Diley Medical Group

Patient Demographic Information

Please complete this entire form. Thank you!

Today's Date: ____ ____ ____ Referred By (if applicable): _____

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	DOB (MM/DD/YYYY):

MAILING ADDRESS (STREET):	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS (if different from mailing address):	CITY:	STATE:	ZIP:

HOME PHONE:	CELL PHONE:	WORK PHONE:
EMAIL ADDRESS:	USE EMAIL FOR PATIENT PORTAL? Yes No Not applicable	SOCIAL SECURITY #:

GENDER: Male Female Transgender Unknown	RACE: American Indian/Alaskan Native Asian Black/African American Hispanic Native Hawaiian/Other Pacific Islander White Prefer not to Answer
ETHNICITY: Hispanic/Latin Non-Hispanic/Latin Prefer not to Answer	PREFERRED LANGUAGE: English Spanish Other Language (please specify):

DO YOU HAVE A CAREGIVER?: Yes No	IF YES, NAME OF CAREGIVER:	IF YES, MAY WE RELEASE PROTECTED HEALTH INFORMATION TO YOUR CAREGIVER?: Yes No

EMERGENCY CONTACT

LAST NAME:	FIRST NAME:	RELATIONSHIP:
HOME PHONE:	CELL PHONE:	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL?: Yes No

EMPLOYER INFORMATION

EMPLOYMENT STATUS: Employed Full Time Part Time Retired Self Employed Unemployed Active Military Student	
EMPLOYER NAME:	EMPLOYER PHONE NUMBER:

INSURANCE INFORMATION - Please give ID and Insurance Card to Front Desk

I HAVE INSURANCE: YES NO (SELF-PAY)			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:		SUBSCRIBER:	
GENDER: Male Female Transgender Unknown		GENDER: Male Female Transgender Unknown	
DOB (MM/DD/YYYY)	SSN:	DOB (MM/DD/YYYY)	SSN:

CONFIDENTIAL COMMUNICATION

I hereby request to receive confidential communications from DMG in the following manner)

TELECOMMUNICATIONS - Please leave messages regarding my protected health information as follows (Check all that apply):	POSTAL COMMUNICATIONS - Please mail my protected health information to me at (Select only one):
Home phone of record Brief Extended Cell phone of record Brief Extended Work phone of record Brief Extended	Mailing address of record Street address of record Other _____ Street City State Zip

ADVANCE DIRECTIVES

Do you have a Living Will? No Yes (If yes, please provide a copy to the front desk)

Do you have a Durable Power of Attorney for Health Care? No Yes (If yes, please provide a copy to the front desk)

Do you have a DO NOT RESCUSITATE? No Yes (If yes, please provide a copy to the front desk)

Diley Medical Group

New Patient History

Please complete this entire form. Thank you!

TODAY'S DATE: _____

NAME _____ _____ _____ **DATE (** _____

LAST **FIRST** **MI** **MM/DD/YYYY**

Current Physicians/Specialists: _____

Pharmacy: _____

Current Medications (please include your directions):

1.	**7.**
2.	**8.**
3.	**9.**
4.	**10.**

Allergies to medication, x-ray dyes, or food: _____

Past Medical History (check all that apply):

( ) **Alzheimer's/Dementia**	( ) **Hypertension**	( ) **Obstructive Sleep Apnea**	( ) **Depression**
( ) **COPD**	( ) **Hypothyroidism**	( ) **Stroke/ TIA**	( ) **Diabetes**
( ) **Cancer**	( ) **Insomnia**	( ) **Seizures**	( ) **Headache/Migraines**
( ) **Coronary Artery Disease**	( ) **Hyperlipidemia**		

Past Surgical History:

_____

_____

Gynecological History: If menopausal, age at menopause: _____ **Last p** _____ **Last M** _____

Family History: _____

Last Colonoscopy: _____ **Last Eye Exam:** _____ **Most Recent Labwork:** _____

Flu Vaccine: _____ **Pneumonia Vaccine:** _____

Social History:

Marital status: ( ) Married ( ) Widowed ( ) Divorced ( ) Single	**Exercise Level:** ( ) None ( ) Occasionally ( ) Moderate ( ) Heavy
Live alone or with others? ( ) Alone ( ) With Others	**Diet:** ( ) Regular ( ) Vegetarian ( ) Vegan ( ) Gluten Free ( ) Cardiac ( ) Diabetic ( ) Other
Live in single or multi-level home: ( ) Single ( ) Multi-Level	**Advance Directive?** ( ) Yes ( ) No
Occupation: _	
Smoking Status: ( ) Never ( ) Former ( ) Current: __ , ay __ __ years	**Chewing Tobacco:** ( ) Never ( ) 1 Day ( ) 2-4 day ( ) 5+ day
Alcohol Intake: ( ) None ( ) Occasional ( ) Moderate ( ) Heavy __ week	**Illicit Drugs**
Caffeine Intake: ( ) None ( ) Occasional ( ) Moderate ( ) Heavy	

DIFFICULTIES WITH ANY OF THE FOLLOWING:

( ) Caring for self ( ) Transportation ( ) Hearing ( ) Seeing ( ) Walking ( ) Climbing Stairs ( ) Dressing ( ) Bathing

( ) Doing errands alone ( ) Concentrating, remembering, or making decisions

Diley Medical Group

Patient Registration and Policy Agreements

Please complete this entire form. Thank you!

Receipt of Notice of Privacy Practices: I have been offered the HIPPA Notice of Privacy Practices at DMG which outlines my privacy rights and how DMG may use and disclose Protected Health Information about me.

YES NO Offered but Declined Initials _____

Photograph for Patient Identification: I give my consent to the use of my photograph for identification on my electronic health record.

Accept Decline Initials _____

Telephone Contacts, Monitoring and Recording: this does not include calls related to appointments, billing or health-related information. I hereby consent and agree that: (1) any calls with DMG may be monitored and/or recorded an that DMG (or anyone acting on DMG's behalf) may contact me, from time to time, regarding my account (including for collections purposes or related to insurance coverage) or regarding my most recent visit with my provider; (2) any and all of DMG's contacts with me may be made via text message or with an automated dialing device; (3) DMG may contact me at any telephone number I provide to them, whether a residential, business number, or mobile number; (4) DMG may e-mail newsletters informing me of new services or suggested health screenings: and (5) I have an established business relationship with DMG and DMG may contact me in any of the ways described above. I understand that, if I accept now, I may opt out at any time by notifying the DMG.

Accept Decline Initials _____

Health Information Exchange (HIE): DMG participates in one or more Health Information Exchanges that share medical information to facilitate improved care through a comprehensive health record. This information is secure and only available to those providers involved in your care delivery. I agree that my DMG provider may allow access to my health information through the Health Information Exchange for treatment or other health care operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying DMG.

All DMG patients are automatically enrolled in the HIE unless the Opt-Out box is checked and initialed.

Opt-Out Initials _____

E-Prescribing: E-Prescribing is a way for doctors to electronically send an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also may provide the health care provider information about which drugs are covered by your drug benefit plan and may also provide the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate compliance with prescribed regimens, therapeutic interventions, drug-drug and drug-allergy interactions, adverse drug reactions,and duplicative therapy.
The medication history information would include medications prescribed by your health care provider at DMG as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

All DMG patients are automatically enrolled in E-Prescribing unless the Opt-Out box is checked and initialed.

Opt-Out Initials _____

Medication Policy: The medication given to you should be taken as prescribed by your doctor. The medications may not be used for any purpose other than that for which they are prescribed. These medications may not be given nor sold to another individual. Keep all narcotic medications locked up. If a medication is stolen or lost it will not be able to be replaced until it is due for a refill. Police reports of theft are not accepted. **Breaking these rules may be cause to terminate your treatment, and discharge you from our practice.**

1. You will be given enough medication to last a specific length of time. Please read the directions each time you get a prescription filled. You must take your medication according to the directions, and no medications will be refilled early. You must keep track of your medications to ensure that you do not run out before the specified time. **It is your responsibility to schedule follow-up appointments far enough in advance so you do not run out of medication.**

2. **Requests for medication will only be considered between 9:00am and 4:00pm Monday through Thursday and 9:00am to 12:00pm on Friday.**

3. Requests for medication should be called directly to our office or through the Patient Portal website. Please allow 48 hours to process your request. We expect you to be seen in the office every three months or as directed for routine medications. **For any narcotic or ADHD medications, you are required to be seen every 30-60 days** as directed by the provider. Your physician may not fill this medication until you are seen in the office.

4. **We do not prescribe for chronic narcotic use**. If there is a need for pain management, we will refer you to a pain specialist.

Confidential Communications: I understand DMG will notify me if DMG is unable to comply with my request for Confidential Communications.

Release of Protected Health Information in Emergency Situation: I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

Appointment cancellations/no shows: I understand keeping scheduled appointments is an important part of your health care. It allows your doctor or dentist to talk about your illnesses and what you can do to stay healthy. When you miss an appointment you also miss out on the opportunity to improve your health. In addition, it takes the appointment away from another patient who may need it. I understand that if I do not show up for an appointment or call to cancel my appointment with more than 24 hours notice three (3) or more times in a twelve (12) month period, I may be terminated as a patient.

Late Policy: We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. If you arrive 15 minutes past your scheduled time, we may have to reschedule your appointment. If you are still able to be seen the same day, you may have an increased wait time.

Financial Policy: I understand that payment of my bill is considered part of my treatment. Fees are due and payable when services are rendered. DMG accepts cash, check, and credit cards. For checks returned unpaid by my bank, a $25.00 fee will be assessed.

Bad Debt Policy: I understand that I will receive monthly statements to the address I provide to DMG, and it is my responsibility to notify DMG of any address changes. I will be placed into bad debt after 4 months of no payments and will no longer be able to be seen in the office until my account is current. After an additional 2 months of no payments, I understand that I could be terminated from the practice.

Insurance assignment and Acknowledgement: I understand my insurance carrier can choose to assign benefits to DMG or my insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information. It is my responsibility to know my own insurance benefits, including whether DMG is a contracted provider with my insurance company; my covered benefits and any exclusions in my insurance policy; and any pre-authorization requirements of my insurance company.

Medicare and Medicaid: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and /or Its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment. I certify that I will pay to DMG any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to DMG any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

By signing below, I am acknowledging that I have read and understand all the above statements.

Patient Printed Name	Patient Signature	Date Signed
Legal Guardian Printed Name* (if applicable)	Legal Guardian Signature* (if applicable)	Date Signed

Please provide a copy of legal guardianship court papers for the patient's record

HIPPA (Health Insurance Portability Accountability Act) Consent

Diley Medical Group consent for disclosure of your Protected Health Information

Diley Medical Group will obtain and maintain protected health information (PHi) pertaining to you, a patient of our practice. Please be advised that we will use and disclose your PHI as necessary to treat you, receive payment for services and facilities provided to you, and for administration of health care operations. Our practice's ability to use and disclose a patient's PHI is more fully discussed in our NOTICE TO PATIENTS regarding Protected Health Information, which can be provided to you at your request and is posted in our waiting room. Prior to signing this consent, you have the right to review the Notice to Patients regarding Protected Health Information and we will provide you with a copy of such Notice or make copies of such Notice available to you if it is materially amended in the future.

As a patient of Diley Medical Group you have the right to restrict our practice's use or disclosure of your PHI for carrying out treatment, payment, or health care operations; however, Diley Medical Group does not have to agree with such restrictions. Nevertheless, if we agree to your restrictions, we agree to be bound by such restrictions.

Unless Diley Medical Group has relied and acted upon your consent to use or disclose your PHI, you have the right to revoke this consent by providing our practice with a written revocation of consent.

If you should have questions regarding such consent, please contact the Privacy Officer of Diley Medical Group.

In accordance with Federal regulation and Diley Medical Group's "Privacy Policy" and "Privacy Procedures," the following has been implemented. At no time shall any person receive Protected Health Information (PHI) that pertains to any individual unless prior authorization has been completed.

I have read and understand this document and authorize the following person(s) to receive PHI in my absence to include, but not limited to: prescriptions, laboratory and radiology requests/results, and medication samples.

Please print name and relationship to patient:

1. Name _____ Phone # _____

   Relationship to Patient: _____

2. Name _____ Phone # _____

   Relationship to Patient: _____

3. Name _____ Phone # _____

   Relationship to Patient: _____

4. Name _____ Phone # _____

   Relationship to Patient: _____

5. Name _____ Phone # _____

   Relationship to Patient: _____

Print Patient Name: _____ **Date of Birth:** _____

Patient Signature: _____ **Effective Date:** _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individuals health information as described below.

PATIENT/RESIDENT/CLIENT

Last Name:	**First Name:**	**Middle Initi**
Address:	**City/State:**	**Zip:**
Phone #:	**SSN (optional):**	**Date of Birth:**

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE:

Last Name or Entity:		
Address:	**City/State:**	**Zip:**

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

Last Name or Entity: DILEY MEDICAL GROUP		
Address: 5762 N HAMILTON RD	**City/State: COLUMBUS, OH**	**Zip: 43230**
Phone #: 614-920-1000	**Date:**	
Treatment Dates:	**Purpose of Request:**	**O at the request of the individual.**

THE FOLLOWING INFORMATION IS TO BE DISCLOSED (PLEASE CHECK):

History and Physical Examination	**Physician Orders**
Discharge Summary	**Pharmacy Records**
Progress Notes	**Immunization Records**
Medication Records	**Nursing Notes**
Interpretation of Images: x-rays, sonograms, etc.	**Billing Records**
Laboratory Results	**Drug/Alcohol Rehabilitation Records**
Dental Records	**Complete Record**
Psychiatric Records including consultations	**Othe**
HIV/AIDS blood test results: any/all reference to those results	

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. Federal and State law generally prohibit recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that autorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may reinspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524

I have the right to receive a copy of this authorization. I would like a copy of this authorization: **Yes** **No**

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	

FOR OFFICE USE
