NAME		PLEASE COMPLETE BOTH SIDES	
DATE OF BIRTH		OCCUPATION	

GENDER	□ FEMALE	□ MALE	□ TRANSGENDERED	
MARITAL STATUS	□ SINGLE	□ MARRIED	□ PARTNERED	□ DIVORCED
EDUCATION COMPLETED	□ ELEMENTARY	□ HIGH SCHOOL	□ COLLEGE	□ OTHER
WHO DO YOU LIVE WITH?				

WHAT ARE YOU MAJOR HEALTH CONCERNS/REASONS FOR TODAY'S VISIT?

FAMILY HISTORY	LIVING/DECEASED	ILLNESSES
MOTHER		
FATHER		
SISTER		
BROTHER		
CHILDREN		

MEDICAL HISTORY — PLEASE LIST ANY MEDICAL DIAGNOSES/ILLNESSES OR ANY SURGERIES

IMMUNIZATIONS	YEAR
TETANUS	
PNEUMOVAX (pneumonia)	
ZOSTAVAX (shingles)	

SCREENING TESTS	YEAR
COLONOSCOPY	
PAP SMEAR	
MAMMOGRAM	

HEALTH HABITS	yes/no/amount
TOBACCO	
ALCOHOL	
DRUGS	
EXERCISE	

OTHER

Is pain a problem for you? yes/no scale 0 to 10 ______

Sexual practice: □ men □ women □ both □ abstinen

Do you have a health care proxy? yes/no Living will? yes/no

Communication barriers? □ hearing impairment □ other langua

Matthew J. Fleig, M.D. 1736 Ridge Road East Rochester, NY 14622
Office: (585) 270-8971
Fax: (585) 270-8976

Name: ______________________ Date: ______________

Address: ____

City: ________________ State: _____ Zip Code: ________

Home Phone: (____)__________ Cell Phone: (____)______________

Work Phone: (____)__________ Ext: _____ OK to call work? Y / N

Date of Birth: __________ Sex: ____ Social Security # : ____________

Marital Status: □ Single □ Partnered □ Married □ Divorced □ Separated

Your Occupation: ________________ Employer: ______________

Employer's Address: ____________________________________

Spouse or Partner Name: ______________ Occupation: ______________

Referred By: ____

Emergency Contact (Required): __________________Relationship: ______

Contact Address: ____

Contact Phone Number: ______________ 2nd #: ________________

Insurance (Required)

□ Medicare □Blue Choice □BCBS □MVP □Aetna □Other:__________

	Primary Insurance	**Secondary Insurance**
Subscribers Name (DOB)	__________(____)	__________(____)
Subscribers Address:	____________	____________
Policy or Contract #:	____________	____________

□ In accordance with the Health Insurance Portability and Accountability Act, I __________________ hereby acknowledge I have reviewed or received a copy of "Matthew Fleig, MD – Family Medicine Notice of Privacy Practices".

Signature: ________________ Date: ________________

Matthew Fleig, MD – Family Medicine
1736 E. Ridge Road
Rochester, NY 14622
585.270.8971

FINANCIAL POLICY AND ACKNOWLEDGEMENT

Matthew Fleig, MD *Family Medicine* believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. **Payment will include charges for visit in full for deductible plans. Payment in full is required for co-insurance, co-payment amounts, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.** If you are unable to pay the full amount due, I encourage you to set up a payment plan on the day of your visit. Please see my Office Manager for more information.

2. **INSURANCE** We are participating providers with several insurance plans. We will file all of these insurance claims. Please remember that insurance is a contract between the patient and the insurance company and **ultimately the patient is responsible for payment in full.** If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

   If our doctor is not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products available, our staff cannot guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim is rejected for the lack of one.
   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. **LATE CHARGES** of $25 will be applied to all patient balances 30 days old or greater.

4. **RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Monroe County. Future visits will require cash or credit card payment, we will no longer accept checks.

5. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

Matthew Fleig, MD – Family Medicine
1736 E. Ridge Road
Rochester, NY 14622
Phone - 585.270.8971
Fax - 585.270.8976

Patient Authorization for Disclosure of Protected Health Information Form

Please print all information.

Patient Name: ____

Date of Birth: ______________________________

Entity Requested to Release Information: Matthew Fleig, MD – Family Medicine

I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information:

Name: ____________________ Relationship: ______________ Phone: __________

Name: ____________________ Relationship: ______________ Phone: __________

Name: ____________________ Relationship: ______________ Phone: __________

I authorize the practice to disclose my protected health information about me to the entity, person, or persons identified above.

- **This authorization will expire upon departure from the practice. You must submit a new authorization if you would like to update or change this authorization.**
- You have the right to terminate this authorization at any time by submitting a written request to our office. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

______________________________ ______________________
Patient or Representative Signature Date

You have the right to receive a copy of signed authorizations upon request.

Matthew Fleig, MD – Family Medicine
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Rochester, NY 14622
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize (your previous Doctor): ______________________

Phone #: ______________ Fax #: ______________

Address: ______________________

To release healthcare information of the patient named above to:

Name: Matthew Fleig, MD – Family Medicine

Address: 1736 E. Ridge Road

City: Rochester State: NY Zip Code: 14622

This request and authorization applies to:

☐ All healthcare information

☐ Other: ______________________

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

By Signing this form, you understand that you have the right to revoke this authorization at any time by sending a written request. You also understand that you give authorization for the release the information detailed above.

Patient Signature: ______________________ Date Signed: ______________

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.

Matthew Fleig, MD – Family Medicine
1736 E. Ridge Road
Rochester, NY 14622

ACKNOWLEDGEMENT OF RECEIPT AND/OR REVIEW OF MATTHEW FLEIG, MD – FAMILY MEDICINE NOTICE OF PRIVACY PRACTICES

In accordance with the Health Insurance Portability and Accountability Act,

I, ____, hereby acknowledge receipt of Matthew Fleig, MD – Family Medicine Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how Matthew Fleig, MD – Family Medicine may use and disclose my confidential information.

I understand that Matthew Fleig, MD – Family Medicine reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

____
Signature

____
Date

If you are not the patient, please specify your relationship to the patient

____
Relationship to Patient