Medical Associates of Drexel Hill, Inc.

Nephrology • Hypertension

MARIA V. LARGOZA, M.D.

FAAHUD A. YAFAI, M.D.

HYE-RAN PARK, M.D

DEBBIE VALSAN, D.O.

Patient Name: _____

We would like to welcome you to our practice and provide you with useful information before your first visit. The following points should be kept in mind to avoid delays or the need to reschedule. Please read these points thoroughly, sign below, and bring this form to your appointment.

- Please try to arrive on time. We do our best to stay on schedule and by arriving on time You will help us stay on time. Your first appointment allows 30 minutes to complete the registration process. If you are 20 minutes or more late for your first appointment or a future follow-up appointment, you will be rescheduled.
- Please bring all of the medications you are currently taking, not just a list; your actual Medication bottles.
- Have all paperwork sent to you **THOROUGHLY COMPLETED** prior to your appointment.
- Bring your insurance card(s) and driver's license or picture ID. If you do not have your Insurance card the day of the visit, you will be required to pay for the visit that day.
- If you are not the primary subscriber for your insurance, we will need to know the Name, Address, Date of Birth and Social Security Number of that person in order to bill the insurance. If you do not know that information we cannot bill your insurance and you will be required to pay for the visit that day.
- If your insurance company requires a referral, it is your responsibility to get one from your Primary Care Physician. If this referral is not in our office at the time of your visit, you will need to reschedule your visit or agree to pay for the visit that day.
- Co-pays are due at the time of service. It is your responsibility to bring with you the entire amount of your co-pay, we accept cash and credit card including Mastercard and Visa. WE DO NOT ACCEPT CHECKS.
- Bring copies of relevant labs and x-ray reports, or have your physician fax or mail them to us. We suggest calling a day or two ahead to see if we have them in our office.
- **All cancellations or reschedules require a 24-hour notice. Failure to give a 24-hour notice will result in a fee.**

By signing below, you acknowledge that you have read and agree to the above policies.

_____ _____

Patient Signature Date

Main Line Health Center Newtown Square
3855 West Chester Pike, Suite 250
Newtown, PA 19073

Phone: (610) 789-6320

Healthplex Pavilion 2
100 W. Sproul Road, Suite 224
Springfield, PA 19064

Fax: (610) 789-6325

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Record Release

Protected Health Information

TO WHOM IT MAY CONCERN:

I am requesting copies of my records from Dr. _____. Please forward them to:

_____

_____

_____

I _____ authorize Dr. _____ to release copies of my records to my care and I will be responsible to forward them to whom I wish.

Any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____.

_____ _____

Signature of Patient or Guardian **Date**

_____

Witness

Since records for Mental Health, Drug & Alcohol, and HIV/Aids are not covered under a general authorization, these records have been specifically requested as indicated by the patient or Guardian's signature below.

This release is valid for 6 months from the signature date, unless a revocation of consent is signed.

_____

Signature of Patient or Guardian

_____

Witness

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Notice of Privacy Practices

Patient Name:_____

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain circumstances:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or to the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.
9. For treatment purposes including sharing medical data with another provider, making referrals, placing lab or prescription orders.
10. For payment purposes, for filing claims either by paper or electronically.
11. For Health care operations, for quality assurance, utilization reviews, credentialing, underwriting and auditing.

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Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure for your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when information is necessary to treat you.
3. You have the right to obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. The practice has 30 days to respond to your request, and to charge an administrative fee of at least $25.00 for this copy.
4. You must submit your request in writing to Medical Associates of Drexel Hill, with the name of your treating physician to the practices Privacy Official, Patricia Hoffman, or to her designee who can be reached at (610) 789-6320 if you need further information.
5. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as it is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the practices Privacy Official, Patricia Hoffman, who can be reached at (610) 789-6320 if you need further information.
6. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the practices Privacy Official, or Patricia Hoffman or her designee at (610) 789-6320.
7. Right to file a complaint with our practices Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the practices Privacy Official, Patricia Hoffman who can be reached at (610) 789-6320. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have read this copy of Medical Associates of Drexel Hill Inc, Notice of Privacy Practices.

Signature: _____ **Date:** _____

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Patient Portal Agreement – Medical Associates of Drexel Hill

In the event of an emergency, dial 911.
Do not use the Patient Portal.

What is the Patient Portal?
The patient portal is a web-based system that allows for secure communications and transfer of information between the physicians and the patient.

Purpose of the Authorization
Medical Associates of Drexel Hill offers a patient portal that provides secure electronic access to your medical health information and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks, we have imposed some terms and conditions of participation. Your acceptance on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works
A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be ready by someone who knows the right username and password to log in to the patient portal site. Our patient portal provides a secure method of messaging to ensure your privacy is in compliance with Federal and State regulations.

After logging in to the patient portal you can
- Use the messaging function to communicate with the office staff
- View results of lab and other diagnostic tests
- Request an appointment
- Request a medication refill
- View health summary information
- Print or save an electronic copy of a Clinical Summary

Protecting Your Private Health Information and Risks
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and the only correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes.

Protect your patient portal username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information.

If you believe someone has learned your password, you should immediately go to the website and reset it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the patient portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential.

Patient Portal Eligibility

Current patients who are at least 18 years of age are eligible to access the patient portal. A username and password is required for each patient.

Participation in the patient portal is entirely voluntary and you are not required to use the patient portal to receive care from Medical Associates of Drexel Hill The patient portal provides access to different parts of your medical record, but not the complete medical record.

Conditions of Participating in the Patient Portal

Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service, we will notify you as promptly as we reasonably can. You agree to not hold Medical Associates of Drexel Hill or any of its staff or physicians or extenders liable for network or security infractions beyond their control. You must be at least 18 years of age to access the patient portal. You must also be an active patient of Medical Associates of Drexel Hill.

Medical Associates of Drexel Hill reserves the right to change the patient portal from time to time. Medical Associates of Drexel Hill may also suspend or terminate the patient portal at any time.

By accepting this agreement, you acknowledge that you understand the policies and procedures, agree to comply with them and all of your questions have been answered to your satisfaction.

Please choose participating status in accessing the Portal Mark and X in one of the choices below:

_____ I agree to access the Patient Portal and agree to abide by the information as cited above.

_____ I do not want to have access to the Patient Portal

Please provide us with your email, sign and date the form.

Email: _____

_____ _____

Signature Date:

Please print your name: _____

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DEBBIE VALSAN, D.O.

PATIENT'S NAME: _____

Thank you for choosing Medical Associates of Drexel Hill as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

- **All patients must complete our information and insurance forms before seeing the doctor.**
- **FULL PAYMENT OF PATIENT RESPONSIBILITY IS DUE AT TIME OF SERVICE.**
- **We accept cash, checks, or money orders.**
- **Insurance cards must be presented at initial visit, or patient will need to reschedule.**
- **Any necessary referrals must be present at time of service or patient will need to reschedule.**
- **All co-pays, deductibles, and payment of non-covered services are due prior to treatment.**

Regarding Insurance:

Non-Participating
Payment for services is due at the time the services are rendered unless payment arrangements have been approved by our staff. We will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form must accompany any such request at each visit. In special instances, we may accept assignment of insurance benefits. Regardless of any prior arrangements, you are responsible for any out of pocket deductible or co-insurance and these amounts must be paid up front. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. ***If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you.***

Participating
Please be aware that some, and perhaps all, of the services provided may be non-covered services. It is our policy not to perform those services unless deemed medically necessary.

Usual and Customary Rates/Non Participating
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

- I acknowledge full responsibility for services rendered by Medical Associates of Drexel Hill.
- I understand that payment of charges incurred is due at time of service unless other financial arrangements have been made prior to treatment.
- I further authorize and request that payments be made directly to Medical Associates of Drexel Hill.
- If my insurance prohibits direct payment to a doctor, I hereby instruct and direct you to make out the check to me and mail it as follows: Medical Associates of Drexel Hill, 510 W. Darby Road, 2nd Floor Havertown, PA 19083.
- I acknowledge that if a referral is required by my insurance, I am responsible for securing that referral.
- I have read the Financial Policy, understand it, and agree to the terms of this Financial Policy.

Patients Signature: _____ **Date:** _____

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MEDICAL ASSOCIATES OF DREXEL HILL

Patient History

To provide you with the best possible care, please complete all sections below. This will give us a full medical and family history. All answers will remain CONFIDENTIAL.

Name: _____ Date: _____

Address: _____ Birthdate: _____

City/Zip: _____ Employer(s) _____

Phone: (H) _____ (W) _____ Referred By: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children: _____ Occupation: Current: _____ Prior: _____

Reason for Visit Today: _____

With whom if anyone, may we discuss your care? _____

Relationship: _____

MEDICAL HISTORY

Do you have any allergies to the following (yes or no) if yes please describe type of reaction (rash, hives, difficulty breathing, etc.)

Latex _____ Foods _____ Medication _____ Other: _____

List item allergic to and describe reaction _____

_____

_____

Please list all medications you are currently taking with dose and directions: (attach list here)

_____

_____

_____

_____

_____

_____

Have you been diagnosed with or had problems with any of the following?

Arthritis or Gout _____ Blood Diseases, clotting problems _____

Bladder or Prostate _____ Breast Lump/Cyst _____

Breathing/Lungs _____ Cancer _____ Type _____

Diabetes ____ Years _____ Eyes/Vision _____

Hearing _____ Heart Disease _____

High Blood Pressure ____ Years ____ Liver/Jaundice/Hepatitis _____

Kidney Diseases _____ Mental Illness _____

Seizures _____ Stomach or Bowel _____

Stroke _____ Thyroid _____

Tuberculosis _____ Venereal Diseases (VD) _____

Blood transfusions _____

SURGERY

Type: _____ Year: _____ Hospital: _____

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

Tobacco: Currently: _____ Stopped: _____ When? _____
Cigarettes: Packs/day _____ Number of years _____
Cigars: Number/day_____ Number of years_____
Pipe: _____
Caffeine: _____
Alcohol Type: _____ Amount: _____
Street Drugs:
Marijuana: _____ Cocaine, Crack: _____ Heroin: _____ Amphetamines, Speed: _____

FAMILY HISTORY

Family Member	Number	Living	Deceased	Age	Medical Problems
Mother					
Father					
Brothers					
Sisters					
Maternal Grandmother					
Grandfather					
Paternal Grandmother					
Grandfather					
Children					

REVIEW OF SYSTEMS

Do you now or have you ever had any of the following?
(CIRCLE ALL THAT APPLY)

Headache, blurred vision, fainting, seizures, etc.

Impaired vision, eye pain, diabetic eye disease, hearing loss, dizziness, trouble swallowing, etc.

Cough, shortness of breath, wheezing, etc.

Chest pain, rapid or irregular heart beat, swelling of the feet or legs, pain with walking (legs, chest), etc.

Nausea, vomiting, constipation, diarrhea, foods that upset you, weight loss, etc.

Pain with urination, blood in urine , difficulty starting, or stopping the urinary stream, foamy urine, urinary infections, stones, cysts, etc.

Arthritis, back pain, injuries, Rashes, skin ulcers, Anemia, bleeding disorders, etc.

For females:
Last menstrual period: _____
Number of pregnancies: _____ Number of living children: _____

Reviewed with Patient:

_____ _____ _____
Date **Patient Signature** **Physician Signature**

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Medical Associates of Drexel Hill. When you schedule an appointment with our practice we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective January 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$40.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee**.
- If a **third,** No Show or cancellation/reschedule with no 24-hour notice should occur you may be dismissed from the practice.
- Any new patient who fails to show for their initial visit will be contacted to reschedule if they do not keep the second appointment, we will send a letter to your primary physician or the physician who referred you to us.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office to discuss.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature Printed Name

_____ _____

Staff Witness Signature Date

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