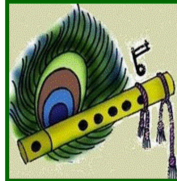


Pelham Healthcare Associates PLLC
49 Atwood Road, Unit 1
PO Box 434
Pelham, NH 03076

TEL: 603-635-2802 FAX 603-635-3070

Srilatha Kodali MD – Internal Medicine ***John Jackson MD – Family Practice***
Tracy Hardy – ARNP ***Samborn Hoey NP-C***

PATIENT INFORMATION

Patient Name: ______________________________ ***Social Security #:*** ____________________ ***DOB:*** ___________

Address: ____ ***City/State:*** _________ ***Zip Code:*** ______________

Home Phone: __________________***Employer:*** _______________________ ***Work Phone:*** ____________________

Gender: M__ F__ ***Marital Status: S__ M __ D __ W __ Spouse's Name:*** _________________________

Email: ____

EMERGENCY CONTACT

Name: ____ ***Phone:*** ____________________________

Address: ____ ***City/State:*** __________ ***Zip Code:*** ________________

Relationship: ____

COVERAGE INFORMATION

Insurance Carrier: ____***Phone:*** __________________________

Address: ____ ***City/State:*** ____________***Zip Code:*** _______________

Insurance ID #:_______________________***Group #:***_______________________

Subscriber Name:____ ***Employer:***________________________________

Relationship of Patient to Subscriber: Self___ Spouse___ Child ___ Dependent ___ Other ___

I authorize the release of any health information necessary to process claims. I authorize payment of health care benefits to the provider that rendered the services.
I understand and agree that (regardless of my insurance status); I am responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above. I certify that this information is true and correct to the best of my knowledge. I will notify you of any change in my status or the above information.

Signature: ____ ***Date:*** __________________________

Parent (if minor): ____ ***Date:*** _________________________

See other side

Pelham Healthcare Associates PLLC

MEDICAL HISTORY RECORD

Patient Name: ____ ***Age:*** ___________ ***DOB:*** ___________

Address: ____ ***City/State:*** _________ ***Zip Code:*** ______________

Home Phone: __________________ ***Work Phone:*** ____________________ ***Marital Status:*** ***S__ M __ D __ W __***

Gender: M__ F__ Emergency Contact: ________________________________ ***Phone:*** _____________________

Spouse's Name: ___________________________ ***Occupation:*** ____

Children's names and ages: ____

Email:____

ALLERGIES TO MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES? ***YES*** ____ ***NO*** _____

(If yes, please list name of medication and type of reaction)

____

____

____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please check off if you have had any problems with or are presently experiencing any of the following:

___High Blood Pressure
___Diabetes
___Cancer
___Heart disease
___Chestpain/tightness
___Hay fever
___Abdominal discomfort
___Hepatitis or jaundice
___Thyroid disease
___Head or neck radiation
___Headache
___Kidney disease
___Kidney stones
___Impotence/erectile dysfunction

___ Bronchitis
___Pneumonia
___Persistent Cough
___T.B.
___Gall bladder disease
___Anxiety
___Depression
___Anemia
___Alcohol abuse
___Drug abuse
___Gout
___Asthma
___Other

___Change in bowel habits
___Unexplained weight gain/loss
___Hemorrhoids
___Blood disorders
___Venereal disease
___Shortness of breath
___Swollen ankles
___Palpitations
___Lightheadedness
___Frequent urination
___Rheumatic fever
___Ulcers

___Arthritis
___Low back Problems
___Skin diseases
___Colitis
___Indigestion
___Nausea
___Vomiting
___Constipation
___Diarrhea
___Blood in stool
___Difficulty urinating

____

____

____

____

____

GYNECOLOGIC & OBSTETRIC HISTORY

Age at onset of periods ________________ ***Frequency***___________________ ***Length of period*** _________

Pregnancies__________________________ ***Births*** _______________________ ***Miscarriages*** _____________

Prolonged or abnormal bleeding? ***Yes*** ___ ***No*** ___ ***Please explain***_________________________________

Leakage of Urine? ***3/4/2011Yes*** ___ ***No*** ___ ***Please explain***_________________________________

Pelvic pain? ***Yes*** ___ ***No*** ___ ***Please explain***_________________________________

Abnormal discharge? ***Yes*** ___ ***No*** ___ ***Please explain***_________________________________

History of abnormal Pap smear? ***Yes*** ___ ***No*** ___ ***Please explain***_________________________________

See other side

Please continue on the next page

PLEASE LIST & SUPPLY THE DATES OF:

Operations:____

____

____

Hospitalization other than for Surgery: ____

____

____

Immunization History:

Have you had		***When was your last?***	
Hepatitis B?	***Yes___ No___ When? ______***	***Pap Smear___________***	***Breast Exam_____________***
Flu immunization?	***Yes___ No___ When? ______***	***Colon Cancer Test _______***	
Mammogram____________			
Pneumovax immunization?	***Yes___ No___ When? ______***	***Cholesterol Check__________***	***Prostate exam____________***
Tetanus immunization?	***Yes___ No___ When? ______***		
Other?	***Yes___ No___ When? ______***		

FAMILY HISTORY: ***Has any member of your family (including parents, grandparents and siblings) ever had any of the following?***

ILLNESS	*WHICH FAMILY MEMBER?*	*AGE WHEN DIAGNOSED?*
Cancer (describe type)	________________________	__________
Hypertension (high blood pressure)	________________________	__________
Heart Disease	________________________	__________
Diabetes	________________________	__________
Strokes	________________________	__________
Mental Disease (anxiety, depression)	________________________	__________
Drug or alcohol addiction	________________________	__________
Glaucoma	________________________	__________
Bleeding diseases	________________________	__________
Other _______________	________________________	__________

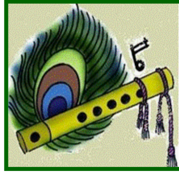
MEDICATIONS (PRESCRIPTIONS, OVER THE COUNTER, VITAMINS, HERBS, ETC.)

Drug Name	***Dose***	***Drug Name***	***Dose***	***Drug Name***	***Dose***
__________	_________	__________	_________	____________	_________
__________	_________	__________	_________	____________	_________
__________	_________	__________	_________	____________	_________

PREVENTION

Do you wear seat belts?	***___Yes ___No***	***If no, why not?___________________________***
Do you wear a bike helmet?	***___Yes ___No ___N/A***	
Do you exercise regularly?	***___Yes ___No***	***Type, frequency ___________________________***
Do you smoke?	***___Yes ___No***	***How many packs per day? __________________***
Do you drink alcoholic beverages?	***___Yes ___No***	***How many per week? ______________________***
Do you drink coffee?	***___Yes ___No***	***How many cups per day? ___________________***
Do you drink tea?	***___Yes ___No***	***How many cups per day? ___________________***
If there is a gun in your home, do you keep it unloaded and out of children's reach?	***___Yes ___No ___N/A***	
Do you use drugs? (marijuana, cocaine etc.)	***___Yes ___No***	***If yes, please explain________________________***
Have you ever engaged in an activity which has put you at risk of getting AIDS?	***___Yes ___No***	***If yes, please explain________________________***
Do you wish to be tested for AIDS?	***___Yes ___No***	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	***___Yes ___No***	***If yes, please explain________________________***
Are you in a relationship in which you have been physically hurt by your partner? (e.g. slapped,kicked,punched,bruised)	***___Yes ___No***	
Do you ever feel afraid of your partner?	***___Yes ___No***	
Do you have a "living will"?	***___Yes ___No***	

____



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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize ____ to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal and state law protecting its confidentiality.

Patient Name: ____ Date of Birth: __________________________

Address: ____

Information to be disclosed to:

Pelham Healthcare Associates PLLC
PO Box 434
Pelham, NH 03076

Disclose the following information for treatment dates ____

Complete Medical Records/ Notes / Hospital Records / Doctor's Records / History Physical X-Ray / Emergency/ Narrative Report / Physical Therapy and all applicable to the above.

I understand that I may inspect or obtain a copy of the protected health information described by this authorization.

I understand that PELHAM HEALTHCARE ASSOCIATES PLLC will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Pelham Healthcare Associates PLLC. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reference on an authorization I have signed.

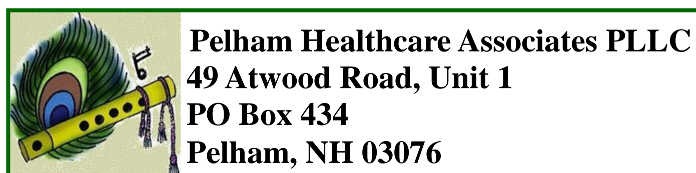
I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

____ ________________________
Signature of Patient *Date*

____

See other side

Print Name of Patient



Office Policies for Pelham Healthcare Associates PLLC

PLEASE REVIEW THE FOLLOWING OFFICE POLICIES AND SIGN BELOW

1. ***It is your responsibility to inform us about any healthcare proxy, living will etc. Please provide us with a copy of that document.***
2. ***If you are a new patient, it is your responsibility to choose us as a Primary Care Physician prior to your scheduled visit if your insurance dictates so.***
3. ***If you are an established patient and there are any changes in your insurance, address or phone numbers, you are responsible to inform us of these changes at the time of your visit. Also, if your new insurance dictates having a Primary Care Physician, you need to contact your insurance company and choose us as one.***
4. ***There will be a fee for missed appointments. $25.00 will be charged for a follow-up missed appointment and $50.00 for a missed Physical appointment.***
5. ***It is very crucial for us to have your emergency contact and alternate phone number to reach you in the case of an emergency.***
6. ***If you had blood work done and it is normal, our office does not call and inform you of this. However, we review each and every blood test. You may call us to get these results if you prefer.***
7. ***If your insurance company denies payment of your claim, you are responsible for the payment.***
8. ***We order tests depending upon the patients needs. It is the patient's responsibility to call the insurance company and confirm with them that a procedure is covered or not. We will take care of all necessary pre-certifications that are needed, but that does not guarantee payment or coverage of services. We are not responsible for insurance denials.***
9. ***Some insurance companies do not pay for physicals, pap smears etc. You will be responsible for any non-covered services.***
10. ***Lab Results: One of the providers will call if any lab results are concerning that they need to discuss with you.***
11. ***Co-payments are expected at the time of services rendered.***
12. ***If you do not have any insurance at the time of your visit full payment is expected at the time services are rendered unless payment arrangements are made prior to your appointment.***

______________________________ ____________________

Patient Signature ***Date***

See other side

Pelham healthcare Associates, PLLC

49 Atwood Rd. Suite 1
Pelham NH 03076
Phone# 603-635-2802 fax#: 603-635-3070

Referral policy: Please note that our referral policy has changed in 2011.

1. **Your physician recommends specialists depending upon your healthcare needs.**

2. **Your referral need to be approved by your primary care physician before you make an appointment with a specialist. As your primary care physician we try to coordinate the care to the best of your our ability.**

1. **Call us for a referral at least one week prior to your appointment. Except in emergency situations, referral takes one week to be processed. When you call please make sure that you have physicians name phone number ,NPI number, and the reason for the visit. Please let us know if your insurance has changed. Without any of this information we are unable to process your referral.**

2. **It is the patient's responsibility to confirm with their insurance that the specialist and procedures are going to be covered.**

3. **Since we are located on the border of Massachusetts and New Hampshire we have patients from both states with different insurance companies . Some insurance companies do not allow you to see a specialist in New Hampshire or Massachusetts. However we have privileges in both states so we are allowed to take patients from Massachusetts and New Hampshire also. Please call your insurance company prior to making appointment with a specialist.**

4. **Pelham Healthcare Associates may not approve or process the referral if you do not comply with the office policies .**

See other side

Pelham healthcare Associates, PLLC

49 Atwood Rd. Suite 1
Pelham NH 03076
Phone# 603-635-2802 fax#: 603-635-3070

Dear Patient,

This letter is to inform you of our office policies regarding non -covered services and in particular laboratory services. Our providers are dedicated to taking care of patient needs and our mission is to serve you as an individual and treat your diseases to the best of our knowledge. Because we are interested in serving your needs as well as possible, we may order blood work or other labs according to your age, gender, medical conditions, or medications that you may be taking. However, we do not have any control over your insurance coverage of these tests, nor do we have any control over how the laboratory which you select may bill you. Because we have no control over any insurance companies or specific laboratories, we unfortunately are not able to answer questions about billing with regard to laboratory services. We understand that it can be very frustrating to receive a bill for non-covered services but unfortunately the providers at Pelham Healthcare Associates are not able to help with this situation. We suggest you call your insurance company or billing facility if problems do arise and always check with your insurance prior to having lab work done to ensure coverage. As always, we do not restrict you to any particular laboratory and ask that you check with the lab you are visiting also to ensure insurance coverage. If there is a problem with a bill that you received from Pelham Healthcare Associates please do not hesitate to call us.

Thank you for you understanding and wishing you good health.

Pelham Healthcare Associates

See other side

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I acknowledge having received a copy of Pelham Healthcare Associate's "Notice of Privacy Practices" and "Office Policies".

____________________________________ __________
Signature **Date**

____
Please Print Name

See other side

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider.

Our Responsibilities

Pelham Healthcare Associates PLLC is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted in the **MAIN RECEPTION ROOM.** The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice that we request you acknowledge with your signature.
We are required by law to abide by the terms of this Notice and notify you if we make changes to this Notice, which may be at any time. Changes to the Notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be posted in the **MAIN RECEPTION ROOM**. You may also request that a revised Notice be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve to advise you as to your rights with regard to your medical information.

How We May Use and Disclose Medical Information About You.

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students, or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile. We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services we recommend for you

For Health Care Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conducting or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include **SOFTWARE SUPPORT**. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract.
Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We also may use and disclose your health information as set forth below. You have the opportunity to agree or object to the use or disclosure of all or part of your health information in these instances. If you are not present or able to agree or object to the use or disclosure of the health information (such as in an emergency situation), then your clinician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the information that is relevant to your health care will be disclosed.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care or who helps to pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Future Communications: *We may communicate to you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services; to remind you that you have an appointment for medical care; or other community based initiatives or activities in which our facility is participating. If you are not interested in receiving these materials, please contact our Privacy Officer. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object*

We may use or disclose your health information in the following situations without your authorization or without providing you with an opportunity to object. These situations include:

As required by law: We may use and disclose health information to the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Authority that receives reports on abuse and neglect

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.

Your Health Information Rights

Although your health record is the physical property of **PELHAM HEALTHCARE ASSOCIATES PLLC** that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We ask that you submit these requests in writing. Usually, this includes medical and billing records, but does not include psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review. Requests for access to and copies of your medical information must be submitted to **PELHAM HEALTHCARE ASSOCIATES PLLC** in writing.

Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information by submitting a request in writing. You have the right to request an amendment for as long as we keep the information. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. **PELHAM HEALTHCARE ASSOCIATES PLLC** will provide the first accounting to you in any 12-month period without charge. The cost for subsequent requests for an accounting within the 12-month period will be **$10.00.** We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had. We ask that you submit these requests in writing.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternative address for billing purposes. We ask that you submit these requests in writing.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling 603-635-2802 and asking for the Privacy Officer or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must be also submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided to you.

Privacy Officer: Tapasya Pandhare

See other side