PIONEER
PHYSICIANS NETWORK
First in Health.

Welcome to Pioneer Physicians Network, please take a minute to fill out this form.

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

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

Home Phone: _____
Cell Phone: _____
Work Phone: _____

Of these, which do you prefer to be called to confirm your appointments? _____

Date of Birth: _____ Social Security Number: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Other: _____

Race: ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian ☐Black or African American ☐White ☐Hispanic ☐Other Race ☐Other Pacific Islander

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino

Language: ☐English ☐French ☐Indian ☐Spanish ☐Russian ☐Italian ☐German ☐Chinese ☐Hindi ☐Greek ☐Arabic ☐Serbian

Email address: _____
Employer: _____
Occupation: _____

Emergency Contact:

Name: _____ Relation: _____ Daytime Phone number: _____

Pharmacy information: (This information will help us choose the correct pharmacy in our electronic medical records)

Which pharmacy do you use? _____ What street is that on? _____
Which City is that in? _____
Do you have a mail order pharmacy as well? If so, what is the name? _____
We need a Phone and Fax number, if you don't have it with you please call us with the information or bring it to your next visit. Phone _____ Fax _____

Primary Insurance:

Insurance Name: _____
Insured's name: _____
Relation to the patient: _____
Insured's DOB: _____
Insured's SSN: _____

Secondary Insurance:

Insurance Name: _____
Insured's name: _____
Relation to the patient: _____
Insured's DOB: _____
Insured's SSN: _____

I UNDERSTAND THAT I WILL BE HELD FINANCIALLY RESPONSIBLE FOR ALL CHARGES RESULTING FROM SERVICES PROVIDED. I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS FROM MY INSUARANCE COMPANY TO **PIONEER PHYSICIANS NETWORK, INC**. IN ADDITION; I AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION NECESSARY FOR THE PROCESSING OF THESE CLAIMS FOR PAYMENT INCLUDING FACSIMILE TRANSMISSION OF INFORMATION.

_____ Signature

_____ Date

Revised 8/2019

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you get access to this information. We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured protected health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164.

Your Rights: When it comes to your health information, you have certain rights. Please review carefully.

- You can ask to see or get an electronic/paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- You can ask us to correct health information about you that you think is incorrect or incomplete. We may say no to your request, but we will tell you why in writing.
- You can ask us to contact you in a specific way (ex: home or office phone) or send mail to a different address. We will say yes to all reasonable requests.
- You can ask us to limit sharing of certain health information for treatment, payment, or our operations. We are not required to agree to your request and may say no if it would affect your care.
- If you pay for a service or healthcare item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your insurer. We will say yes unless a law requires us to share that information.
- You can ask for a paper copy of this notice at any time.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has authority and can act for you before we take any action.

Your Choices: For certain health information, you can tell us your choice on what we share. If you have a clear preference for how we share your information, talk to us.

- You have both the right and choice to share information with your family, friends, or others involved in your care.
- We never share your information for marketing purposes, sale of your information, and most psychotherapy notes.

Other Uses and Disclosures: We share your information to treat you, run our organization, and/or bill for services.

- We can use your health information and share it with other professionals who are treating you.
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- We can use and share your information to bill and get payment from health plans or other entities.
- We are allowed/required to share your information in ways that contribute to public good such as preventing disease, product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing/reducing a serious threat to anyone's health or safety.
- We will share your information if state or federal laws require it, including the Department of Health and Human Services.
- We can share health information with organ/tissue organizations per request, coroner, medical examiner, or funeral director.
- We can share information for workers' compensation claims, for law enforcement purposes, health oversight agencies authorized by law, and government functions such as military, national security, presidential protective services, and in response to a court order or subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not share your information other than as described there unless we have written consent.

HIE Notice

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying your physician's office.

Changes to the terms of this notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

If you have any questions about this notice or would like to file a complaint, please contact our privacy officer listed below:
Kathleen Kostelnick · (330) 899-9350 ext 2024 · 3515 Massillon Rd. Suite 300, Uniontown, Ohio 44685 · kkostelnick@pioneerphysicians.com

Annual Patient Consent for Release of Information and Medical Claims Processing

By signing below, I (the patient) understand that I will be held financially responsible for all charges resulting from services provided. I authorize direct payment of medical benefits from my insurance company to Pioneer Physicians Network, Inc. In addition, I authorize release of any medical information necessary for reprocessing of these claims for payment including, but not limited to, facsimile transmission of information.

I consent to the use of my medical information necessary for transmission of prescriptions to the pharmacy and as needed for the coordination of formulary and/or benefits eligibility with my insurance provider. I consent to the query of my external prescription history as necessary to manage my healthcare and related services.

In accordance with the notices of privacy practices, I authorize the use and disclosure of any medical information with a third party to coordinate or manage my healthcare or any related services.

- **Co-pays, deductibles and/or co-insurance are to be paid when you arrive at check-in**. In accordance with your health insurance policy, your co-pay or other time of service responsibility payment is to be paid in full at the time of your office visit. We accept cash, personal checks, Visa, MasterCard, Discover and American Express. You may also use your HSA or debit card. *Please note that if you use your HSA card – refunds can only be returned to the HSA card and cannot be directly refunded to the patient or to the patient account.
- **If you are covered by a High Deductible Health Plan (HDHP)**: Health Reimbursement Account (HRA) and Health Savings Account (HSA), you will be required to pay a fee of $150 at the time of service if you have not met your deductible. Your required payment may be adjusted based on the level of services to be provided.
- **If you do not have health insurance, payment must be made at the time of service**. A driver's license or other identification will be required for all self pay accounts. Note: until insurance eligibility is verified, your account will remain as "self pay" and you will be required to make payment at the time of service.
- **Self Pay Time of Service Discount**: If your financial status is "self pay" you are expected to pay in full at the time of service. For payment in full at the time of service, you will receive a 20% discount on all office-based services and a 40% discount on all laboratory services.
- **Worker's Compensation (BWC) claims require special processing**. You will be required to complete BCW claims processing information at the time of service. If information is not provided, your account will remain as self pay. Not all Pioneer Physicians are BWC providers. Please contact your office location and inquire. They will direct you to the proper location. This also includes ODOT physicals.
- **Motor Vehicle Accident (MVA) will be considered self pay and will require payment at the time of service** as well as completion of a patient consent form. Pioneer Physicians will provide necessary information to you regarding your MVA claims however, will not process claims to your health or auto insurance carrier.
- **We will ask you for payment on your outstanding balance when you arrive for your visit** unless payment arrangement has previously been made. If you are unaware that you have an outstanding balance, it may be because we do not mail billing statements if your account balance is less than $4.99. Our office staff would be happy to provide you an itemized statement at your request.
- **Your balance is due in full upon receipt of your monthly statement.** This includes co-insurance, deductibles, and services not covered by your insurance policy and services billed to your insurance company but were denied for payment after repeated attempts by our billing department to resolve the disputed claim. You are responsible for working with your health insurance company should they request additional information from you for your claims to be paid.
- **Returned checks:** For each NSF check, our fee is $45.00. If we receive an NSF check, we will not accept another personal check from you until the NSF fees are paid and a payment for the returned check has been made. If we receive two (2) returned checks on an account, we will no longer accept personal checks.

- **Failure to make your payment in full**, or as arranged, may result in your account being turned over to a collection agency. If your account is sent to collection, it may appear on your credit report. Your healthcare services relationship with Pioneer Physicians Network and your physician may be impacted as our policy is to dismiss patients that have been sent to collections and their household members from all physicians and ongoing services of the practices.
- **Refund Checks**: Patient/Guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will be automatically refunded to the patient/guarantor. Refunds are processed within 30 days.
- We will work with you in every possible way to resolve any discrepancies with your account and/or to make acceptable payment arrangements when you contact us for assistance. If you have any questions and/or feel you are not receiving the service you should, please contact our **billing department at 330-899-9350.** Pioneer Physicians Network billing services are provided by our revenue cycle department located in our administration office in Uniontown, Ohio.
- A "no-show" appointment patient is a patient who has failed to report for a scheduled appointment without previous notification of cancellation. Missed appointments are disruptive to the provider and do not allow for the scheduling of other patients that are waiting to be seen, Please give 24 hours notice if you need to cancel a scheduled appointment, so that we will be able to utilize that time slot for a patient in need of an appointment. You will be given a courtesy call before your appointment to remind you of your appointment. If you fail to show for an appointment you may be sent a letter warning you of a possible fee and/or dismissal from our practice. **Ultrasound Appointments: $35.00, Office Visits: $50.00, Dietitian Appointments: $75.00**

I have read and understand the Pioneer Physicians Network Financial and Annual Patient Consent for Release of Information and Medical Claims Processing Policy. I agree to assign insurance benefits to Pioneer Physicians Network whenever necessary.

Patient Name (printed): _____

Patient Signature (or authorized representative): _____

Date: _____

New Patient Questionnaire

Name: _____ Date of birth: _____Today's Date: _____
Spouses name if married: _____
Children's names and ages: _____
_____

Family History: *If any blood relative has suffered from any of the following, please circle*

1. Epilepsy
2. Migraine
3. Mental illness
4. Glaucoma
5. Diabetes
6. Thyroid
7. Hay fever
8. Asthma
9. Anemia
10. Bleeds easily
11. Osteoporosis
12. Arthritis
13. Heart Disease
14. Stroke
15. High Blood pressure
16. High Cholesterol
17. Alcoholism
18. Hepatitis
19. Cancer

Medical History: *Please check the box if you have been diagnosed with any of the following:*

☐ Hypertension ☐ Diabetes ☐ Asthma ☐ Stroke
☐ Thyroid Problems ☐ High Cholesterol ☐ Cancer ☐ Heart Disease
☐ Dizziness/Fainting ☐ Mental Illness ☐ Epilepsy/Seizures ☐ Migraine
☐ Other: _____

Surgical History:

Year	Illness or operation	Year	Illness or operation

Medications: *(include over the counter and natural/herbal and alternative medicines)*

Name	Dose	Frequency

Allergies: -
_____
_____

Please list the top 3 concerns that you wish to address with your physician at your visit:

1. _____
2. _____
3. _____

PIONEER
PHYSICIANS NETWORK

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME	DATE OF BIRTH	LAST 4 of SS#
_____	_____	_____

I hereby authorize Pioneer Physicians Network, Inc. to use and disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and that it may include information relating to **AIDs, HIV Infection, behavioral health services, psychiatric care, and treatment for alcohol and/or drug abuse.** I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by Federal Privacy Regulations. I understand that I need not sign this authorization to ensure treatment and that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules.

1.) I give permission to the staff and physicians of Pioneer Physicians Network, Inc. to leave detailed phone messages at the following number: _____

2.) Pioneer Physicians Network, Inc. can share the following protected health information with the people listed below:

☐ **ALL**

☐ Consultation Reports	☐ Laboratory Results	☐ Radiology Images
☐ Discharge Summary	☐ Progress Notes	☐ Referral Information
☐ History and Physical Examination	☐ Radiology Reports	☐ **DECLINED ALL**

Name and Relationship To Patient	Phone Number

I certify that I have read the provisions of this authorization, understand the content, and agree to the terms set forth within the authorization. I understand that this authorization is valid for one year from signature date unless there is a Power of Attorney or Durable Healthcare Power of Attorney on file in my record.

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
(subsequent visit) Patient Signature Date

_____ _____/_____/_____
(subsequent visit) Patient Signature Date

Pioneer Physicians Network
3515 Massillon Road, Suite 300
Uniontown, OH 44685
Phone (330) 899-9350 Fax (330) 634-1329

MEDICAL RECORD RELEASE AUTHORIZATION

PATIENT INFORMATION:

Patient's Last Name, First Name, MI | Previous Name | Date of Birth (Month/Day/Year)

Street Address, Apt # / Suite (Include Complete Mailing Address) | Social Security Number | Home Phone Number/Alternate Number

City State Zip | Email Address

I HEREBY AUTHORIZE RECORDS AND PLAN OF CARE FROM:
❑ **Pioneer Physicians Network**
"or" ❑ **Other** - _____
Organization/Person/Entity/Name

Street Address, Apt # / Suite (Include Complete Mailing Address)

City/State/Zip Phone/**Fax Number**

TO BE RELEASED TO:
❑ **Pioneer Physicians Network – Att:** _____
"or" ❑ **Other** - _____
Organization/Person/Entity/Name

Street Address, Apt # / Suite (Include Complete Mailing Address)

City/State/Zip Phone/**Fax Number**

TREATMENT DATE(S) TO BE DISCLOSED: From _____**to**_____.

DESCRIPTION OF INFORMATION TO BE DISCLOSED FOR THE ABOVE TREATMENT DATE(S) ABOVE:
❑ Abstract/Summary of Medical Records for personal or physician use ❑ Complete Medical Records
"OR" SPECIFIC DOCUMENT(S) TO BE DISCLOSED FOR THE ABOVE TREATMENT DATE(S) ABOVE:
❑ Physician Office Note(s) ❑ Laboratory Report(s) ❑ Diagnostic Test/Report(s) ❑ Itemized Bill(s) ❑ Immunizations
❑ Radiology/X-ray/MRI Report(s) ❑ Pathology Report(s) ❑ Operative Report(s) ❑ Other, specify _____

This information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.
SPECIFIC INFORMATION NOT TO BE DISCLOSED:_____

PURPOSE OF DISCLSOURE:
(Check all that apply).

❑ Self/Personal Use
❑ Disability
❑ Legal/Litigation
❑ Workers Comp
❑ Insurance
❑ Continuation of Care
❑ Transfer
❑ Other, explain -
_____

- I authorize that this information to be mailed, faxed, and/or sent electronic delivery when applicable.
- I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to **re-disclosure** and will no longer be protected by Privacy Protection Rules. I understand that I have the **right to revoke** this authorization at any time and that my revocation must be submitted to Medical Records Department at Pioneer Physicians Network. I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits.
- I hereby authorize Pioneer Physicians Network and/or MediCopy Services, Inc. to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I hereby release Pioneer Physicians Network and/or MediCopy Services, Inc. from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released via mail, fax, and/or electronic delivery.
- **Fee Information***:* Pioneer Physicians Network contracts with MediCopy Services, Inc. to provide release of information services from our office. We reserve the right to charge the medical record state fee structure as set forth in the state statute. You may visit http://www.odh.ohio.gov/ . By signing this authorization, you are **agreeing to pay MediCopy Services, Inc. for any duplication fees or charges** at the time of service or when applicable.
  Questions regarding your invoice may be answered at 866-587-6274.
- Unless withdrawn, this consent will **expire 180 days** from the date signed unless another date or event is specified. _____

Signature of Patient Date

Signature of Legally Appointed Representative Date

Witness Date

The fee schedule for a patient's personal representative (Durable Healthcare Power of Attorney, Parent or Legal Guardian):

- No records search fee
- For data recorded on paper:
  - $3.25 per page for the first 10 pages
  - $0.68 per page for pages 11 through 50
  - $0.27 per page for pages 51 and higher
- For data recorded other than on paper (i.e. -rays, MRI, or CAT scan, recorded on paper or film):
  - $2.23 per page
- Actual cost of postage