TRANSVALLEY FAMILY HEALTH, PLLC

Name _____ Date of birth ____/____/____

Address_____

Home phone (____)_____-_____ Mobile phone (____)_____-_____

Work phone (____)_____-_____ Email: _____

Emergency contact _____ Relationship _____

Phone (____)_____-_____

HIPAA (Health Insurance Portability and Accountability Act of 1996) Permission for Medical Information Release

It is our office policy that we will not release confidential and/or unauthorized information by home/ work/cell phone, voicemail or answering machine unless instructed by you to do so. When we call to speak with you, we will only leave a message if the name and telephone number is provided on the recorded message to identify the residence and you have authorized us to leave a message. We will not leave information with any unauthorized person who may answer the telephone.
By signing below, I give this medical office and its staff permission to leave medical information pertaining to my care in the manner(s) set forth below. I assume responsibility to notify this office of any changes in this information and shall not hold the office liable for failure to do so.

	YES	NO
May we **e-mail** you your appointment reminder?	____	____
May we send you a **text** message for appointment reminder	____	____
May we leave a message with a household member?	____	____
May we give medical information to a household member?	____	____

Name of person(s) authorized to receive your medical information	Relationship
_____	_____
_____	_____

I **authorize** the staff of TransValley Family Health, PLLC, to leave appointment changes, appointment reminders or any other protected health information on an answering machine at the following number:

_____ (VOID if blank).

_____ _____
Patient or Parent/Guardian/Representative's name Relationship to patient

_____ _____
Signature of Patient or Parent/Guardian/Representative Date

Office Policy

Welcome! Thank you for allowing us to assist you in your journey of health & healing. Please review our policy carefully, so that we may serve you better. If you have any questions, feel free to discuss it when you come in for your appointment or call our office (484-350-5141).

New Patients

If you have not already completed registration package for new patient, please arrive at least 20 minutes early to allow for traffic conditions, complete your registration and not extend into your evaluation and treatment time. Henceforth, early arrival is encouraged. To avoid any possible delays, you may pick up the package beforehand, download it from our website, or request a fax copy.

Appointment

As a courtesy to our patients, we attempt to confirm appointments at least the day before. However, it is your responsibility to keep the appointment even if we have not been able to contact you. Please allow at minimum 40-60 minutes for new patient visits and at least 30-40 minutes for follow-up appointments. Although we strive to keep our patients' waiting time to a minimal, we may occasionally need to spend additional time with a patient before you to complete his/her treatment. Your understanding and patience is greatly appreciated.

Clothing

In order to provide more effective treatment, we recommend loose fitting clothing - no jeans or tight pants that can't easily be pulled up above the knees (alternatively, you may bring shorts/sweat pants and t-shirts to change into at the office). Belts and shoes will need to be removed before treatment.

Medical records

If available, please obtain copies of laboratory and imaging **reports** (x-rays, CT scans, MRI's, etc) pertaining to your current medical problem from your previous physician and bring to your first visit.

Silence

Please turn your cell phone or electronic devices on vibrate before entering the treatment room. Please refrain from talking and other physical activities as they may interfere with your treatment.

Primary care physician

Please be aware that although Dr. Nguyen is also a board certified family physician, visits through this office will be limited to management of a specific medical problem through the use of osteopathic manipulation and/or medical acupuncture. All patients should have their own regular primary care physician for overall management of all their medical needs.

Family Physician _____ Phone (____)_____-_____

Address _____

Late Arrivals
TransValley Family Health makes every effort to keep to its appointment schedule. If you are late for your appointment, it may affect your treatment time or we may have to reschedule your appointment.

Cancellation
If you cannot keep your appointment, please notify us as soon as possible, so another patient needing medical attention can be seen earlier or we can use this slot to schedule another appointment. We require at least 24 hour notice (or before 12 pm on Friday for Monday appointment). Failure to cancel or reschedule within this time frame will result in a $50 "no-show" fee. However, the fee is reduced to $25 if the appointment is filled by another patient. Please call as soon as possible if you cannot keep your appointment time.

Payment
We do **not** participate with insurance companies at TransValley Family Health, PLLC. Payment is due in full upon service rendered. We accept cash, check, debit or credit card (Visa/Master/Discover). A fee of $35 will also be charged for each returned check, or delinquent credit card transaction. A medical bill will be provided to you for submission to your insurance for reimbursement. It is your responsibility to first check with your health insurance company to verify coverage for "out-of-network" acupuncture and osteopathic manipulative treatment services.

I have read and understand the above information.

_____ _____
Signature of Patient or Parent/Guardian/Representative Date

Insurance coverage

Primary Insurance company _____

Guarantor's name_____

ID # _____ Group # _____

Billing address _____

Phone (_____)_____-_____

Secondary Insurance company _____

Guarantor's name_____

ID # _____ Group # _____

Billing address _____

Phone (_____)_____-_____

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **TransValley Family Health, PLLC** to use and/or disclose certain protected health information (PHI) about me to Medicare or other insurance companies.

This authorization permits **TransValley Family Health, PLLC** to use and/or disclose the following individually identifiable health information about me: medical history and exam findings, dates of service, type of services, diagnosis of condition

The information will be used or disclosed for the following purpose: submitting claims in order to collect reimbursement for costs of services. Payment may be sent to TransValley Family Health, PLLC or to patient, depending on previously agreed arrangement.

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

The Practice may receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **TransValley Family Health, PLLC**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

TransValley Family Health, PLLC
600A West Broad Street. Quakertown, PA 18951
or
205 Telford Pike. Telford, PA 18969

_____ _____

Signature of Patient or Parent/Guardian/Representative Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Signature of Patient or Parent/Guardian/Representative Date

Financial Responsibility Notice

I understand and agree that, regardless of my insurance status, I am ***primarily responsible*** for the payment of any and all professional services rendered. I understand that the ***TransValley Family Health, PLLC does NOT participate with any insurance plans.*** Depending on your insurance plan ***TransValley Family Health, PLLC*** may submit the initial claim to your insurance company, but ***I am responsible for any follow-up contact regarding claims with my insurance company myself***. I understand that any decisions regarding reimbursement are solely based on the parameters of my insurance plan.

I understand that I am also responsible for missed-appointment and returned check fees. Nonpayment of any outstanding balance may result in my inability to schedule new appointment or receiving future services, unless otherwise negotiated.

I authorize the physician to release any necessary information acquired during the course of my examination or treatment to Medicare or other insurance companies for the purpose of acquiring payment for services rendered.

For medicare patients: Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. You are responsible for payment for the office visit and any osteopathic manipulation and acupuncture services rendered at time of service. I will bill Medicare for you. Medicare will only reimburse you if they agree that these services were reasonable and necessary. In my opinion, I am delivering these services in good faith that they are reasonable and necessary, but I cannot guarantee that Medicare will agree.

_____

Patient's Name

_____ _____

Guardian/Parent/Representative's name Relationship to patient

_____ _____

Signature of Patient or Parent/Guardian/Representative Date