PIONEER PHYSICIANS NETWORK
First in Health.

Family Child Information Sheet

Patient's Name_____
Date of Birth _____

Please list all of the people living in the home with the child.

Name	age	relationship	Name	age	relationship

Mother's name_____Date of Birth_____ Occupation_____ School Grade completed_____
Father's name _____ Date of Birth_____ Occupation_____ School Grade completed_____

Who is the primary caregiver(s)? _____
Does the child live with the parent(s)? _____ Legal guardian_____ Relationship_____

Child's Birth (Complete this section if your child is less than 2 years of age)
Birth Weight_____ Length _____
Was the baby born premature? □ Yes or □ no If yes, how early? _____
Any problems during pregnancy or delivery? _____
Was the birth □ vaginal □ C-section If C-section, why? _____
During pregnancy did mother smoke, drink or use drugs? □ yes or □ no
If yes, please explain _____
Please name any medications taken by mother during pregnancy _____
At what hospital was the baby born? _____ Baby's length of stay at hospital _____
Was (is) the baby □ Breast fed? □ Bottle fed

Allergies – Please list any medications, foods, latex, or environmental allergies that the patient may have and what happened when they were exposed to that item. _____
_____

Past Medical History

Medications- Please list all of your child's medications, doses of medications and frequency that you give them. Include any prescription medications, over the counter medications, or alternative medications/treatments.

_____ _____
_____ _____
_____ _____

Has your child ever been diagnosed with any of the following? (Please check all that apply)

□ Behavior/Mental Health Problems	□ Seizures	□ Breathing Problems	□ Skin Problems
□ Heart Problems	□ Stomach Problems	□ Dental Problems	□ Urinary Problems
□ Developmental delays	□ Urinary Problems	□ Ear Problems	□ Vision Problems
□ Learning Problems	□ Other _____		

Please describe child's significant health problems (include any overnight hospitalizations, surgeries or serious injuries).
_____
_____

Family Medical History

Have child's parents, brothers or sisters, grandparents, aunts or uncles have ever had any of the following diseases?
□ Allergies □ Anemia □ Arthritis □ Asthma □ Bleeding problems □ Cancer
□ Crib death/SIDS □ Diabetes □ Depression □Learning disorder □ Skin problems □ Eye problems
□ Hearing problems □ High Cholesterol □ Kidney disease □ Lung disease □ Muscle/nerve disease □ Seizures
□ Stomach problems □Thyroid problems □ Tuberculosis □ Heart disease/Attack □ High Blood Pressure

Signature:_____ **Relationship to child:** _____ **Date:** _____

Welcome to Pioneer Physicians Network

Patient Information:

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

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

Home Phone: _____ Cell Phone: _____

Work Phone: _____ ☐ **Check here** to authorize text messages for appointment reminders and information about your healthcare

Email address: _____

Date of Birth: _____ Social Security Number: _____

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

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

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Language: ☐ English ☐ Spanish ☐ Russian ☐ Hindi ☐ Serbian Other: _____

Employer: _____

Emergency Contact:

Name: _____ Relation: _____ Daytime Phone number: _____

Pharmacy information:

Which pharmacy do you use? _____ What street is it on? _____

Which City is that in? _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Do you have a mail order pharmacy as well? If so, what is the name? _____

Who was your Previous Primary Care Physician? _____

Why did you leave that practice? _____

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

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

CONFIDENTIAL

PIONEER PHYSICIANS NETWORK

MEDICAL RECORD RELEASE AUTHORIZATION

Please fax to: (330) 634-1329

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