

New Patient Intake



Jeffrey B. Taylor, D.O.

Kaylee Roberts, FNP-BC o Chaney Young, FNP-C o Carson Scheidler, FNP-C

Demographic Information

Name: _____ Date of Birth: ____/____/____

Social Security # ____-____-____ Sex: Male Female Other (Please Specify): _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Marital Status: Single Married Divorced Widowed

Street Address: _____

Street Address Line 2: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____)____-____ Home Phone: (____)____-____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Mobile Phone Number: (____)____-____ Email: _____

Preferred Pharmacy

Name: _____ Phone #: (____)____-____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance

Policyholder Name: _____ Date of Birth: ____/____/____

Relationship to Policyholder (Circle One): SELF SPOUSE CHILD OTHER: _____

Insurance: _____ Policyholder Social Security # ____-____-____

Policy #: _____ Group #: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance

Insurance: _____ Policyholder Social Security # _____ - _____ - _____

Policy #: _____ Group #: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Financial Responsibility Agreement

Please be aware that we collect your estimated insurance portions at each visit. Your insurance policy is a contract between you and your insurance company. You are responsible for any unpaid balances and services rendered, regardless of the original estimate of insurance benefit. You are responsible to know the benefits of your specific insurance policy. As a courtesy to you, we will file your claims with your insurance company. Insurance payments are normally received within 30 to 45 days. Any unpaid balances after 60 days are your responsibility and are due at that time. All deductibles and copayments are due at the time of service. A completed claim form or copy of your insurance card will need to be kept on file in our office. We try to answer any questions you may have about your insurance company, however, you may need to contact your insurance company for additional information. If your insurance changes, it is your responsibility to provide updated information to our office. If your insurance requires assignment of Primary Care Provider, it is your responsibility to have this information updated with your insurance company.

Please note that coverage for every insurance policy is different. Laboratory or diagnostic testing ordered during visits may not be covered by your insurance. In the event the patient receives a bill for these services, it is the responsibility of the patient and not the responsibility of Our Family Doctor.

Assignment of Benefit: Please read and sign to have our office file your insurance: I authorize the release of information and understand that I am responsible for all costs of medical treatment and services rendered. I hereby authorize payment directly to Our Family Doctor of the insurance benefits otherwise payable to me.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____

New Patient History

Name: _____ Date of Birth: ____/____/____

Primary Reason for Today's Visit: _____

Previous Primary Care Practice or Provider: _____

Other Providers / Specialists

Specialty (ie. Cardiologist or Heart Doctor)	Provider's Name (ie. Dr. Missy Meadows)

Allergies

Medication	Reaction

Medications

Medication (ie. Metformin)	Dose (ie. 500 mg)	Frequency (ie . twice daily)

Health Maintenance

Type of Screening	Location/Provider	Date
Colon Cancer Screening: Colonoscopy / Cologuard / FIT (circle one)		
Osteoporosis Screening (Bone Density Study)		
Breast Cancer Screening (Mammogram)		

Cervical Cancer Screening (Pap Smear)		
Eye Exam	Were your eyes dilated? Yes / No (circle one)	
Lung Cancer Screening (Low-Dose Chest CT Scan)		

Medical History - Have you ever been diagnosed with any medical problems? Examples can include, high blood pressure, high cholesterol, diabetes, COPD, etc..

Medical Problem	Comments

Surgical History

Surgery	Date

General Consent for Care and Treatment

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____

HIPAA Compliance Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.

- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

By signing this form, you consent to phone, email, or text to confirm appointments and allow the office to leave messages on your answering machine at home or on your cell phone.

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____

Medication Refill Policy

Our Family Doctor participates with electronic prescribing directly to your mail order and local pharmacies. Our goal is to assist our patients with prescription requests in an efficient and timely manner. Due to the volume of prescription requests, we have created the following guidelines to help meet these goals.

1. It is the patient’s responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three (3) business days, so do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
2. Medication refills will only be addressed during regular office hours, Monday – Friday (Please remember we close at noon on Thursdays). Notify our office on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturdays, Sundays, or observed holidays.
3. Prescription refills require close monitoring by your providers to ensure its safety and effectiveness. Your providers will prescribe the appropriate number of prescription refills to last until your next scheduled appointment. Generally, when you are down to zero refills, it is time to schedule a follow up appointment. We prefer you request any refills of your medications at the beginning of your office visit.
4. Patients requesting new prescriptions or medications for an acute issue (ie. antibiotics) must be seen for an appointment. The appointment can be via telehealth or in-office. They are not prescribed over the phone because it generally requires an office visit.
5. Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers, unless approved during a visit.
6. Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your providers. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
7. It is important to keep your scheduled appointments to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills.
8. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately.
9. We reserve the right to charge an administrative fee for if there are multiple requests for prescriptions requested outside of a visit.

Controlled Medications

At some point in your treatment, you may be prescribed a controlled medication by Dr. Jeffrey Taylor or his designee(s).

Per the DEA, a controlled substance is, "narcotics, depressants, and stimulants manufactured for legitimate medical use (that) are subject to abuse and have, therefore, been brought under legal control" and "all health professionals licensed to dispense, administer, or prescribe them."

Depending on the risk level of the drug, the DEA assigns each drug a "Schedule." The Schedule of the medication ranges from I to V with I being the most dangerous and V being the least dangerous. Depending on the patient's case and the schedule of the medication, patients are required to be seen at least quarterly, but may be required to come in monthly. Urine Drug Screens are obtained quarterly. Failure to maintain an up to date Urine Drug Screen and Face to Face Visit at the required interval will result in the denial of refills.

Please note the providers at Our Family Doctor utilize the Prescription Drug Monitoring Program website to obtain information on controlled prescription medication history.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____

Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. *It is required that you must cancel your appointment more than 24 hours prior to your appointment time.* This will enable another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other patients.

Patients who do not arrive for their appointment without notification 24 hours prior are considered a No Show. Patients who arrive 30 minutes late to scheduled appointments without prior notice are considered a No Show and will be accommodated depending on availability. Any patients qualifying for a No Show will be assessed a \$25.00 No Show Fee. Outstanding No Show Fees must be paid prior to the scheduling of further appointments. Patients who No-Show three (3) or more times may be dismissed from the practice.

The Cancellation and No Show fees are the sole responsibility of the patient, not their insurance company, and must be paid in full prior to scheduling further appointments.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our Family Doctor believes that a good physician/patient relationship is based upon understanding and good communication.

Thank you for your understanding.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____

Telehealth Policy

At Our Family Doctor, we strive to provide high quality and compassionate healthcare while remaining compliant with insurance guidelines. As of February 1, 2024, we are utilizing Google Meet, a HIPAA compliant platform, to meet with patients for telehealth appointments utilizing audio and video.

Google Meet requires a device with either cellular data or WiFi, a camera, and a microphone. If on a mobile device, the patient must have access to their text messages or email inbox and have the Google Meet application downloaded. If on a desktop or laptop computer, the patient must have access to a camera and microphone. (Note: Most desktop computers do not have these.)

The providers and staff at Our Family Doctor will make every effort to help patients set up Google Meet on their device prior to the appointment, but it is ultimately the responsibility of the patient and their family. If at the time of the appointment the provider is unable to secure connection with the patient through Google Meet, the patient may forfeit their appointment and arrangements will have to be made to continue the visit. Patients who are unable to use Google Meet for whatever reason will only be able to utilize in-person visits.

Not all insurance policies include telehealth coverage. Our scheduling staff will make every effort to be sure patients without telehealth coverage will be scheduled in person only, but it is ultimately the responsibility of the patient to be aware of their coverage. In the event that insurance will not cover a telehealth appointment, the patient will be responsible for the unpaid portion of their visit.

Please note that the same standard of care offered during an in-office visit will apply to all telehealth visits.

If the patient or the provider feels that care would better be handled in the office setting, either party may discontinue the future use of telehealth. Telehealth can be incredibly useful, convenient, and improve access to care. We hope you enjoy this option we provide despite some of the requirements it comes along with.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____

FollowMyHealth Enrollment

FollowMyHealth is Our Family Doctor's online portal. FollowMyHealth is an online, innovative tool that provides access to your personal health records, and enables you to take a proactive role in managing your care. After the visit, you will be emailed an invitation to sign up. The pin to activate the account will be the last 4 digits of your Social Security Number.

With FollowMyHealth, you can:

- Review Medical Records
- Communicate Privately with Providers
- View Test Results
- Update your Health Information
- Request Prescription Refills
- Schedule or change appointments

Name: _____ Date of Birth: ____/____/____

Last 4 Digits of SSN: _____ Email Address: _____

For Staff Use Only:

Date Invitation Sent: _____ Staff Signature: _____

Established Patient Intake



Jeffrey B. Taylor, D.O.

Kaylee Roberts, FNP-BC ◦ Chaney Young, FNP-C ◦ Carson Scheidler, FNP-C

Demographic Information

Name: _____ Date of Birth: ____/____/____

Social Security # ____-____-____ Sex: Male Female Other (Please Specify): _____

Preferred Language: _____ Race: _____ Ethnicity: _____

Marital Status: Single Married Divorced Widowed

Street Address: _____

Street Address Line 2: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____)____-____ Home Phone: (____)____-____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Mobile Phone Number: (____)____-____ Email: _____

Preferred Pharmacy

Name: _____ Phone #: (____)____-____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information

Primary Insurance

Policyholder Name: _____ Date of Birth: ____/____/____

Relationship to Policyholder (Circle One): SELF SPOUSE CHILD OTHER: _____

Insurance: _____ Policyholder Social Security # ____ - ____ - ____

Policy #: _____ Group #: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance

Insurance: _____ Policyholder Social Security # ____ - ____ - ____

Policy #: _____ Group #: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Policy Acknowledgements

I certify that I have read and fully understand the Financial Agreement, General Consent for Care and Treatment, HIPAA Consent, Medication Refill Policy, Cancellation and No Show Policy, and the Telehealth Policy. I consent fully and voluntarily to each policy.

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____

HIPAA Consent Update

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

Signature of Patient or Authorized Representative: _____ Date: _____

Printed Name of Patient or Authorized Representative: _____

Consents



Jeffrey B. Taylor, D.O.

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