Honeoye Valley Family Practice
23 Ontario Street
Honeoye Falls, NY 14472
Phone: (585) 624-2121
Fax: (585) 624-7283

New Patient Letter

(Please retain this letter for your records)

Welcome to our practice. We are genuinely pleased that you have chosen our practice for your medical care.
To register as a new patient in our practice, please print and complete the new patient registration forms and submit to our practice by either, faxing, mailing, or dropping the forms off at our office.

LOCATION AND HOURS:

- We are located at 23 Ontario Street, Honeoye Falls, NY, 14472
- Our office hours are: Monday and Wednesday 8:00 am to 8:30 pm; Tuesday, Thursday, and Friday 8:00 am to 5:00 pm; Saturday 8:00 am to 12:00 pm.
- We are closed for lunch daily from 12:30 pm to 1:00 pm.
- If you need medical care after our office hours, we do have an on-call service. We provide 24-hour on-call service. After hours answering service phone: (585) 258-4831.
- The practice phone line is on Monday through Friday 8:30 am to 4:30 pm. The practice is closed for lunch 12:00 to 1:30 pm. We have available appointment scheduling from 7:30 am to 8:30 am Monday through Friday. Please note this hour time is for scheduling appointments only and ask that you call after 8:30 am for all other calls. **In case of an emergency, please call 911 or go to the nearest hospital emergency room.**

APPOINTMENTS AND POLICIES:

- We request that you give us at least 24-hour notice if you are unable to keep a scheduled appointment. This will give us ample time to schedule someone else who may have an urgent need for care. We ask that you make every effort to keep your appointments with our practice. Missing an appointment disrupts proper sequencing of care and delays completion in your treatment. If you need to reschedule or cancel your appointment, again, please call us at least 24 hours prior to your visit.
- Patients that arrive more than 15 minutes late for an appointment may be asked to reschedule.
- If you fail to keep or cancel your first new patient appointment, in advance, you will not be rescheduled. Additionally, if you fail to notify us in advance and do not show for 3 scheduled appointments, you will be dismissed from the practice. You may be charged a $50 fee for missed appointments.

FINANCIALS:

Insurance: If you have medical insurance, be sure to provide all requested information to assist us in the benefit verification process. Also we ask that you bring your insurance card with you the day of your first visit with us. If you currently have medical insurance that requires you to list a primary care physician (PCP) with your insurance, you will need to call your insurance and change your PCP to one of the providers you are choosing in our practice, before your first appointment with us.

Co-Pays: It is necessary for you to bring any co-payments you will owe, according to your insurance benefits, to your office visits. A $10 service charge may be added if your co-pay is not made the day of your visits.

Self-Pay Patients: If you do not have health insurance payment is expected at the time of your visit. We will give a 15% discount at the time of the visit.

Deductible and Coinsurance: Patient's with deductible insurance plans are required to make a pre-payment of $25 at the time of the visit. There is no discount for high deductible plans. Once your deductible is met, you are responsible for any coinsurance or copayments for your visits.

Payments: We accept cash, checks, money orders, and most major credit cards. There is a $25.00 insufficient (bounced check) fee if your check does not clear the bank, in addition to the amount of your check.

PRIOR MEDICL RECORDS: We request that you have any past medical records mailed to our office. Please **DO NOT** have your medical records faxed to our office as faxed records are often illegible. Attached is a medical records release form that **you are responsible for submitting to your previous doctor's office.**

MEDICATIONS: At your first new patient visit with our practice, we ask that you bring in your original bottles of all medications that you are taking including prescription and over the counter (OTC) medications and supplements.

WORKER'S COMPENSATION: We do not see/schedule worker's compensation injuries.

INSURANCE BILLING: Our office participates with a number of insurance plans. If you have a question concerning your insurance plan, please call our billing staff. If our office does not participate with your insurance you will be responsible for the full amount of our charge at the time of your visits.

We submit all insurance claims for you and bill the deductible, coinsurance and non-covered balance directly to you upon receipt of the explanation of benefits from your insurance. These balances are due immediately upon receipt of the statement from our office. A $10 service charge will be applied to your account if payment is not made within 30 days of statement and additional $10 services charges with each monthly statement thereafter.

PRESCRIPTION REFILLS: Monitor your medications carefully so that you do not run the risk of running out. Controlled prescriptions now require monitoring through NYS I-STOP program and we will need at least **48 hours** notification from you to the office for refill.

Mail-In Pharmacies: We can complete electronic requests for new or refill prescriptions to mail-order pharmacies, however, please be prepared to submit your request to your mail order company in a timely manner in order to avoid being without medications. Even if no refills are left on your mail order, please request a refill and the mail order company will contact our office to authorize the request.

Prescription Prior Authorization: Some prescriptions will require a prior authorization from your insurance. Most prior authorizations take 2 to 3 business days once we receive the request from your pharmacy.

We will respond to prescription requests and refills, however, please allow 48 hours for your request to be accommodated.

EMERGENCIES: At any time – If you feel you are having a ***"life-threatening"*** medical emergency, DO NOT CALL OUR OFFICE but instead – REPORT DIRECTLY TO THE CLOSEST EMERGENCY ROOM OR CALL 911 and contact our office within 24 hours after you have been treated.

After Hours: **CALL (585) 258-4831 – the answering service will contact the physician on call. You will receive further instructions from the on-call physician.** For a listing of Urgent Care facilities visit the Medical Society's website at www.MCMS.org and click on Resources.

PHYSICIAN CALL-BACKS: Non-urgent messages to speak directly with a physician will not be returned until after office hours.

LABORATORY & DIAGNOSITC TEST RESULTS: Some lab tests are available within 24 hours, HOWEVER, remember *your physician must review these tests* before clinical staff may release the results to you. Diagnostic tests can take longer, sometimes up to 7 days or more depending on the type of test or the laboratory performing the tests.

INSURANCE REFERRALS & PRIOR AUTHORIZATIONS:
Referrals: Referrals to specialty providers are available the following day of your visit in our office. If you call and request a referral to a specialist and are not seen by a provider in this office, then a message is given to your physician for approval and may take 48 hours for approval. Please try to call our office to allow enough time to get the referral to the specialist's office in a timely manner. Not all referrals to specialists require a referral from your insurance company.

Imaging Prior Authorizations: Most insurance companies now require prior authorization for "high-tech" imaging which includes MRI, MRA, PET CT scans, CT scans, nuclear medicine, and ECHO cardiograms. Prior authorizations are done daily, and could take up to a week for approval from your insurance company.

PRE-OPERATIVE CLEARANCE EXAMS: In the event your surgeon is requesting that you obtain pre-operative clearance from us, keep in mind that this request is NOT just a form to be completed. This request may require testing such as an EKG, blood work, as well as a complete exam. Please contact our office as soon as possible to allow enough time for you to be evaluated and to respond to your surgeon in a timely manner. Appointments that do not allow us to make a complete evaluation may result in your surgery having to be rescheduled.

FORMS: There will be a $10.00 charge to complete forms that are mailed to the office or dropped off at the office to be completed by the provider. There is no charge if the form is presented at the time of the office visit, (form examples: school health exam forms, camp forms, insurance form, etc).

HIPAA REGULATIONS: We follow HIPAA regulations as required by law (see attached HIPAA form for your review and signature). If you wish for us to release your protected health information to family members or friends, please complete the authorization form enclosed in order for us to do so. In addition, once an established patient turns age 18 he/she will need to fill out and sign new HIPAA forms.

COPYING OF MEDICAL RECORDS: If you are transferring out of our practice and request your medical record be forwarded to your new physician, there will be a fee for copying your medical record.

We very much appreciate your confidence in us and look forward to meeting you.

Sincerely,

Honeoye Valley Family Practice

Honeoye Valley Family Practice, LLP
23 Ontario Street, Honeoye Falls, NY 14472
PHONE: (585)624-2121 FAX: (585)624-7283

RESPONSIBLE PARTY INFORMATION

Today's Date_____ Requesting Physician_____

Name_____

Street Address_____

City_____ State_____ Zip Code_____

Telephone (___)_____ Cell (___)_____ Social Security _____

Date of Birth_____ Male ☐ Female ☐

*** Will you be coming a patient in our practice Yes ☐ No ☐

_____

Employer Address Telephone #

SPOUSE AND/OR DEPENDENTS
(Becoming a patient with our practice)

Patient Name	Date of Birth	Sex	Social Security #	Requesting Physician

HEALTH INSURANCE

Plan Name_____ Contract #_____

Subscriber Name_____ Date of Birth_____

PLEASE PRESENT YOUR INSURANCE CARD TO THE SECRETARY SO A COPY MAY BE MADE FOR YOUR FILE.

PERSON TO CONTACT OTHER THAN SPOUSE, IN CASE OF EMERGENCY

_____

Name Relationship Telephone #

Honeoye Valley Family Practice
23 Ontario Street
Honeoye Falls, NY 14472
Phone: (585) 624-2121
FAX: (585) 624-7283

OFFICE FINANCIAL POLICY

Our financial policy has been set up to prevent misunderstandings. We like to acknowledge patients who take a responsible approach to paying for their medical care.

1) Full payment is expected at the time of service unless other arrangements are made.

2) If an appointment is broken or cancelled within 24 hours, a charge of $50.00 may be applied to your account.

3) Returned checks are subject to a $10.00 service charge and will terminate your privilege to pay by check on future visits.

4) A past due fee of $10.00 will be added every month after receiving three (3) statements from our office for any unpaid balance.

5) It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, you will be fully responsible for all collection agency fees and attorney's fees.

Please sign below to indicate that you have read and fully understood said policy.

_____ _____

Patient Name (Print name) Date of Birth

_____ _____

Patient Signature Today's Date

_____

Signature of parent or guardian
(If patient is under the age of 18)

Patient Consent

I consent to the user of disclosure of my protected health information by **Honeoye Valley Family Practice**, ("the Practice"), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills and to conduct health care operations of the Practice.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Practice is not required to agree to the restrictions that I may request. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has taken action in reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, and health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Practice. The Notice of Privacy Practices also describes my rights and the Practice's duties with respect of my protected health information.

I understand that the Notice of Privacy Practices is posted in the waiting room. The Practice reserves the right to change the Notice of Privacy Practices. I understand that I may request a copy of the Notice of Privacy by asking the receptionist for one during my next appointment or during regular business hours.

In addition, once an established patient turns age 18 he/she will need to fill out and sign new HIPAA forms. This will include allowing the nurse's to access the NYSIIS immunization database.

_____ _____

Signature of Patient or Personal Representative Date of Birth

_____ _____

Print Name of Patient Social Security No.

_____

Date

Honeoye Valley Family Practice
23 Ontario Street
Honeoye Falls, NY 14472
Phone: (585) 624-2121
FAX: (585) 624-7283

INVOLVEMENT IN CARE DISCUSSION FORM

Patient Name:_____ Date of Birth:_____
(print)

Social Security #:_____

HVFP may discuss protected health information, including lab/test results and payment issues with the following people.

NAME	RELATIONSHIP	PHONE NUMBER

COMMUNICATION REQUESTS:

Y	N		
		Phone me using the following number.	(#) _____
☐	☐	May phone me at work	(#) _____
☐	☐	May leave messages on answering machine	(#) _____
☐	☐	Other: _____.	

This will remain in effect unless notified otherwise by the above patient.

Emergency Contact Person and phone #: _____

Signed: _____ Date: _____

***** This completed form is your responsibility to submit to your previous/current doctor's office *****
******* Do not have your medical records faxed to our office, mail only – Thank you *******

Honeoye Valley Family Practice
23 Ontario Street
Honeoye Falls, NY 14472
Phone: (585)624-2121

Authorization for Release of Medical and/or Behavioral Health Information

Please Print

Patient Name:_____ DOB:_____

Address:_____ Patient's Phone #: ( )_____

City/State/Zip:_____

This Authorization allows HVFP to: (check one or both)

☐ **SEND** copies of your record to (or discuss your information with) the provider/person/facility below

☐ **RECEIVE** copies of your record from (or discuss your information with) the provider/person/facility below

_____ _____
Name of Provider/Person/Facility Phone # (include area code)

_____ _____
Address Fax # (include area code)

_____
City, State, Zip Code

TYPE OF RECORDS or INFORMATION REQUESTED: Check all that apply:

The records requested are to include: ___ Mental Health Treatment Records ___ Alcohol/Drug Treatment Records
(Release/disclosure of HIV-related information requires additional authorization on form NYS DOH2556 or OCA 960)

☐ **Complete Medical Records—date(s):_____ and/or specific illness/injury:_____**

AUTHORIZATION VALID FOR: (If nothing is checked below, this authorization is valid for this request only).

☐ This request only
☐ One year from the date of this authorization **OR** _____ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization, except in very limited circumstances (e.g. non-emergent mental health or chemical dependency treatment).
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative _____ Date_____

Relationship to Patient *(if Representative)* _____

****** *PLEASE MAIL medical records only to: (FAXES ARE FREQUENTLY ILLEGIBLE)* ******
Honeoye Valley Family Practice, 23 Ontario Street, Honeoye Falls, NY 14472

Adult and Child Health History

Please Print Clearly or Type

Date: _____

Name: _____ Gender: Male Female

Date of Birth: _____ Birthplace: _____

Address: _____

Home Phone: _____ Work: _____ Cell: _____

Education: Highest level of school: Elementary High School College Other

Occupation: _____

How would your rate your overall health and well being? Excellent Good Fair Poor

What are your major health concerns? _____

_____

HEALTH FACTORS (Circle)

1. Do you use tobacco?..... Yes No
   _____ # of cigarettes per day
   _____ # pipes/cigars per day
   _____ # chewing tobacco cuds per day
   _____ # electric cigarettes

2. If you do not now use tobacco, have you every used tobacco?..... Yes No
   If yes, indicate quit date _____

3. Do you regularly eat: Breakfast _____ Lunch _____ Dinner _____ Snacks/Fluids_____

4. Do you consider yourself: correct weight _____ underweight _____ overweight _____

5. Do you drink caffeinated beverages? (i.e., coffee, tea, colas, other sodas) ..... Yes No

6. Are you on a special diet? ..... Yes No

   Explain: _____

7. Do you exercise? ..... Yes No

   How often? _____ What type of exercise? _____

8. Do you wear a seatbelt when you drive? Always ___ Usually ___ Occasionally ___ Never ____

HEALTH PROBLEMS

9. Have you ever had an allergic reaction or side effect to any medications ..... Yes No
If yes, list medication and explain reaction:_____

_____

Do you have an allergy to Latex: _____ Yes _____ No

10. Have you ever had any other allergic reactions (environmental, foods, etc. severe poison ivy, special foods, injections) Yes No
Indicate allergy and explain reaction:_____

_____

11. Please list all hospitalizations: (medical and surgical, biopsies, fractures, obstetric/gynecological, and psychiatric)

Nature of Problem	**Date**	**City & State**	**Hospital**

12. Please check "previous" if you have had the **condition or problem** in the past. Check "now" if you currently have any of the following.

	Previous	Now		Previous	Now
Glaucoma			Seasonal allergy/Hay fever		
Thyroid problems			Alcoholism		
Increased cholesterol			Bleeding tendency		
Diabetes			Polio		
Lung problems			Rheumatic Fever		
Abnormal chest x-ray			Scarlet Fever		
Abnormal cardiogram (EKG)			Sinus or ear infections		
Heart murmur			Tuberculosis		
High blood pressure			Pneumonia or bronchitis		
Heart problems			Syphilis		
Stroke			Gonorrhea		
Bowel problems			Other sexually transmitted disease		
Hepatitis or liver problems			Depression or anxiety		
Ulcer			Drug addiction		
Gall bladder disease			Mental health problems		
Headaches			Work related disabilities		
Back pain			Cancer		
Gout			HIV infection		
Epilepsy (seizures)			Blood transfusion		

13. Please check the **symptoms** which you have had during the past year and symptoms which are of concern to you now.

	Past Year	Concern Now		Past Year	Concern Now
Skin lumps, rashes, or sores			Frequent or severe headaches		
Mole changing in color or size			Loss of consciousness		
Eye/Visual problems			Loss of balance/falls		
Dental or denture problems			Speech difficulties		
Hoarseness			Shortness of breath		
Excessive thirst or appetite			Chest pain		
Coughing up/vomiting blood			Swollen ankles		
Wheezing			Weight gain or loss		
Chronic cough			Difficulty sleeping		
Irregular heartbeat			Excessive tiredness		
Heartburn			Loss of appetite		
Difficulty swallowing			Unusual bleeding or bruising		
Leg pain with exertion/or at rest			Feeling tension or unhappiness		
Nausea or vomiting			Difficulty concentrating		
Diarrhea or constipation			Problems with sexual function		
Black or bloody stools			Problems with infertility		
Hemorrhoids			**For Men:** Sores or discharge from penis		
Changes in bowel habits			Pain or swollen testicles		
Difficulty urinating			**For Women:** Unexpected vaginal bleeding		
Cloudy or bloody urine			Vaginal discharge		
Joint or muscle pain			Hot flashes		
Dizziness			Pain or lump in breast		
Weakness or paralysis			Discharge from nipples		
Tingling or numbness			Difficulty with menstrual periods		

MEDICATIONS

14. Please list the names of all medications that you now take including prescription medications, over the counter medications, vitamins and supplements. **Include name of medication, dosage, dispensed as written** (example: Amoxicillin, 250mg, 1 pill 3 times/day, orally):

_____

_____

_____

_____

_____

Please indicate your pharmacy we should have on file:

Pharmacy Name: _____
Address: _____
Phone: _____
Fax: _____

FAMILY HISTORY

15. Check and indicate which family member(s) has or had the following heath problems: (mother = M, father = F, brother = B, sister = S, aunt = A, uncle = U, grandparent = G, maternal grandparent = MGM/MGF, paternal grandparent = PGM/PGF)

___ Bleeding tendency	___ Diabetes	___ Emphysema	___ Mental illness
___ Birth defects	___ Heart disease	___ Hypertension	___ Kidney disease
___ Stroke	___ Glaucoma	___ Tuberculosis	___ Alzheimer's
___ Miscarriage	___ Cancer	___ DES (mother)	___ Alcohol or drug
___ Cholesterol	___ Thyroid		

Other Family Health Problems: (Please list)

_____

_____

_____

_____

_____

16. Please list family members (parent(s), brother(s), sister(s), spouse, children) and their current health:

Name	**Relationship**	**If alive, indicate health: good -- poor**	**If deceased, indicate age & cause of death**

17. Do you live with others? (please describe with whom)..... Yes No

OTHER HEALTH PROVIDERS

18. Please list other health care providers seen within the last 3-5 years:

Physician, Dentist, Therapist, name & phone #	**Specialty**	**Date of last visit**

19. Please attach a copy of your immunization history.

20. Please have a copy of your medical records from your previous doctor's office mailed to our office. We ask that you **do not** have your records faxed to our office as sometimes the records are illegible when faxed.