Davenshire Medical Center

PEDIATRIC

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Dover, PA 17315
Phone: 717-292-3168 Fax: 717-292-3479
Email: info@davenshiremc.com
www.DavenshireMC.com
Like us on Facebook!

Welcome to Davenshire Medical Center! Thank you for choosing us as your primary care physicians. We are dedicated to providing the best possible care to our patients. Please take a few moments to look over our practice information and policies to help prepare you for your first appointment.

About Our Providers: Dr. Gary Czulada, DO graduated from the Philadelphia College of Osteopathic Medicine in 1987 and has been with our practice since 1989. He has three sons & a daughter.
Dr. Melissa Baylor, DO graduated from the Philadelphia College of Osteopathic Medicine in 1996 and has been with our practice since 1998. She has two sons and a daughter.
Each doctor has completed a family practice residency, are board certified, and are affiliated with Wellspan York Hospital & UPMC Memorial Hospital.
Christine Holtz, CRNP received her Master's Degree from the University of Cincinnati in 2013, and she began practicing as a CRNP in 2014. She is able to see patients aged 12 and up. She has two sons and two grandsons.

Office hours*:* Our regular office hours are listed below. Please be aware that these hours are subject to change with physician vacations and inclement weather. A physician is available after hours and can be reached by following the recorded instructions you will receive when calling our office. For a true emergency, please do not hesitate to go to the ER. Our phone hours are from 8:00AM to approximately 30 minutes prior to closing.

Monday 8:00am - 7:30pm
Tuesday 7:00am – 5:00pm
Wednesday 8:00am - 7:30pm
Thursday 8:00am - 5:00pm
Friday 8:00am - 4:00pm

Scheduling Appointments: When calling to schedule a non-urgent appointment, (ex: check-up, physical, ear wash, or office surgery), please call several weeks in advance so we may schedule a time that is convenient for you. You may also schedule appointments through our patient portal. This allows you to view all of our available appointment times and select a time that suites your own needs. Please check with your insurance company to verify your possible out of pocket expense PRIOR to scheduling surgeries, physicals, or procedures. For your protection, please be prepared to present your insurance card and a form of photo I.D. (ex. Driver's license, student I.D., etc.) at each office visit. If you have HMO insurance, you will need to contact your insurance company PRIOR to your appointment to make sure we are listed as your primary care physician or "PCP".

No-Show/Cancellation Policy: We understand that there may be times when an emergency or circumstances may arise making it impossible for you to keep your appointment. If you know that you are unable to keep an appointment, please call AS SOON AS POSSIBLE so that we may offer this time to another patient in need. You also may cancel and reschedule your appointments via our patient portal. It is our office policy to charge a fee to patients who cancel scheduled appointments with a less than 2 hour notice. If you are scheduled for an upcoming appointment and you cancel this appointment in less than 2 hours prior to the scheduled time, your account may be charged a fee of $25 or more. There is a fee for missed appointments and patients who chronically miss appointments may be charged a fee and/or asked to find another physician.
NEW PATIENTS who miss their first appointment will <u>NOT</u> be allowed to reschedule.

Copays: Please be prepared to pay your copay at every office visit. We accept cash, checks, Visa, MasterCard, and Discover. Copays are a contractual obligation between you and your insurance company, and we are required by your insurance company to collect copays at the time of service. Disregarding this obligation may jeopardize your relationship with our office and your insurance company. If you do not pay your copay on the same date that you are seen, you may be charged an extra fee of $5 or more. If you come in for your appointment and are not able to pay your copay while in the office, you may visit our patient portal to pay this later the same day.

Motor Vehicle Accident/ Workman's Comp: If you are being seen as a result of a Motor Vehicle Accident or Workman's Comp Claim, please notify our front office staff upon arrival of your appointment so that we may obtain the necessary & correct billing information. You may also submit this information via our patient portal so that our billing department has the information prior to your appointment. If you fail to provide this information to us at your first MVA/WC appointment, there may be a fee of $50 or more charged to your account to cover the costly retraction and resubmission fees.

Insurance Referrals/ Authorizations: Please check with your insurance company if a referral or prior authorization is required and notify our office as soon as possible. Some insurance companies require up to a week's notice prior to issuing approval. For your convenience, we have a dedicated referral voicemail that you may leave detailed information pertaining to your request. You may also send all of the necessary information through our patient portal so our referral team may complete these tasks.

Insurance Cards: When returning this paperwork, please attach a photocopy of your insurance cards with the forms. If you do not have the ability to attach a copy, please email a photo of the front and back of your card to info@davenshiremc.com. If you are unable to fulfill either of these options, please bring your insurance cards to the office when returning these forms. Also, please bring your insurance card to ALL appointments, so we are able to ensure that we have the most up-to-date insurance information on file for you.

Prescription Refills: All prescription *renewals* may be done through your pharmacy. For your convenience, we have a dedicated voicemail for prescription requests. All requests will be addressed as quickly as possible, but we kindly ask for 48 hours' notice Monday – Thursdays. Requests received on a Friday will be addressed as quickly as possible, but may take until the following Monday to be filled. If you are unable to call to request a refill, you may send a request via our patient portal also. If you have any questions, please leave a message on the dedicated prescription line or send us a message through our patient portal.

Request of Medical Records/Form Completion: Please let us know in advance if you require these services. A small fee may apply.

Please feel free to contact our dedicated staff with any additional questions. Thank you for allowing us the opportunity to partner in your care.

Please ask us how to obtain your activation code for our online Patient Portal.
Here you can schedule appointments, send messages, and request prescription refills!

PEDIATRIC REGISTRATION FORM

First Name: ______________________________ **MI:** _______ **Last Name:** _______________________________________

Preferred Name: _________________________ **DOB:** _____/_____/_____ **Social Security #:** _______-_______-_______

Patient Resides with: ____ Mother & Father ____ Mother ____ Father ____ Other: ________________________________

Primary Contact Information: **Name & Relationship:** ____

Street Address: ____ **City, State, Zip:** ________________________________

Home Phone: (______) _________-____________ **Cell#:** (______) _________-____________

Email: ____

Employer: _________________________ **Work Phone #:** (______) _______-___________ **Occupation:** ________________

Secondary Contact Information (If Applicable): **Name & Relationship:** ____

Street Address: ____ **City, State, Zip:** ________________________________

Home Phone: (______) _________-____________ **Cell#:** (______) _________-____________

Email: ____

Employer: _________________________ **Work Phone #:** (______) _______-___________ **Occupation:** ________________

Sex: ____M ____F **Sex at birth:** ____M ____F **Gender Identity:** ___________________________________

Pronoun: ____ She ____ He ____ They ____ We ____ Other ____ Decline

Race: ________________________ **Ethnicity:** ______________________ **Language:** _____________________

Siblings Living at Home:

Name	DOB	Name	DOB
___________________________	__________	___________________________	__________
___________________________	__________	___________________________	__________

Provider Preference: (Christine Holtz, CRNP may only see patients aged 12 and up)
____ No Preference ____ Gary Czulada, DO ____ Melissa Baylor, DO ____ Christine Holtz, CRNP

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Pharmacy Choices (in order of preference):

Name of Pharmacy	Location of Pharmacy
____	_______________________________________
____	_______________________________________

Mail Order Pharmacy (if applicable):____

MEDICAL HISTORY FORM

Patient Name: ____________________________________ DOB: ______/______/______

Medications: (prescription[s], over-the-counter, vitamins, herbs, etc.)

Drug Name & DAILY DOSE (*ex: Lisinopril 10 mg 1 tab a day*)	**Drug Name & DAILY DOSE**
____	____
____	____
____	____
____	____

Please provide any suppliers used for medical equipment {DME} (cpap supplies, oxygen, etc.):

____

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Allergies to Medications, X-ray Dyes, or other Substances: ______ No ______ Yes

(If yes, please list name of the substance **and type of reaction**)

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

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Past Medical History and Review of Systems:

Please check off any items that apply to your current diagnoses/conditions:

____ ADD	____ Crohn's/Colitis	____ Heart Disease	____ Lupus
____ ADHD	____ Convulsions/Seizures	____ Hepatitis or Jaundice	____ Osteopenia/Osteoporosis
____ Alcoholism	____ Depression	____ HIV/AIDS	____ Palpitations
____ Anemia	____ Diabetes: Type _____	____ High Blood Pressure	____ Skin Disease
____ Anxiety	____ Drug Abuse	____ High Cholesterol	____ STD/STI
____ Arthritis	____ Gallbladder Disease	____ Impotence or E.D.	____ Stroke
____ Asthma	____ GERD (acid reflux)	____ Kidney Disease	____ T.B.
____ Bleeding Disorders	____ Gout	____ Liver Disease	____ Thyroid Disorder
____ Cancer: ____________	____ Headache/Migraine	____ Lung Disease	

Others: ____

____

>>>

Please supply past history of operations and hospitalizations. Please supply type of operation and/or reason for hospitalization:

____

____

____

>>>

Please list all of your current specialty providers (please list your specific provider's name or their office name):

____

____

FAMILY & SOCIAL HISTORY FORM

Patient Name: ____________________________________ DOB: ______/______/______

Family History:
(Have any of your family members including parents, grandparents, or siblings ever had the following?)

	Which family members?	**Age when diagnosed**
Cancer **(specify type)**	___________________________________	__________________
Hypertension (high blood pressure)	___________________________________	__________________
Heart Disease	___________________________________	__________________
Diabetes	___________________________________	__________________
Strokes	___________________________________	__________________
Drug/ Alcohol Addiction (specify)	___________________________________	__________________
Glaucoma	___________________________________	__________________
Bleeding Disease	___________________________________	__________________
Mental Disease (specify anxiety, depression, etc.)	___________________________________	__________________
Miscarriages	___________________________________	__________________
Tuberculosis	___________________________________	__________________
Allergy	___________________________________	__________________
Seizures	___________________________________	__________________
T.B. Contacts	___________________________________	__________________
Other	___________________________________	__________________

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Social History & Prevention:

Do you smoke?	___ No	___ Yes	If yes, how many packs per day? _________
Do you drink alcoholic beverages?	___ No	___ Yes	If yes, how many per week? ____________
Do you use drugs? (marijuana, cocaine, etc.)	___ No	___ Yes	If yes, explain: ________________________
Have you ever engaged in any activity which has put you at risk of getting AIDS?	___ No	___ Yes	If yes, explain: ________________________
Do you wish to be tested for AIDS?	___ No	___ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	___ No	___ Yes	If yes, explain: ________________________
Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, etc.)?	___ No	___ Yes	
Do you ever feel afraid of your partner?	___ No	___ Yes	___ N/A
Do you have a Living Will?	___ No	___ Yes	
Do you have an organ donor card?	___ No	___ Yes	

INSURANCE SUBMISSION & PAYMENT AUTHORIZATION

Patient Name: ___________________________________ DOB: ______/______/______

Who is responsible for Medical Expenses? **Self [ ]** **Parent [ ]** **Other [ ]**

Responsible Party's Name: ____ DOB: ______/______/______

Social Security #:_______-________-________

Address: ____ Phone #: (_____) ________-___________

Who is the holder of your health insurance? **Self [ ]** **Parent [ ]** **Other [ ]**

Responsible Party's Name: ____ DOB: ______/______/______

Social Security #:_______-________-________

Address: ____ Phone #: (_____) ________-___________

INSURANCE POLICY--PLEASE BE SURE TO BRING YOUR INSURANCE CARD(S) TO ALL APPOINTMENTS

Primary Current Insurance Carrier: ____

ID # ________________________________ Group # _________________________________

Secondary Current Insurance Carrier: ____

ID # ________________________________ Group # _________________________________

WHEN RETURNING THIS PAPERWORK- PLEASE ATTACH A COPY OF YOUR INSURANCE CARDS (FRONT & BACK), OR EMAIL A COPY TO INFO@DAVENSHIREMC.COM

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MEDICARE LIFETIME ASSIGNMENT (Including Medicare plans under commercial insurances):

I request payment of authorized Medicare benefits be made either to me or on my behalf to Davenshire Medical Center for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration ("HCFA") and its agents any information needed to determine these benefits or the benefits payable for related services.

____ ______/______/______

Patient/Guardian Signature Date

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ALL COMMERICAL INSURANCES (Not Medicare) AUTHORIZATION TO PAY BENEFITS TO PRACTICE:

I hereby authorize my insurance company to pay benefits directly to Davenshire Medical Center Partnership. I understand that I am financially responsible for charges not covered by this authorization. I authorize my physician to release any medical information to my insurance company or its agents which may be necessary to determine benefits payable for related services.

____ ______/______/______

Patient/Guardian Signature Date

FINANCIAL POLICY

Please understand that as your health care provider, our relationship is with you, not the insurance company. While our practice is dedicated to providing the best care possible, it is your responsibility to know your insurance policy and to be aware of any non-covered charges. Also, please know that if you are experiencing financial difficulties, our Billing Staff is here to assist you.

PATIENT RESPONSIBILITIES/NOTICES:

- Present your **current** insurance card at every office visit.
- Copays **must** be paid at time of service. A small fee may apply if not paid.
- PCP assignment: contact your insurance company PRIOR to your appointment to assign us as your primary care physician (PCP) to avoid charges becoming your financial responsibility.
- Verify if services are covered by your insurance company PRIOR to scheduling.
- While physicals, well exams, & pap smears are usually a covered service, discussion of any other problems during these preventative visits is a separate charge and may be considered your financial responsibility by your insurance company.
- Appointments must be scheduled. Additional fees may incur if you were to walk-in to be seen.
- Payment for outstanding balances may be requested at time of check-in.
- There is a service fee for returned checks.
- You may be charged a fee for missed appointments and cancellations within less than two hours of your scheduled time.
- Unpaid balances may be sent to a collection agency (under the parent/guardian for a minor), which may incur additional fees. Being sent to collections will likely result in dismissal from our practice as well.
- Please contact our Billing Staff for assistance if you are experiencing financial difficulties.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. At Davenshire Medical Center, I understand that this information can and will be used to:

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

I acknowledge that I have received a copy of Davenshire Medical Center Partnership's "Notice of Privacy Practices" which explains these practices in more detail. I understand that I may request an additional copy at any time either by picking up an extra copy located in the reception area/waiting room or by asking an employee of Davenshire Medical Center Partnership.

I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that you are not required to agree to my request, but if you do agree, then you are bound to abide by such restrictions.

Please acknowledge that you have read & understand these policies by signing below.

PATIENT NAME: _____ DATE: _____

SIGNATURE: _____ RELATIONSHIP TO PATIENT: _____

BELOW IS FOR OFFICE USE ONLY…….

As an authorized representative of Davenshire Medical Center, I have made a reasonable attempt to obtain the patient's signature but was unable to do so as documented below:

_____

Initials & Date & Reason

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

PLEASE CIRCLE YOUR SELECTIONS

Can detailed APPOINTMENT messages be left…			**Can detailed MEDICAL messages be left…**		
On a Home Phone?	Yes	No	On a Home Phone?	Yes	No
On a Mobile Phone?	Yes	No	On a Mobile Phone?	Yes	No
Via Mobile Text?	Yes	No	Via Mobile Text?	Yes	No
On a Work Phone?	Yes	No	On a Work Phone?	Yes	No
Via E-Mail/Portal?	Yes	No	Via E-Mail/Portal?	Yes	No

Special HIPAA Contact Instructions (if applicable): _____

_____

Emergency Contact: Name_____ Phone# (_____) _____-_____

Relationship: _____ Address: _____

Can appointment/medical information be released to this person? **Yes** **No**

Under the privacy act known as "HIPAA", I authorize Davenshire Medical Center to release information regarding my health care, health records and/or test results to the person(s) listed below.

FOR PEDIATRIC PATIENTS: PLEASE LIST ALL PARENT/GUARDIAN NAMES

1. **Name**_____

   Relationship_____ **Phone#** (_____) _____-_____

2. **Name**_____

   Relationship_____ **Phone#** (_____) _____-_____

3. **Name**_____

   Relationship_____ **Phone#** (_____) _____-_____

4. **Name**_____

   Relationship_____ **Phone#** (_____) _____-_____

PATIENT'S NAME *(please print)*: _____

DOB: _____/_____/_____

_____ ____ _____

Signature of Patient or Responsible Party **Date**

EVALUATION AND TREATMENT OF MINORS CONSENT

By signing this form, it allows us to treat your child when they are brought into the office by another caregiver, such as a grandparent or other family member. If you do not have a need for this form at the present time, please keep this form for your records so that it may be completed in the future as needed.

I, _____, the parent or legal guardian of _____,
(Name of parent/guardian) **(Name of child)**

with DOB _____, allow _____,
(Date of Birth) **(Name of adult)**

to bring my above-named child to medical appointments with **Davenshire Medical Center**, and consent to the treatment and immunization of my child.

This consent is active:

- ○ only on _____
  (Specify month, day, year)
- ○ from _____ to _____
  (Specify time period)
- ○ until cancelled by me in writing

I maintain the right to cancel this consent at any time by writing to the above named provider(s).

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Signature of Witness **Date**

THE FOLLOWING PAGES ARE FOR RELEASE OF INFORMATION.

PLEASE READ CAREFULLY AND COMPLETE
ALL APPROPRIATE PAGES.

IF YOU HAVE EVER USED, OR PLAN TO USE WELLSPAN FOR ANY SERVICE (PRIMARY CARE, SPECIALISTS, LABS, IMAGING, ETC.) – PLEASE COMPLETE THE WELLSPAN FORM.

IF YOU HAVE EVER USED, OR PLAN TO USE UPMC FOR ANY SERVICE (PRIMARY CARE, SPECIALISTS, LABS, IMAGING, ETC.) – PLEASE COMPLETE
BOTH UPMC FORMS.

ALL OTHER FACILITIES/PROVIDERS SHOULD BE LISTED ON THE RELEASE WITH THE DAVENSHIRE MEDICAL CENTER LETTERHEAD.

WELLSPAN HEALTH

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

*** PLEASE READ AND COMPLETE ALL ITEMS ***

Patient Name: _____ **Alias/Maiden Name:** _____

Date of Birth: _____ **Last 4 of Social Security Number:** _____ **Phone Number:** _____

Address: _____

I authorize the use/disclosure of health information about me as described below:

☐ Obtain from:

To obtain from: _____
(What Hospital/Practice/Service)

☐ Disclose to: _____
(Release to What Organization/Practice/To Whom)

Address: _____

Address: _____

Fax No.: _____

Fax No.: _____

Share the following information from my medical record:

From: _____ To: _____
(Please Specify the Dates of Service)

☐ **Abstract of Hospital Medical Records:**
History & Physical, Emergency Department Physician Notes, Discharge Summary, Consultation Reports, Operative & Procedure Reports, Laboratory Reports, Imaging Reports, All Other Diagnostic Studies, etc.

☐ **Abstract of Medical Group Records:**
Physician Office Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, All Other Diagnostic Studies, Psychiatric and Psychological Evaluations, Therapy Notes, Mental Health Progress Notes, etc.

☐ **Diagnostic Test Results** (please specify): _____

☐ **Imaging** (please select **one** format): ☐ **CD and Reports** ☐ **Film and Reports** ☐ **Reports Only**

☐ **Billing Statements**

☒ **Grant the following authorized user,** Davenshire Medical Center **, access to my entire Electronic Medical Record.**
This **DOES NOT** authorize the user to disclose, modify, or provide any official medical advice on my behalf.

☐ **Other** (please specify): _____

For the **purpose** of:

☐ **Further Medical Care** ☐ **Personal** ☐ **Insurance Benefits**

☐ **Legal Investigation** ☐ **Billing Inquiries** ☐ **Establish Payment Plan**

☐ **Other** (please specify): _____

I would like to receive this information via (please select **one**): ☐ **Paper** ☐ **CD** ☐ **Secure Email Notification**

Email Address: _____

- I must provide a valid email address, either my own or that of my designated recipient.
- An email notification will be provided with instructions to retrieve the requested records from a secure portal. These records will only be available as PDF documents on the secure portal for 30 days following the date of the email Notification of Availability.

This Authorization includes the release of any records identified below unless I check **NOT** to disclose such records. Checking or not checking the box is no indicator that such information exists. Records **NOT** to disclose: ☐ AIDS/HIV Related Information and/or Testing; ☐ Behavioral/Mental Health Services; ☐ Drug and/or Alcohol Treatment.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I understand the following:

- There may be charges for the copies of my health record due to procedural and regulated steps involved with the release of information process. All fees are regulated by state and federal law, and are updated annually by the Pennsylvania State Legislature.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected under the terms of this authorization. However, certain protected records may not be redisclosed per Pennsylvania state laws and regulations, and/or Federal confidentiality rules.
- I may revoke this authorization at any time. If I decide to revoke this authorization, I must present my written revocation to the Health Information Management – Release of Information Office. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This document authorizes release of information entered into my medical records prior to or within 12 months after the date of my signature. This authorization will expire in 12 months from the date of signature.
- This authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.

My signature acknowledges that my representative or I received a copy of this document, that I have read and understand the content of this authorization, and voluntarily consent to the release of the information.

Signature of Patient/Representative * _____ Date _____

Print Name of Representative and Relationship to Patient * _____

Signature of Witness _____ Date _____

* A personal representative is the person, under applicable law, with authority to act on behalf of the patient or decedent. **Legal documentation may be required.**

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE:

We, the undersigned, do verify that the above Authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for the release of the above information.

Verbal consent requires the signatures of two witnesses:

Signature of Witness _____ Date _____

Signature of Witness _____ Date _____

PLEASE MAIL OR FAX THIS FORM TO:

WellSpan Health
Health Information Management – Release of Information
912 South George Street
York, PA 17403

Phone Number: (717) 851-6396
Fax Number: (717) 812-8119

*** * * IMPORTANT: Please send copies of medical records directly to the requesting practice or physician. * * ***

Requests for health information and invoices are processed by:

MRO

I authorize the following UPMC facilities to release information from the record of:

FACILITIES:
☐ HARRISBURG ☐ CGOH ☐ WEST SHORE ☐ CARLISLE ☐ YORK ☐ HANOVER ☐ LITITZ ☐ LANCASTER
☐ OTHER *(Provide name of non-hospital or practice location)*: _____

_____ _____ _____ as described below to:
Patient Name | Birth Date | Last 4 Digits SSN

_____ _____ _____
Facility/Person to Receive Records | Phone | FAX

Mailing address of facility or person to whom records are to be released:

_____ _____ _____ _____
Street | City | PA | ZIP Code

A. Records are requested for the purpose of: ☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance
(Please check one): ☐ Other: _____ ***Note: Purpose is not required for patient access.***

B. Disclosure Format ☐ Paper ☐ CD ☐ FAX (Providers Only) *(fax number)*: _____
☐ Other: _____

Method Received ☐ US Mail ☐ In-Person Pickup ☐ FAX *(Providers Only) (fax number)*: _____
☐ Email: _____ ☐ Direct Address: _____

C. Parts 1 and 2 below must be completed to properly identify the records to be released.

1. Type of records to be released and date(s) of service (check all that apply):
☐ Inpatient – Dates: _____ ☐ Emergency Dept - Dates: _____
☐ Same Day Surgery – Dates: _____ ☐ Physician Office/Clinic - Dates: _____
☐ Outpatient – Dates: _____ ☐ Other - Dates: _____

2. Specific information to be released (check all that apply): **** For Radiology Images, please contact location where test was performed***
☐ Abstract *(H&P, Consult, Test Results, Discharge Summary)*
☐ Allergies ☐ Emergency Department Report ☐ Operative Report ☐ Problem List
☐ Consultation Report ☐ History & Physical Exam ☐ Pathology Report ☐ Procedure List
☐ Diagnostic Tests (cardiology studies, ECHO, EEG, EMG, pulmonary function, audiology) ☐ Physician Office/Clinic ☐ Psych Evaluation
☐ Discharge Instructions ☐ Laboratory Report/Test ☐ Physician Orders ☐ Radiology Report*
☐ Discharge Summary ☐ Medication Administration Records ☐ Physician Progress Notes ☐ Rehabilitation Records
☐ EKG Report ☐ Nurses Notes
☐ Other, specify: _____

HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.
☐ **DO NOT RELEASE**

A CHECK MARK IS REQUIRED to release information from a licensed mental health facility, licensed drug and alcohol facility
☐ **Drug/Alcohol** ☐ **Mental Health** *(Psychiatric)*

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information. **See side two of this form for additional patient rights and responsibilities.**
If applicable, specify other expiration date/event here: _____

Date of Signature	Signature of Patient (14 years of age or older) may authorize release of inpatient & outpatient mental health information from a licensed facility. A minor can authorize release of Drug & Alcohol treatment information from a licensed facility.	Date of Signature	Signature of Authorized Representative Appropriate paperwork required: ☐ Parent or Legal Guardian (copy of guardianship order attached) ☐ Power of Attorney (copy attached) ☐ Next of Kin of Deceased (copy of death certificate attached) ☐ Executor of Estate (letter of administration or testamentary attached)

ORAL AUTHORIZATION (for persons physically unable to sign) NOT Applicable to HIV related Information or Drug & Alcohol Treatment Information
I witness that the patient understood the nature of this release and freely gave their oral authorization. (two witnesses are required)

Date | Witness #1 | Date | Witness #2

UPMC LIFE CHANGING MEDICINE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
ADDITIONAL PATIENT RIGHTS AND RESPONSIBILITIES

Please be aware that health care facilities are authorized by Pennsylvania State law to charge for reproduction of medical records and that charges may be associated with this request. Requestors may be notified in advance of the amount due for the request and records will be sent upon receipt of payment.

- A disclosure statement, as required by law, will accompany all records released.
- Release of my records will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records, I understand that it is possible that the facility/person that receives the records may re-disclose the information, therefore (1) UPMC and its staff/employees have no responsibility or liability as a result of a redisclosure and (2) such information would no longer be protected by the Privacy Rule.
- My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim. To revoke your Authorization, please send your request in writing to the facility listed on the front of this form.
- UPMC will not condition treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization.
- In accordance with 4 Pa Code 255.5 (b), Drug & Alcohol treatment information to be released to judges, probation or parole officers, insurance company, health or hospital plan or government officials shall be restricted to the following: 1) Whether the client is or is not in treatment, 2) The prognosis of the client, 3) The nature of the program, 4) A brief description of the progress of the client, 5) A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.
- By signing this authorization, the patient/requestor acknowledges and understands the risk associated with the communication of emails between UPMC and the recipient and consent as outlined herein, as well as other instructions that UPMC may impose to communicate via email.
- I am entitled to a copy of this completed Authorization form.

UPMC LIFE CHANGING MEDICINE

PATIENT IDENTIFICATION

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION - GENERAL

UPMC

UPMC - CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO) IN PENNSYLVANIA

Imprint Patient Identification Here

I. CONSENT TO TREATMENT

This consent cannot be modified. Any hand written changes to the form shall not be legally binding or enforceable.

1. I, _____ (print or type name) on behalf of _____ (patient name and relationship) give my permission to be treated. This may include examinations, tests and procedures, medical treatment, mental health, and drug/alcohol abuse treatment. This may include admission to UPMC hospitals, and other health care facilities under the care of a doctor and/or care provider (all "affiliates"), which they or their authorized agent (someone who has the power to act on their behalf), may think is necessary or the best course of action. I understand specific consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided, I may ask UPMC not to provide that care.
2. I understand and agree that my care may include taking photographs/video and making sound recordings that may be used for my care and/or by UPMC for education, as well as, health care operations purposes.
3. I understand and agree that others, under the direction of a doctor and/or care provider, may help with or take part in giving hospital and/or medical care to me at UPMC teaching facilities. These may include but are not limited to doctors and/or care providers in training (residents and fellows), and medical/nursing students.
4. If it applies to me, I give UPMC permission to properly dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissue cannot be recovered. I understand and agree that UPMC and those it chooses can use these specimens/tissue for educational purposes. I understand that state and federal laws let UPMC use my specimens/ tissue for research without my permission as long as my identity cannot be linked to the specimens/tissue. If my identity is/can be linked to the specimens/tissue, I will be asked to give permission first.
5. I understand that no guarantees have been made about the outcome or results of any examination or treatment.
6. I understand and agree that UPMC may provide care or services to me through video, called "telehealth". Telehealth may include sending videos, sound recordings, images, pictures, and other types of information in real time, or it may be stored and forwarded through an application, or "web or mobile app". The telehealth provider will decide whether the condition being diagnosed or treated can be properly managed through telehealth. I understand that a separate consent may be required to provide mental health and drug and alcohol abuse treatment "telehealth" services.
7. When a doctor and/or care provider orders home health, hospice, or additional services they will be directed to a UPMC provider unless you ask us not to or if it is required by your insurance. UPMC honors patient choice for your providers of health care.

II. MEDICARE CERTIFICATION (IF APPLICABLE)

I confirm that the information gave when applying for payment under Title XIX of the Social Security Act is correct. I give permission to those who have medical or other necessary information about me to share it with the Centers for Medicare and Medicaid Services or its agents or carriers, as needed for this or any related Medicare claims. I ask that approved benefit payments to be made for me. I give permission to transfer the payments for doctors and/or care providers to them or their organization providing the services or give them permission to submit a claim to Medicare for payment for me. I confirm that I received an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS/CHAMPVA) and does not give up any of my rights to ask for a review.

III. MEDICAID CERTIFICATION (IF APPLICABLE)

I confirm that the information given in this consent is true, complete, and correct. I understand that federal and state funds will be used to pay for and settle this claim and that federal and state laws can be used to punish any false claims, statements, documents, or hiding of important facts.

IV. RECEIPT OF NOTICE OF PRIVACY PRACTICE/RELEASE OF INFORMATION

1. I have received the UPMC Notice of Privacy Practices, either now or in the past.
2. I understand and agree that UPMC and the people it identifies can use my information as described in the UPMC Notice of Privacy Practices.
3. UPMC can store information about me and my care in different ways, including on computer systems, electronic media, paper, etc. This information may include sensitive information such as HIV information, mental health information and drug and alcohol abuse treatment information.
4. To the extent allowed under state and federal law, UPMC hospitals, staff, doctors and/or care providers, and other facilities and programs may access and share my medical and other information as is necessary for UPMC to provide treatment to me, seek payment for services it provides, or for UPMC's own health care-related operations.
5. I understand and agree that UPMC may release my information, including but not limited to, automated notifications of encounters, to my primary care/family doctor(s) and other providers as is necessary for treatment, consultation referral and/or other treatment related health care services to me. However, to follow certain federal and state laws, I may be required to sign a separate consent in order for UPMC to release certain types of sensitive information – including HIV information, mental health information and drug and alcohol abuse treatment information. I also give permission for UPMC to release patient and educational information to my home caregiver.
6. I understand and agree that UPMC may contact me using the contact information I have provided, including by phone (including cell phone), text message, and email to communicate with me about my care, scheduled services, and financial accounts. This may include pre-recorded messages.

7. I understand that UPMC is a research institution and may contact me with opportunities to participate in research studies in accordance with applicable laws. If I do not wish to be contacted about research opportunities, I can opt out by calling 412-624-1030 .
8. I understand and agree that my information may be released if required by local, state, or federal law.

V. FINANCIAL ARRANGEMENTS

I agree to the following terms related to payment for services provided by UPMC and affiliates:

1. I give UPMC permission to bill my insurance company, and I ask for those payments to be made to UPMC. I verify that the information I have given about my insurance or other payment sources is correct.
2. I give UPMC the right to insurance payments or benefits that I may be owed for services that UPMC has provided. I give UPMC permission to represent me and ask my managed care plan for an internal and/or external review process or an appeal of my coverage.
3. I give UPMC permission to release any medical or other information required by third parties, my insurer, other payers, and their agents for payment related purposes. I also give UPMC permission to release medical or other information required by third parties, my insurer, other payers and their agents, government agencies or their chosen representatives for review of the care provided to me.
4. I give UPMC the rights to benefits, insurance proceeds or other payments or judgments that I may be entitled to for hospital-based doctor and/or care provider services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services, and/or rehabilitation services to the doctor and/or care provider or organization providing the service. I also give permission to submit a claim for payment on my behalf to my insurance carrier.
5. I understand and agree that any hospital and doctor and/or care provider charges not paid by my insurance are my responsibility. I understand and agree that final billing will be made once all charges have been included, minus any payments actually received, and/or allowed adjustments from insurers contracted with UPMC. I understand that it is my responsibility to pay UPMC all charges so incurred in line with UPMC's standard charges as set forth in UPMC's Charge Description Master (CDM). For more information about UPMC's Charge Description Master, please go to https://www.upmc.com/patients-visitors/paying-bill/services.
6. If I choose to pay for certain services out of pocket and exercise my right to limit sharing of the information to my payer about those services, I understand that a separate financial agreement will be put into place about the self-pay services and this section will not apply to those services.
7. If I apply for Medical Assistance/Financial Assistance (or one is made on my behalf), UPMC is allowed to provide information as is necessary to determine if I am eligible.

VI. PATIENT VALUABLES

I release UPMC from any responsibility for any loss, damage, or theft of my personal property, including clothing, cash, jewelry, dentures, glasses, or other valuables that I choose to keep with me while I am a patient. I agree UPMC will not be responsible for replacing any lost, damaged, or stolen, items that I choose to keep with me, or anything that is brought to me while I am a patient.

VII. AGREEMENT THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED

I understand and agree that any lawsuit or legal action which is in any way related to the medical care I receive must be filed in the County where the care at issue is provided.

VIII. MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s) _____,
I am allowed under Pennsylvania Law to consent to medical, dental or other health services for myself, and if applicable, for my minor children without the consent of any other person. _____ **Patient Initials (required if completing this section)**

I have read this Authorization/Consent for Treatment, Payment and Health Care Operations (TPO) form or have had it read to me, and it has been explained to my satisfaction. I understand pursuant to this TPO form, the component of my consent relating specifically to treatment may be valid for up to one (1) year from the date that I sign it and applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.) All other promises set forth in this agreement remain enforceable upon the expiration of the consent for treatment.

Patient Signature (Witness is required for verbal consent)	Date	Time	Signature of UPMC Representative/Witness
Signature/Identify on behalf of patient/relationship Name	Date	Time	

DAVENSHIRE MEDICAL CENTER

3740 Carlisle Road, Dover, PA 17315
Phone # 717-292-3168 ● Fax # 717-292-3479 ● www.DavenshireMC.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Full Name: _____ Maiden Name/Alias: _____

DOB: _____ Social Security #:_____/_____/_____

1) Purpose of this request:
☐Personal ☐Changing Physicians ☐Continuing Care ☐Insurance/Billing ☐Other: _____

2) I hereby authorize Davenshire Medical Center to:
☐ Release to ☐ Receive from the entity listed/selected below.
Please write the Physician/Facility Name, Address, Phone, &/or Fax #:
_____
_____
_____

3) THIS SECTION IS ONLY FOR USE OF RECORDS <u>TO BE RECEIVED:</u>
By selecting these facilities, I hereby authorize Davenshire Medical Center to **obtain** available records.
Which of the following facilities have you used in the past? **Select all that apply**

☐Wellspan Health ☐OSS Health
☐UPMC Health ☐Johns Hopkins
☐Penn State Hershey ☐Lancaster General/Penn Medicine
☐Penn State Holy Spirit

4) Please release the following records within the service date years from _____ to _____.
** If service date range is not specified, a minimum of the last two years' worth of records will be released/obtained.
Please select all that apply:
☐All Medical Health Records
☐MVA or Workers Comp notes & reports
☐Other, as specified: _____

5) The following information **<u>will be released</u>.**
Please write your initials next to any items you **<u>do not want</u>** to be released.
_____ HIV related information
_____ Mental health information (ex. anxiety, depression, etc.)
_____ Drug & Alcohol abuse or dependency information

You have the right to revoke this authorization in writing by sending a dated and signed letter to our Privacy Officer at the address above. Revoking this authorization will not affect your care by our physicians or the staff employed by Davenshire Medical Center.
By signing below, I understand the nature of this authorization:

_____ _____
Signature of Patient/Responsible Party Relationship to Patient

_____ _____
Employee Signature Date **(valid for one year from this date)**

This information has been disclosed to you from records whose confidentiality is protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

This information is for use by your physician as part of your confidential medical records.
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