

WELCOME



222Route 299 Highland, NY 12528
845-691-DOCS (3627)

Patient # _____

PATIENT INFORMATION Date _____

NAME _____

ADDRESS _____

Home Phone # _____

Work Phone # _____

Cell Phone # _____ BIRTHDATE _____

SEX: M F AGE _____

Patient SS# _____

Employer Name & Address _____

Email Address (for health newsletter & medical alerts) _____

In case of emergency contact:

Name _____

Address _____

Home _____ Cell _____

Work _____ Relationship _____

ARE WE ABLE TO RELEASE YOUR HEALTH INFORMATION TO THIS PERSON? YES NO, EMERGENIES ONLY

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Insurance Co. _____

Group # _____ ID# _____

Policy Holders Name _____

Date of Birth _____ SS# _____

Relationship to Patient _____

Is patient covered by additional Insurance? YES NO

SECONDARY INSURANCE INFORMATION

Insurance Co. _____

Group # _____ ID# _____

Policy Holders Name _____

Date of Birth _____ SS# _____

Relationship to Patient _____

Primary Care Physician _____

Address _____

Local Pharmacy _____

Address _____

How did you hear about us? _____

Please complete the reverse side of this form

Medical History

Patient Name: _____

Primary reason for your visit today _____

Check all symptoms that apply for today's visit

- | | | |
|---|---|--|
| <input type="checkbox"/> Aches/Pains | <input type="checkbox"/> Eye Irritation | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Fever | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Change in Moles | <input type="checkbox"/> Headache | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chills/Sweats | <input type="checkbox"/> Hives | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Sore that will not heal |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Itching | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Swelling of Extremities |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Loss/Gain Weight | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Earache/Discharge | <input type="checkbox"/> Nausea | |

MEN

- Erection Difficulty
 Lump in Testicles
 Penis Discharge
 Sore on Penis
- ### WOMEN
- Abnormal Pap
 Bleeding between periods
 Breast Lump
 Vaginal Discharge
Currently Pregnant? YES
Date of last Period _____
Date of last PAP _____
Date of last Mammogram _____

MEDICATIONS

List any medications you are currently taking _____

List any allergies to medications or substances that you have _____

HEALTH HABITS

Check which substances you use and how much you use them.

- Caffeine _____ Drugs _____ Tobacco _____
 Alcohol _____ Other _____

Check if your work exposes you to any of the following:

- Stress Heavy lifting Hazardous Substances
 Other _____

PAST MEDICAL HISTORY (Check all that apply)

- | | | | | | | |
|--|--|--|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Breast lump | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Cancer - Type _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| | <input type="checkbox"/> COPD | | | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever | |

Last Physical Exam _____ Past Surgeries _____

FAMILY HISTORY

Check illnesses which have occurred in any of your blood relatives (Parents, Grandparents and Siblings)

- Diabetes Cancer (type) _____ Bleeding tendency Kidney disease Tuberculosis Heart Disease Stroke
 High Blood Pressure Nervous Illness Allergy
 Other _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE _____ DATE _____



FirstCare Billing Policies and Procedures

Welcome to FirstCare and thank you for allowing us the opportunity to participate in your care.

We have streamlined our billing process to reduce expenses and allow us to deliver quality care to all, including those without insurance.

Insured Patients:

Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company, and it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and or/pre authorization, you are responsible for obtaining it. Failure to obtain the referral and or preauthorization may result in a lower payment from the insurance company.

Any co-payments required by your insurance company must be paid at the time of service.

When your insurance company reimburses us for your visit, your responsible balance will be billed to you. If payment is not received before the next billing cycle (30 days) and a second bill needs to be sent a \$5.00 charge will be added. If this payment is not received within the next billing cycle the bill is sent to a collection agency and you and your immediate family will not be able to receive services at FirstCare until the balance (plus any collection agency or legal fees) is paid.

Self pay Patients:

Payment for services can be with cash, check or credit card (MC,VISA,American Express or Discover) and must be paid at the time of service. If for any reason you need to be billed for your services a \$5.00 fee will be applied to your outstanding balance.

Returned Checks: There is a \$25.00 fee for any returned checks by the bank for any reason.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received services at our office may become a matter of public record.

Medical offices often incur significant expenses trying to collect payment for services rendered. This is one of the reasons medical care is so expensive in our country. We appreciate your understanding.

Thank you.

Signature: _____ Date: _____



FirstCare

FAMILY PRACTICE

Welcome to FirstCare Family Practice and thank you for allowing us the opportunity to provide quality medical care for you and your family.

FirstCare Family Practice provides out-patient medical services. This means we do not admit to hospitals. Any patient of FirstCare Family Practice that needs to be admitted will be admitted through the hospitalist service at St. Francis Hospital or Vassar Brothers Hospital. If any of our patients need medical care after-hours they will need to go to the emergency department of St. Francis Hospital or Vassar Brothers Hospital preferably, but any emergency department would be acceptable.

FirstCare Family Practice is open 8:30-4:30 Monday-Thursday. FirstCare Walk-In Medical Center is open 8-7:30 on weekdays and 10-4 on weekends. There are no practitioners available after these hours. If any of our patients has a problem after hours that cannot wait until the next day they will need to go directly to the emergency department.

To be seen by Dr. Vigna, patients will need to make appointments. Appointments that cannot be kept must be cancelled with a 24 hour notice. Cancellations without 24 hour notice and no-shows for appointments will be charged \$40.00. This fee is not covered by health insurance. Patients are expected to arrive on time for appointments. Arrivals 15 minutes late for appointments may need to reschedule. We will be unable to maintain a relationship with patients who have multiple late arrivals or cancellations.

FirstCare Family Practice will strive to provide you with a very high standard of medical care. We will be working to schedule extra time for patients to spend with Dr. Vigna and to avoid having patients wait long periods of time to see the doctor; the tradeoff being if you don't keep an appointment it puts us in an especially difficult situation. It is important that you understand the above information and agree that you can work with an office that has these guidelines. If you feel you cannot we will be happy to refer you to offices that may provide you with services more amenable to you.

I understand the above and agree to abide by FirstCare Family Practice policies:

Patient

Date