Multicare Plus

225 Erdman Ave., Bangor, PA 18013
P: 610-588-2225 F: 610-588-2292

Patient Information

Patient Name:_____ DOB:_____Sex:_____

Home Phone:_____Cell:_____Work:_____

Address:_____SSN: _____

Employer:_____Position:_____

Employer Address:_____

Emergency Contact Info

Dependant?_____ If yes, Guardian's Name:_____

Guardian's Phone: _____Cell:_____Work:_____

Marital Status:_____Spouse's Name: _____

Emergency Contact:_____ Relationship:_____

Home Phone:_____Cell:_____Work:_____

Emergency Contact:_____Relationship:_____

Home Phone:_____Cell:_____Work:_____

Medication	Dose	Frequency taken

PHARMACY NAME AND ADDRESS:_____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copays is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that all information above is factual and correct including insurance information.

Patient Signature: _____Date:_____

Multicare Plus Patient Questionnaire Form

What Medical Concerns Bring you to the office today:_____

Name:_____ Gender: M/F DOB:_____Date:_____

Allergies to medications:_____What type of reaction occurs:_____

Date of last: Chest Xray:_____ Colonoscopy:_____Blood Test:_____

Eye Exam:_____ Vaccines:_____EKG:_____

Personal Medical History (please circle all that apply)

ADHD	COPD/Emphysema	High Cholesterol	Rheumatiod Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disease
Arrythmia	DVT (blood clots)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (acid reflux)	Macular Degeneration	Asthma
Glaucoma	Neuropathy	Bipolar	Heart Disease
Osteopenia/Osteoporosis		Bladder Problems/ Incontinence	Heart Attack (MI)
Parkinson's Disease	Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease
Cancer:_____			High Blood Pressure
Peptic Ulcer	Headaches	Kidney Stones	Psoriasis
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period date:_____Normal/abnormal **Last Mammogram date**:_____normal/abnormal

Last Pap smear date: _____Normal/abnormal **Last Dexa date**:_____normal/abnormal

Other medical Problems not listed above:_____

Surgical History with dates:_____

_____

List Other Medical providers you see regularly (ie Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Social/Cultural History:

Education Level (circle): High School Vocational College Graduate/Professional

Are there any vision problems that affect your communication: yes/no

Are there any hearing problems that affect your communication: yes/no

Are there any limitations to understanding or following instructions (either written of verbal) yes/no

Current living situation: _____

Smoking/Tobacco Use: Current Past Never Type:_____Amount/day_____Number of years_____

Alcohol: Current Past Never Drinks/Week:____**Recreational Drug Use**: Current Past Never Type:_____

Are there any personal problems or concerns at home, work or school you would like to discuss today? Yes or no

Are there any cultural or religious concerns you have related to our delivery of care? Yes or no

How often do you get the social and emotional support you need? Always Usually Sometimes Rarely Never

Family History:

FATHER: Living Age:_____ Deceased Age:_____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:_____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysmea	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

MOTHER: Living Age:_____Deceased Age:_____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:_____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysmea	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

SIBLINGS:_____

Patient Signature:_____ Date:_____

Release of Records

I do hereby authorize MAK Healthcare PC (DBA) Multicare Plus to release my medical and billing records to any of its billing companies, attorneys, adjusters, etc. for the sole purpose of getting my bill paid.

Consent to Treat

I hereby authorize MAK Healthcare PC (DBA) Multicare Plus and its assistants to perform medical examination, procedures, invasive diagnostic testing, and/or treatment on me today.

Assignments of Benefits

I understand that my insurance company may not accept assignment. I understand that my insurance company will pay me directly for the services rendered to me from MAK Healthcare PC (DBA) Multicare Plus. I also understand that I will receive check(s) from the insurance company made payable in my name to me directly. I also understand that it is my responsibility to forward these checks and all explanation of benefits to MAK Healthcare PC (DBA) Multicare Plus immediately upon receipt. I understand that it is illegal for me to cash or deposit the insurance check that I receive for services provided to me. I know that I will be given five business days to settle my account before legal proceedings begin. If my account is not settled, I will also be responsible for any additional costs, such as court costs and legal fees. I understand that services provided to me today may be issued on more than one check and I agree to forward ALL checks regarding todays treatment to MAK Healthcare PC (DBA) Multicare Plus. I willingly sign this agreement.

Prescriptions

We certainly strive to complete refill requests as soon as possible. It is your responsibility to inform our office a week before you run out medications. Please allow our providers at least 5 working days to get your prescription filled. If you call to request a refill but are overdue for a follow-up visit the provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit. It is your responsibility to schedule an appointment before you run out of medication. Please note, our office requires a faxed request form from your pharmacy in order to have your meds refilled by our providers. I hereby authorized the following person to pick up my prescriptions from Multicare Plus when I am unable to do so myself:_____

Patient Signature to all of the above:_____Date:_____

If you believe your privacy rights have been violated, we encourage you to contact our privacy administrators at the telephone number or office address set forth immediately below. You can also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

If you have questions, wish to obtain a copy of your health information or an accounting of disclosure of your health information, wish to amend your health information, or would like additional information, you may contact our office at 610-588-2225.

MAK Healthcare P.C.

(DBA) Multicare Plus

225 Erdman Ave.

Bangor, PA 18013

610-588-2225

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I give my permission to Multicare Plus to release any medical information to the following person(s). If you do not list anyone please write "NONE"

_____

_____

Patient name: _____

Signature: _____

Date: _____

Office Representative Signature: _____

NOTICE OF PRIVACY PRACTICES FOR

MAK HEALTHCARE P.C.

(dba) MULTICARE PLUS

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Understanding your medical record:

Each time you visit our office, a record of your visit made. Our office may also keep records relating to telephone and mail communications with you and with others involved in your healthcare. Typically, our records contain information regarding your symptoms, examinations and test results, diagnosis, treatment, and plans for future care and treatment. This information, often referred to as your medical record or health information serves as a:

- Basis for planning your care and treatment
- Means of communicating amount the healthcare professionals who contribute to your care
- Tool for education health professional
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning
- Told with which we can assess and work to improve the care we render and the outcome we achieve.

Examples of how your health information may be used and disclosed for treatment, payment and health operations.

We will use your health information for treatment purposes.

- For example, information about you obtained by a member of this office's healthcare team will be recorded in your record and will be shared by other members of this office's healthcare team who are involved in your care and treatment. If you are referred for testing, care or treatment to another health car professional, our office will provide that healthcare professional with information about you that should assist him or her in providing serviced to you.

We will use and disclose your health information for payment purposes.

For example, a bill may be sent to you or to an insurer/third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, test results, treatments and attendant supplies.

We will use and disclose your health information for regular health operations.

The following are examples of how your health information may be used and disclosed for regular health operations:

- There are some services provided for and to our office through agreements with business associates. These may include transcription and copying services, billing services, office management services, and the service of professionals such as our attorneys, accountants and insurance agents. We may disclose your health information to our business associates so that they can perform their services.

To protect your health information, we require our business associates to safeguard your health information appropriately.

- We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
- Health professionals may disclose to a family member, or other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care of payment related to your care
- To further medical science, we may disclose information to researchers when their research ahs been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
- Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.
- We may contact you as part of a fundraising campaign.
- We may disclose to the FDA health information concerning adverse events with respect to food, supplements, product and product defects, or post marking surveillance information to enable product recalls, repairs or replacement.
- We may disclose health information to the extent authorized by and to the extend necessary to comply with laws relating to workers compensation or other similar programs established by law.
- As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease or injury or disability.
- Should you be an inmate of correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.
- We may disclose health information for law enforcement purposes as required by law in response to a subpoena.

Your health information rights

Your medical records are the physical property of our office. You do, however, have rights with respect to your health information. Subject to certain requirements and limitations set our in federal and state laws, you have the right to:

- Review this Notice of Privacy Practices
- Authorize uses of disclosures of health information for purposes other than treatment, payment and health operations.
- Opt-out of disclosures of information to family members or others who may be assisting with your care.
- Request restrictions on certain uses and disclosures of your health information (our office, however, is not required to agree to such restrictions).
- Receive confidential communications from this office if requested.
- Obtain a written copy of this notice, upon request
- Inspect and copy your own health information
- Under certain circumstances, to appeal denials of access to your own health information
- Amend incorrect or incomplete health information, subject to certain limitations.

- Obtain an accounting of disclosures of your health information, subject to certain limitations.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or disclose your health information (except to the extent that action has already been taken)
- File a complaint with this office or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated.

Our office's responsibilities

Subject to limitations set out in the Health Insurance Portability and Accountability Act (HIPAA) and other relevant laws, or office is required to:

- Maintain the privacy of your health information
- Provide you with a notice regarding our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternatives means or at alternatives locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, you may request from us and obtain a revised notice.

For more information to obtain a copy of your health information, to obtain an accounting of disclosures of your health information, to amend you health information or to report a problem.