disease**	**Stroke**
Lung cancer	**Chemical dependency**	**Alzheimer's disease**
Diabetes	**Depression**	**Melanoma**

Other cancer: ____

Other: ____

Health Habits

Have you ever used tobacco? □ Yes □ No If yes, for how long and how much per day?

____

How much alcohol do you drink in an average week? ____

Have you ever used illicit drugs? □ Yes □ No If yes, what type and how frequently?

____

Hospitalizations and Serious Illnesses

Please list and explain all hospitalizations and serious illnesses during your lifetime, including outpatient procedures. ____

____

____

____

Preventive Health

What is your cholesterol?_______________ Blood pressure?_____________________

Have you ever had a blood transfusion? □ Yes □ No

When was your last dilated eye exam? ____

For Men: Have you ever had your prostate checked? □ Yes □ No Date: ______________________

For Women: Do you do monthly breast exams? □ Yes □ No

When was your last pap smear? ______________ Results: ____________________________

Last Mammogram? _______________ Results: ____________________________

If you are over 50:

Have you ever had a:

Screening colonoscopy? □ Yes □ No Date: ___________ Results: ____________________

Bone density scan? □ Yes □ No Date: __________ Results: ________________________

EKG? □ Yes □ No Pneumonia shot? □ Yes □ No Shingles vaccine? □ Yes □ No

Would you say your life is stressful? □ Yes □ No If yes, explain why. If no, tell us how you do it. _____________

____

____

Do you have other concerns? ____

Capstone Family Practice
2014 Patient Information and Policies

Welcome to Capstone Family Practice! We are blessed and thankful that you have chosen us to provide healthcare services for you and your family. We will do all that we can to provide the best healthcare available. We would like you to be aware of a few of our policies so that we can best serve all of our patients. Your signature on the consent page signifies that you have read and agree to these policies.

1. Our office is open Monday through Friday 8:00 AM to 5:00 PM. We work **by appointment only** for both office visits and blood draws.

2. We see patients of all ages from newborns to seniors. We offer a wide range of services including well exams, school physicals, sick visits, gynecological exams, vaccinations, EKGs, mole and wart removals and primary medical care for acute and chronic problems such as diabetes and thyroid disease. Dr. Spafford and Dr. Corkran do not deliver babies. We will see pregnant patients referred to us by an obstetrician for medical problems unrelated to pregnancy. We have a Quest Diagnostics lab in-house for your convenience. It is your responsibility to know your lab benefits. Capstone does not bill lab charges- it is done by Quest. All questions regarding labs need to be directed to Quest.

3. Our phone system is accessible 24 hours a day, 7 days a week, and 365 days a year. A doctor is always available to handle your needs after regular business hours. If you need to speak to the physician on call, our answering service is available to relay your message and your call will be returned as soon as possible. For a non-urgent matter after regular office hours please leave a message in our voicemail system.

4. When making appointments, please be specific with the receptionist regarding the nature of your visit. We try to schedule enough time to address your concerns. If you tell us that you want to be seen for a cold, we will book enough time for that issue, but if you also want to discuss your diabetes and your son's ADHD, it is best to let us know up front. This way we can ensure timely care and address your needs appropriately.

5. Please bring your medications or an up-to-date list of your current medications, including supplements, herbal remedies, over the counter and prescription medications to all of your appointments.

6. Dr. Spafford and Dr. Corkran do not do hospital work- they use a hospitalist to take care of patients when they are hospitalized. This hospital physician stays in close contact with them and updates them on your progress. Our hospitalist primarily works out of Methodist Willowbrook Hospital, but we do have coverage available at other local hospitals.

7. We accept most insurance plans. Please ensure that all of your insurance information is up to date so that we can bill office visits and blood draws correctly. If you do not provide us with correct information, you will be billed for services not paid. If you don't have insurance, we are still happy to see you. Payment for your visit is expected the day of the visit. Payment plans can be arranged. Please discuss them with the office prior to your visit.

8. Prescription refills are best handled by calling your pharmacy. They will contact us directly about your prescription. If it is a new prescription, please call your doctor's nurse. We may ask you to follow up with us before refilling medications if it has been awhile since your last visit or if you need blood work.

9. There is a $20 charge for letters requested by patients outside of an office visit. You will be notified of this at the time of your request and payment is expected at that time.

10. Controlled substance prescriptions expire 21 days from the day they are written. There will be a $10 fee for any controlled substance prescription that is re-written because it was not picked up and filled before the expiration date. Called-in prescriptions will be ready the morning of the next business day following the day they are requested. NO EXCEPTIONS.

11. For patients who need referrals, please plan ahead. It can take 48 hours for insurance companies to approve our request.

12. Patient care is very important to us. If, for some reason, you cannot make your appointment, please notify us in advance. A missed appointment fee of $25 will be charged if you do not cancel your appointment. If you miss three appointments without notifying us, we reserve the right to ask you to seek care from another physician. This may seem harsh, but it makes it difficult to see our patients in a timely manner if you habitually arrive late or miss appointments. If you are more than 30 minutes late for your appointment, you may be asked to reschedule.

13. We try our best to return all messages on the day that we receive them. Please do not leave multiple messages. Calls will be returned in the order received.

We look forward to working together and meeting your healthcare needs. Blessings to all!

Andy Spafford, MD

Tina Thorpe Corkran, MD

Patient Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all patients have certain rights to privacy regarding health information. This protected information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

We wish to inform all patients of our document, Notice of Privacy Practices, containing a more complete description of the uses and disclosures of health information. As a patient you have the right to review such Notice of Privacy Practices prior to signing the consent. Please understand that Capstone Family Practice has the right to change its Notice of Privacy Practices at any time and a current copy of Notice of Privacy Practices will always be available.

Patients may request, in writing, to restrict how private information is used or disclosed to carry out treatment, payment, or healthcare operations. Though not required to agree to requested restrictions, we are bound to abide by agreed upon restrictions.

Your signature on the consent page signifies that you have read and agree to these policies. Patients may revoke consent at any time in writing, except to the extent that action has been taken relying on prior consent.