



Rose S. Ebel, D.O.  
Janna Starkey, PA-C  
Justin Taylor, PA-C

## Privacy Information

### CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I \_\_\_\_\_, give my consent to use and disclose health information for treatment, payment or health care operations to the following individuals:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Phone No. \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Phone No. \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

Phone No. \_\_\_\_\_

\*\*\*Please specify if there is any personal health information you **DO NOT** want to be disclosed to those named above \_\_\_\_\_

### CONTACT INFORMATION

E-mail address: \_\_\_\_\_

For patient portal use

Home number (including area code) \_\_\_\_\_

Can we call you at this number? YES / NO

Can we leave a message on your voicemail to return our call? YES / NO

Can we leave a message on your voicemail stating lab results? YES / NO

Can we leave a message on your voicemail regarding appointments/ prescriptions? YES / NO

Can we leave a message with the person answering the phone to return our call? YES / NO

Work number (including area code) \_\_\_\_\_

Can we call you at this number? YES/ NO

Can we leave a message on your voicemail to return our call? YES / NO

Can we leave a message on your voicemail stating lab results? YES / NO

Can we leave a message on your voicemail regarding appointments/prescriptions? YES / NO

Can we leave a message with the person answering the phone to return our call? YES / NO

Cell number (including area code) \_\_\_\_\_

Can we call you at this number? YES / NO

Can we leave a message on your voicemail to return our call? YES / NO

Can we leave a message on your voicemail stating lab results? YES / NO

Can we leave a message on your voicemail regarding appointments/prescriptions? YES / NO

Signature (If patient is a minor, list your relationship)

Date

\*\*\*Notify the office in writing of your request to change or update any of the above information\*\*\*

Name (print) \_\_\_\_\_

Social Security No. \_\_\_\_\_

**Financial Policy**

All professional services rendered are charged to the patient (or the party financially responsible). Necessary forms will be completed to expedite insurance payments. The patient is responsible for all fees regardless of insurance coverage. It is necessary to pay for services rendered at the time of service, unless other arrangements have been made. Patients with copays are required to pay the copay on the date of service. I understand that I am responsible for any amount not covered by insurance. I agree to pay the balance due in full, within 10 days of the statement, unless other arrangements have been made in advance. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. If payment is not made in a timely manner and collection action becomes necessary, the signature below shall serve as authorization to release any financial information necessary to the collection agency selected by the physicians(s) who have treated me.

**Prescription Call In Fees**

If the physician calls in an emergency prescription to the pharmacy, a fee may be assessed. I understand this fee is my responsibility to pay.

**Consent for Treatment, Insurance Authorization and Assignment**

I consent to treatment necessary for the care of the above named patient. I hereby authorize the release of any medical or other information necessary to process this claim to my insurance carrier. I also authorize and request payment of government benefits (if any apply) and insurance payments be made directly to Broadway Family Medicine, Inc. or to the party who accepts assignment, should they elect to receive such payments. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

**Notice of Privacy Practices**

I have been given the opportunity to read a copy of the Notice of privacy Practices (HIPPA) from the office of Broadway Family Medicine, Inc. on this date.

**Chronic Care Management (CCM) Program**

I acknowledge receipt of the pertinent details regarding this program and I **CONSENT TO** or **DECLINE** (circle answer) participation. Patient Initials \_\_\_\_\_  
*If not applicable, circle N/A*

**Signature on File**

I authorize use of this form on all my insurance submissions.  
I authorize release of information to all my insurance carriers.  
I understand that I am responsible for my bill.  
I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.  
I authorize payment directly to my doctor.  
I permit a copy of the authorization to be used in place of the original.  
I authorize my doctor to mail any medical records to any specialist, hospital, or attending doctor when it is in regard to my medical condition, with no liability should the papers end at the wrong fax machine.  
This signature on file paper is valid from the date of signature and will be valid indefinitely, unless I terminate my association with the doctors in a formal request.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Financially Responsible Party (if other than patient):**

**Printed Name:** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

*A copy of this authorization shall be as valid as the original.*

# PATIENT AGREEMENT REGARDING THE USE OF CONTROLLED SUBSTANCES

The following statements represent the policy of **Broadway Family Medicine, Inc.** It is the intent of Rose S. Ebel, D.O., Janna Starkey, PA-C and Justin Taylor, PA-C to be clear with their patients regarding the use of controlled substances.

- 1) These medications are used only to improve the lifestyle of patients. There is no intent to completely eliminate pain but only to make a productive and rewarding life possible.
- 2) Controlled substances require close monitoring, regular office visits and regular drug testing. Broadway Family Medicine, Inc. will perform periodic unannounced drug screenings and at our discretion call for random *same-day* pill counts. Compliance with the established treatment plan is required.
- 3) Medications may never be shared with or sold to other persons.
- 4) Prescriptions should be filled at only **ONE** pharmacy and that pharmacy will be notified of this policy. **List pharmacy name:** \_\_\_\_\_
- 5) Lost, stolen, or destroyed medications and/or written prescriptions will never be replaced.
- 6) Controlled substance may **NEVER** be obtained from any other physician, dentist, or other provider.
- 7) Medications will never be given by telephone order. Any abusive behavior towards the office staff will not be tolerated.
- 8) Any alteration or deception regarding prescriptions will be reported to law enforcement.
- 9) Medications are to be used in the dosage that provides an adequate and intended result. Any deviation from the prescribed dosage will result in the physicians' decision to stop prescribing the controlled substance to the patient immediately.
- 10) Use of any non-legal drug or alcohol along with the prescribed controlled substance is prohibited.
- 11) ALL controlled substances should be kept in a locked cabinet/drawer at all times.

*I understand that non-compliance with any part of this agreement is grounds for the physician to stop prescribing controlled substances to the patient immediately.*

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

\*\*Decline agreement: *x* \_\_\_\_\_ Date: \_\_\_\_\_

Reason(s): \_\_\_\_\_



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### Medical Records Release Authorization

I authorize: \_\_\_\_\_  
(Name of Physician or Facility)

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To release the medical records of:

Patient Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_ SS#: \_\_\_\_\_

To: Broadway Family Medicine, Inc.  
1470 N. Broadway, Suite 100  
Lebanon, OH 45036

#### INFORMATION TO BE RELEASED:

\_\_\_\_\_ Pertinent office notes (last one year)  
\_\_\_\_\_ Specific dates of service from \_\_\_\_\_ to \_\_\_\_\_  
\_\_\_\_\_ Other information including; last lab, MRI, consults,  
medication list and x-rays, growth charts, vaccination records

I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that in any event this authorization expires automatically as described below.

This authorization will expire 1 year from the date of my signature or as otherwise specified by date, event, or condition as follows:

\_\_\_\_\_  
\_\_\_\_\_

This authorization *includes* release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drugs, or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions.

This authorization may also include redisclosure of information supplied to the originating office by another provider for the purpose of continuity of care.

\_\_\_\_\_  
Signature of Patient Date

\_\_\_\_\_  
Witness Signature Date



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## Patient Medical Information

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. Please list your current **medications** and **dosages** also any **vitamins** and or **herbs**.

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2. Do you have any **allergies to medications**? Please list them below:

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3. **Past Medical History.** Please list any medical condition for which you see a doctor. (for example: high blood pressure, asthma, arthritis).

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4. **Past Surgical History.** Please list any surgeries you have had in the past.

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5. **Habits**
- |                                    |                                  |
|------------------------------------|----------------------------------|
| Alcoholic drinks/day or week _____ | Meals/day _____                  |
| Packs Cigarettes/day or week _____ | Veggies & fruits/day _____       |
| Cups of coffee/ day _____          | Exercise/day or week _____       |
| Cans of pop/day _____              | Sleep/night _____ good/fair/poor |

5. **Family History.** Are there any serious illnesses in your family:

Parents: \_\_\_\_\_

Siblings: \_\_\_\_\_

Patient Initials: \_\_\_\_\_

Physician Initials: \_\_\_\_\_



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## Review of Systems

Have you had problems recently with any of these symptoms?

**Constitutional**

|                       |    |     |
|-----------------------|----|-----|
| Good Health Lately    | No | Yes |
| Recent weight changes | No | Yes |
| Fever                 | No | Yes |
| Fatigue               | No | Yes |

**Eyes**

|                |    |     |
|----------------|----|-----|
| Eye disease    | No | Yes |
| Blurred vision | No | Yes |
| Glaucoma       | No | Yes |

**Ears/Nose/Mouth/Throat**

|                 |    |     |
|-----------------|----|-----|
| Hearing loss    | No | Yes |
| Ringing in ears | No | Yes |
| Mouth sores     | No | Yes |
| Bad taste       | No | Yes |
| Sore tongue     | No | Yes |
| Sore throat     | No | Yes |

**Cardiovascular**

|                     |    |     |
|---------------------|----|-----|
| Chest pain          | No | Yes |
| Shortness of breath | No | Yes |
| Swelling of ankles  | No | Yes |

**Respiratory**

|                   |    |     |
|-------------------|----|-----|
| Chronic cough     | No | Yes |
| Spitting up blood | No | Yes |
| Wheezing          | No | Yes |

**Gastrointestinal**

|                       |    |     |
|-----------------------|----|-----|
| Poor appetite         | No | Yes |
| Difficulty swallowing | No | Yes |
| Heartburn             | No | Yes |
| Nausea or Vomiting    | No | Yes |
| Bloating              | No | Yes |
| Belching              | No | Yes |
| Regurgitation         | No | Yes |
| Constipation          | No | Yes |
| Diarrhea              | No | Yes |
| Abdominal pain        | No | Yes |
| Rectal discomfort     | No | Yes |
| Rectal bleeding       | No | Yes |

**Genitourinary**

|                        |       |     |
|------------------------|-------|-----|
| Burning with urination | No    | Yes |
| Blood in urine         | No    | Yes |
| Incontinence           | No    | Yes |
| Irregular periods      | No    | Yes |
| Number of pregnancies  | _____ |     |
| Number of miscarriages | _____ |     |

**Musculoskeletal**

|                        |    |     |
|------------------------|----|-----|
| Joint pain or swelling | No | Yes |
| Back pain              | No | Yes |
| Muscle pain            | No | Yes |

**Skin**

|         |    |     |
|---------|----|-----|
| Rash    | No | Yes |
| Itching | No | Yes |

**Neurological**

|           |    |     |
|-----------|----|-----|
| Headaches | No | Yes |
| Seizures  | No | Yes |
| Strokes   | No | Yes |
| Numbness  | No | Yes |
| Weakness  | No | Yes |

**Psychiatric**

|                          |    |     |
|--------------------------|----|-----|
| Memory loss or confusion | No | Yes |
| Insomnia                 | No | Yes |
| Depression               | No | Yes |
| Nervousness              | No | Yes |

**Endocrine**

|                               |    |     |
|-------------------------------|----|-----|
| Heat or cold intolerance      | No | Yes |
| Excessive thirst or urination | No | Yes |

**Hematological**

|                               |    |     |
|-------------------------------|----|-----|
| Bleeding or bruising tendency | No | Yes |
| Anemia                        | No | Yes |
| Phlebitis                     | No | Yes |
| Past transfusion              | No | Yes |
| Enlarged glands               | No | Yes |

**Comments on any of the symptoms above:**

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Patient Signature: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_