Amy Jo Davison, D.O., LLC
Osteopathic Manipulative Medicine

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New Patient Registration Sheet

Name:_____ Date:_____
First Last Middle Initial

Date of Birth:_____ Age:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:(_____)_____ Cell Phone:(_____)_____

Work Phone:(_____)_____ Email Address: _____

Marital Status: S M D W Sex: Male Female

Social Security #:_____

Employer:_____

Employers Address:_____

Emergency Contact:_____ Phone:(_____)_____

Referral Source:_____

Primary Care Doctor:_____

Please Note

If you are covered by Medicare, or retired from the federal government, you must tell our staff and be prepared to sign a waiver.

Notice of Patient Privacy Practices

Amy Jo Davison, D.O., LLC

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.

Amy Jo Davison, D.O., LLC does not participate with any third party carriers, and does no electronic billing, therefore our patients have virtually no risk of their medical records becoming part of the public healthcare data bank. We will do everything to protect your privacy.

According to HIPPA, effective April 2003, the following guidelines are to become policy at Amy Jo Davison, D.O., LLC to fall within the purview of the law.

When healthcare information can be used or disclosed without prior authorization:

There are certain situations where Amy Jo Davison, D.O., LLC may be forced to release some of your private medical information without your prior authorization, such as the following:

- When our office receives a written request/subpoena from any law enforcement agency, or representative. Our office is under legal obligation to provide the subpoenaed materials to the requesting authority.
- If your physician (Amy Jo Davison, D.O., LLC) refers you to another physician or specialist for further medical evaluation and treatment, we will share information deemed necessary for your medical treatment.
- Amy Jo Davison, D.O., LLC will only share the necessary information from your patient medical records with the pharmacy for prescriptions written by our physicians.
- Amy Jo Davison, D.O., LLC has the right to share any and all medical information with third party carriers of all of our workmen's compensation or similar programs in the interest of seeking financial reimbursement. Any information other than what is needed for financial reimbursement will not be shared.
- Amy Jo Davison, D.O., LLC will disclose your health information if there is a risk to the public health.
- Amy Jo Davison, D.O., LLC will disclose your health information to a coroner or medical examiner or funeral director so they may carry out their official duties.

Except for the above listed circumstances, Amy Jo Davison, D.O., LLC will not use or disclose your health information without first notifying you and obtaining your written permission to do so.

All patients have the following rights:

- Right to request certain restrictions on the release of your medical information. If you desire to maintain a certain restriction, please ask for a waiver form, and it will be added to your medical chart. Amy Jo Davison, D.O., LLC has the right not to agree to this waiver.
- Right to confidential communication between your doctor and yourself.
- Right to view and obtain a copy of your medical and/or billing records. Amy Jo Davison, D.O., LLC retains the right to charge a reasonable fee to cover the expense of copying these records.
- Right to amend your healthcare information if you believe it is incomplete or incorrect. A request to amend your records must be made in writing, and describe the reasons why such an amendment is requested. This right extends to only the records created by and contained in your medical chart in this office. Amy Jo Davison, D.O., LLC retains the right to deny your request for amending your records. This denial will be provided to you in writing.
- Right to request an accounting of all of the disclosures of your records made by Amy Jo Davison, D.O., LLC for any reason other than treatment/referral or payment reimbursement made within the last six years. This request must be made in writing.
- Right to receive a paper copy of the *Notice of Patient Privacy Practices* at any time.

Practice Policies

Amy Jo Davison, D.O., LLC

Emergencies:	During non-business hours we will refer you to your local emergency department, or your primary care physician.
Cancellations/Missed Appointments:	The doctor does not double or over book. Our office has a 24-hour cancellation policy. If this is not possible please call us as early as possible. Failing to cancel and appointment in advance may result in a normal appointment charge.
Scheduling:	Appointments are scheduled back to back. The doctor does not have the freedom to spend additional time with a patient who arrives late.
Payment:	Payment is requested and expected at the time service is provided. Payment can be made by local check or cash.
Returned Checks:	A fee of $25.00 will be applied to each returned check.
Insurance(s):	Dr. Amy Jo Davison does not participate with any insurance carrier or Medicare. Our office will provide you with a statement that you can submit to your carrier for reimbursement. I you are covered by Medicare or are a retired federal employee, you must tell our staff, and sign a treatment wavier. MEDICARE PATIENTS CANNOT SUBMIT TO MEDICARE; however you may submit to your secondary insurance carrier.
Authorization:	I hereby authorize Dr. Amy Jo Davison and the office staff to release to my insurance carrier any information needed to process my insurance claim. I understand that payment for services rendered is due and payable by me regardless of insurance coverage. I also agree to pay for the cost of collections should my account become delinquent (including associated attorney fees).
Consent:	Due to health risks involving accidental needle sticks, in the event of an accidental needle stick incurred by any personnel, I here by give my permission to have my blood drawn for testing, at no additional cost.
Privacy Policy:	My signature below acknowledges that I have received a copy of and have read the *Notices of Patient Privacy Practices* and *Practice Policies* of Amy Jo Davison, D.O., LLC.

Patient's Name

Patient's Signature Date

Patients Request and Consent for Non-Medicare Services

Amy Jo Davison, D.O., LLC

I provide this Request and Consent form to protect my future access to private medical care based on payments using private payment methods. I request and consent that the office of Dr. Amy Jo Davison to provide medical services to me outside of Medicare and other government programs in emergency and non-emergency circumstances. I acknowledge an consent that no documentation will be provided for such services to enable reimbursement from Medicare or other government programs.

Neither I nor my heirs, executors, administrators, successors, beneficiaries, or assigns will submit a claim (or request that a claim be submitted) for services provided by this private physician. I acknowledge that such services may fall within the scope of Medicare or other government programs, and that I have the right to seek such services from other providers if I wish to obtain reimbursement by the government. I consent that the fees charged by this private physician for such services may be greater or less then limiting charges established by Medicare or other government programs.

I hereby acknowledge and consent that this private physician is justified in relying upon this Request and Consent in providing all future services to me, whether during an emergency or not. In the event that I take action contrary to this Request and Consent that causes administrative or legal expense to this private physician, I will provide reasonable reimbursement.

This it not a private contract in any item or service. The undersigned is not obligates in any manner to obtain medical services from the private physician and remains free to seek medical care from any other provider at any time. This form is confidential and may not be construed to allow disclosure of any information concerning the patient.

Patient's Name

Patient's Signature Date

Patient Name:_____

Medical History

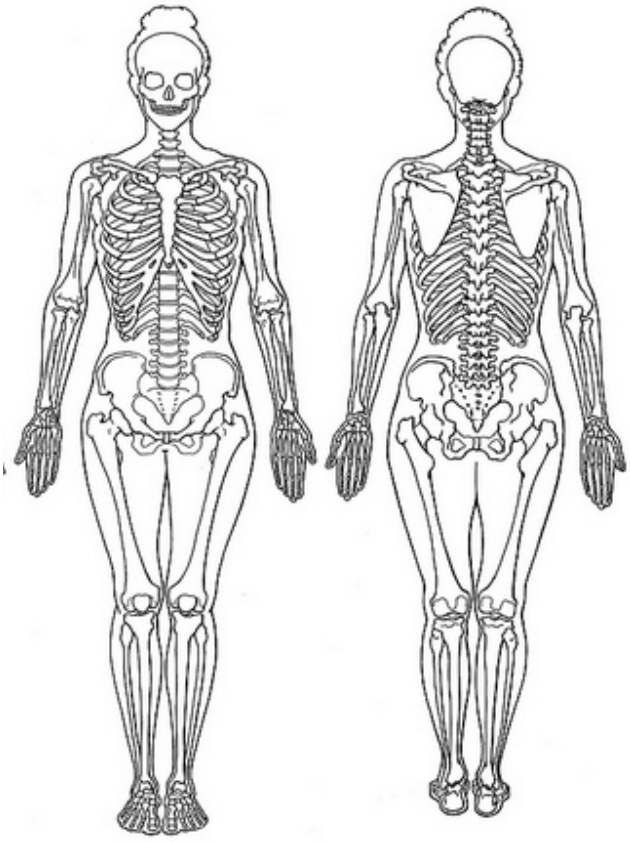
Chief Complaint _____

_____

Current Medications _____

Medication Allergies/Other_____

Do you have any allergies to Latex? Y N Exercise (type/how often)_____



Shade in regions of pain:

Family Medical History

Please mark any conditions that have been suffered by a blood relative and indicate which relative.

- ☐ Allergies
- ☐ Cancer
- ☐ Glaucoma
- ☐ Stroke
- ☐ Mental Illness
- ☐ Asthma
- ☐ Alcoholism
- ☐ Genetic Diseases
- ☐ Ulcers
- ☐ Heart Disease
- ☐ Anemia
- ☐ Diabetes
- ☐ Gout
- ☐ Tuberculosis
- ☐ Blood Clotting Problems
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Headaches
- ☐ Kidney/Bladder Problems
- ☐ High Blood Pressure
- ☐ Other_____

Hospitalizations

Year	Operation/Illness	Hospital	City, State

Patient Name:_____

Personal Medical History

Please mark the conditions that you have had in the past and are no longer present. Circle the conditions that you are currently experiencing. Indicate the onset age for all conditions that you have had oar are currently experiencing.

- ☐ Failing Vision
- ☐ Double/Blurred Vision
- ☐ Eye Pain
- ☐ Eye Infections
- ☐ Decreased Hearing
- ☐ Ringing/Buzzing in Ears
- ☐ Ear Infections
- ☐ Allergies/Hay Fever
- ☐ Sinus Trouble
- ☐ Nose Bleeds
- ☐ Frequent Sore Throats
- ☐ Prolonged Hoarseness
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Short Breaths/Exertion
- ☐ Short Breaths/Lying Flat
- ☐ Chest Pain
- ☐ Heart Murmurs
- ☐ Palpitations
- ☐ Swollen Ankles
- ☐ Fainting Spells
- ☐ Leg Pain/Walking
- ☐ Varicose Veins
- ☐ Recent Loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Heart Burn
- ☐ Persistent Nausea/ Vomiting
- ☐ Ulcers
- ☐ Chronic Abdominal Pain
- ☐ Recent Change in Bowel Habits
- ☐ Diarrhea
- ☐ Difficulty Sleeping
- ☐ Constipation
- ☐ Black or Tarry Stool
- ☐ Red Blood in Stool
- ☐ Hemorrhoids
- ☐ Diverticulosis
- ☐ Hernia
- ☐ Bladder Infections
- ☐ Kidney Infections
- ☐ Pain on Urination
- ☐ Poor Control of Urination
- ☐ Decreased Force of Urination
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Sexually Transmitted Diseases
- ☐ Chronic Fatigue
- ☐ Recent Weight Loss
- ☐ Excessive Weight Gain
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Convulsion/ Seizures
- ☐ Stroke
- ☐ Tremors
- ☐ Muscle Weakness
- ☐ Numbness/ Tingling Sensation
- ☐ Frequent Headaches
- ☐ Migraine Headaches
- ☐ Broken Bones:_____
  _____
  _____
- ☐ Arthritis
- ☐ Gout
- ☐ Cold or Numb Feet
- ☐ Rashes
- ☐ Psoriasis
- ☐ Eczema
- ☐ Hives
- ☐ Nervousness
- ☐ Anxiety/ Depression
- ☐ Memory Loss
- ☐ Moodiness
- ☐ Alcoholism
- ☐ Phobias
- ☐ Mumps
- ☐ Measles
- ☐ German Measles
- ☐ Chicken Pox
- ☐ Polio
- ☐ Gall Bladder Problems
- ☐ Jaundice/ Hepatitis
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Recreational Drug Use
- ☐ Alcohol
- ☐ Cigarettes
  - ○ Packs per day:_____
- ☐ Caffeine
  - ○ Cups per day:_____
- ☐ Other:_____
  _____
  _____
  _____
- ☐ # Live Births_____
- ☐ # Miscarriages_____
- ☐ Birth Control Type
  _____
- ☐ Age/Onset of Menses
  _____
- ☐ Regular Period? Y N
- ☐ Light Flow
- ☐ Moderate Flow
- ☐ Heavy Flow
- ☐ Length of Flow: _____
- ☐ Length of Cycle:_____
- ☐ Pain/Bleeding with Intercourse: Y N
- ☐ PMS (Moderate to Severe)