EMMAUS
Health LLC

PATIENT INFORMATION

Last Name_____First Name _____M.I. ___Maiden or Nickname _____
Street Address _____Apt. _____P.O. _____City _____
State _____Zip _____DOB _____Last Four Digits of SS# _____Preferred Language _____
Pharmacy Name/Phone: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Partner ☐ Other
Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Native American ☐ Pacific Islands ☐ Other _____
Sex: ☐ Female ☐ Male ☐ Intersex ☐ MtF Female ☐ FtM Male

INSURANCE INFORMATION- Primary / Secondary / Other Do you have health insurance? ☐ YES ☐ NO

Primary Insurance _____Copy of card? ☐ YES ☐ NO
Subscriber _____DOB _____Relationship _____
Secondary Insurance _____Copy of card? ☐ YES ☐ NO
Subscriber _____DOB _____Relationship _____

☐ **SPOUSE'S OR** ☐ **PARENT'S INFORMATION**

Name _____DOB _____ Last Four Digits of SS# _____
Employer _____ Employer's Phone # _____
Employer's Address _____

EMERGENCY INFORMATION- MUST BE COMPLETED (e.g. nearest relative preferably not living with you.)
In case of an emergency / urgent matter we may contact: _____
Phone # _____Relationship to Patient _____

Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to the Emmaus Health LLC, its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Emmaus Health LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Emmaus Health LLC, its successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I understand and acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

_____

Signature of Patient or Parent of Minor **Date**

Notice of Privacy: ☐ Received ☐ Refused _____

Signature of Patient or Parent of Minor **Date**

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign. both Authorizations.

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Emmaus Health LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

_____

Patient's Signature **Date**

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Kelly A. Pfeiffer, APRN

CONFIDENTIAL COMMUNICATION REQUEST

Practice Name/Address: Emmaus Health LLC 945 Main Street Suite 205, Manchester, CT 06040
Phone/Fax: (860) 553-3020 / (860) 553-3232

As required by the Health Insurance Portability and Accountability Act (HIPAA) as amended, you have a right to request communications concerning your personal health information, including appointment reminders, and other health-care related information, be made through confidential channels. This medical practice will not ask you why you are making your request and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided. This medical practice will respond to your written request to make changes within 14 days after receiving a new request. Please complete entire form and forward to Privacy Officer at address listed above.

I, _____ hereby request use of confidential channels for communication of
(print name)
information related to personal health, treatment or payment for treatment of _____
(print patient name)

Patient: Date of Birth: _____ Social Security # (last 4 digits): _____

Preferred Method of Contact

Home Phone Number _____
☐ Do NOT leave message ☐ May leave message

Cell Phone Number _____
☐ Do NOT leave message ☐ May leave message ☐ May use for text and voice reminders

Email Address (When Available) _____
☐ May use for appointment reminders and Practice Portal

I understand that it is my responsibility to notify the office of any changes to the above listed choices.
Patient Signature: _____ **Date:** _____

If this form was not completed by the patient, please sign below and state relationship to patient.
Signature: _____ **Date:** _____
Relationship to Patient: ☐ Parent ☐ Legal guardian ☐ Conservator ☐ Personal representative

Effective February 1, 2020

EMMAUS
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Patient Expectations and Payment Policy

We believe the best healthcare outcomes are based on mutual trust between patient and provider.

We believe patients and families are partners in ensuring that the best possible care is provided in a healthful, safe environment. We count on you to participate in your care in the following ways:

- To the best of your knowledge, provide accurate and complete information about your present symptoms, past illnesses, allergies, hospitalizations, medications and other matters relating to your health.
- Ask questions if you do not clearly understand the proposed plan of care and what is expected of you.
- Sign up for the patient portal through Practice Fusion in order to receive appointment reminders and be able to electronically communicate with your provider and verify current medications.
- Arrive at least 10 minutes before your appointment to ensure you are seen on time.
- Keep appointments. When you are unable to do so for any reason, notify the office reception staff in advance. A **$40** fee may be applied for any visit missed without proper notice (24 hours). Excessive missed appointments may result in discharge from the practice. Medicaid patients will not be charged a fee, but 3 missed appointments in a 6 month period will result in discharge.
- Be honest with your provider.
- Follow the treatment plan agreed upon.
- Provide accurate insurance information and promptly pay balances not covered by your insurance.
- Understand the requirements of your own health insurance. (We will do our best to assist you as we are able however, it is virtually impossible for us to keep all of the different health plans.)
- Pay your co-payment at the time of your appointment.
- Understand how your pharmacy plan works.
- Maintain an active Primary Care Provider for chronic and acute health needs not provided by Emmaus Health LLC.
- If you have a life-threatening situation, call 911 or go to the nearest emergency room.

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Emmaus Health LLC Will

- Fill or refill prescriptions within twenty-four (24) hours. Refills may take longer if they are called in afterhours or on weekends.
- Process any requested forms you may need for physicals, disability, FMLA, etc. within 7 days. A form completion fee of **$25** will be applied.
- Do our best to find you a suitable appointment date and time.
- Provide prompt and accurate billing.
- Keep all your records and communications concerning care and treatment confidential.
- Handle routine medical questions during normal business hours. Every effort will be made to return your call in a timely manner, however, you may need to be seen in our office to properly diagnose and treat a problem. We can only truly treat all medical problems in person.
- Nonpayment. If your account is past due, you will receive a letter stating that your account may be heading to collections. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail.

I have read and understand the patient expectations and payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

_____

Printed Name

EMMAUS
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Brief Health Screen

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your provider if you have any questions. Your answers on this form will remain confidential.

Patient Name:_____

Date of Birth:_____

Date:_____

Alcohol: One Drink =  12 oz. Beer  5 oz. Wine  1.5 oz. Liquor (One Shot)

		None	1 or More
Men:	How many times in the past year have you had 5 or more drinks in a day?	◯	◯
Women:	How many times in the past year have you had 4 or more drinks in a day?	◯	◯

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or More
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	◯	◯

Mood:	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	◯	◯
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	◯	◯