LACKAWANNA MEDICAL GROUP P.C.
SCRANTON MEDICAL CLINIC

201 SMALLACOMBE DR., SCRANTON, PA 18508
(570) 961-0171

Date:

Dear :

Welcome to Lackawanna Medical Group! Thank you for choosing us for your medical care.

You have scheduled an appointment with _____
on_____ at _____.

To offer you the best quality of medical attention and efficient, timely medical service, we please ask that you will make note of the following list for your first appointment:

- Have your current physician send pertinent records and recent test results by mail to the listed address or by fax to (570) 207-2411.
- Provide a list of the current medications you are taking, including over the counter medications, herbal supplements, and vitamins.
- Bring your insurance card.
- Fill out the enclosed sheet and bring it with you to your first appointment.

Lackawanna Medical Group appreciates your cooperation! If you have any questions about your first appointment and the information we are requesting about you, feel free to call our office at (570) 961-0171, anytime between our business hours of 8:00am to 4:30pm. We have provided directions at the bottom for your convenience. We appreciate 24 hours notice with any appointment cancellation. Thank you!

Directions to Lackawanna Medical Group:

Take the Scranton Expressway to the Keyser Avenue exit.
Make a right turn onto the Morgan Highway.
Make the second left turn into the Allied Services complex.
Once in, take the second left down a hill and around to 201 Smallacombe Drive, where LACKAWANNA MEDICAL GROUP can be seen in bold, white letters on a brick building.

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Patient Consent to the Use and Disclosure of Health Information

I, _____, understand that as part of my healthcare, Lackawanna Medical Group originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my health and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Privacy Notice that provides a more complete description of the information and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, and health care operations.

I understand that Lackawanna Medical Group is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Lackawanna Medical Group reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent and acknowledge receipt of the Privacy Notice.

_____
Patient's Signature

_____
Date

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent added to the patient's medical record on _____.

Lackawanna Medical Group

201 Smallacombe Drive Scranton, Pa 18508
Tel (570) 961-0171

Please complete this form and bring it with you to your next appointment. ***Please note backside.

Name _____ Date of Birth _____
What is the reason for today's visit? _____

Referring Physician_____ Visit Date _____

Present Family Doctor_____ Since _____
Previous Family Doctor_____
Do you see any specialists on a regular basis? YES _____ NO_____ If YES, what specialist? _____
Do you have a history of any allergies to medications? YES _____ NO _____
If so, what medications are you allergic to:

_____

Do you have any other allergies such as hay fever, etc.?

_____

Medications:
***At the time of your office visit*, please bring all medications you are taking, or a current list of your medications you are taking from your pharmacist. Include all over the counter medications, herbal supplements, and vitamins.**

Personal Past Medical History – Do You Have Any History Of:

	YES	NO
Diabetes		
Hiatal Hernia		
Peptic Ulcer Disease		
Ileitis		
Colitis		
Irritable Bowel		
Diverticulitis		
Colon Polyps or Tumors		
Hepatitus or Yellow Jaundice		
Gallbladder Disease/Gallstones		
Hypertensions		
Angina		
Heart Attack		
Cardiac Arrhythmia/Palpitations		
Heart Murmur		
Valvular Heart Disease		
Rheumatic Fever		
Congestive Heart Failure		
Anemia &/or Low Blood Counts		
Bronchitis		
Emphysema		
Tuberculosis or Exposure to Tuberculosis		
Other Lung Problems		
Male – Testicle Pain		
Female – Menstrual Pain		
Female – Irregular Periods		
Female – Vaginal Discharge		
Female - # of Pregnancies		
Female - # of Miscarriages		
Female - # of Live Births		
Female – Last Menstrual Period		
Female – Date of Last Pap Smear		
Female – Date of Last Mammogram		
Have you ever had a colonoscopy? Date?		
Have you ever had a stress test? Date?		

	YES	NO
Gout		
Chronic Back Problems		
Thyroid Disease		
HIV		
Asthma		
Kidney Stones		
Bladder Infections		
Kidney Failure		
Other Kidney Problems		
Blood Transfusions		
Other Blood Disorders		
Bleeding Problems		
Clotting Problem(Phlebitis)		
Cancer		
Seizure Disorder		
Stroke		
Mini-Stroke		
Trauma(fractures, head injuries)		
Skin Disorders		
Frequent Infections		
Venereal Disease		
Hereditary Defects		
Other: _____		
_____		
_____		

Please Tell Us About:

Previous Hospitalizations: YES NO
If answer is "Yes," please provide the following information.

Date Location Reason

_____

_____

_____

Previous Surgeries: YES NO
Date Location Reason

_____

_____

_____

Are you currently taking any medications? YES NO
If "Yes," list medications with dose & frequency. Include all over the counter medications and vitamins.
Medication Dose Frequency

_____

_____

_____

Social History:
Do you use tobacco? _____ YES _____ NO If so, what kind? (cigarettes, cigars, etc.): _____
How many years? _____ How many packs per day?
If you currently do not use tobacco, have you ever smoked? _____ YES _____ NO
When did you quit smoking? _____
Does anyone in your household smoke? _____ YES _____ NO
Do you drink alcohol? _____ YES_____ NO If yes, how frequently? _____
Have you ever had a history of heavy drinking? _____ YES _____ NO
Have you used recreational drugs? _____ YES _____ NO
Marital Status: _____ Married _____ Single _____ Divorced _____ Widow/Widower
Do you live alone? _____ YES _____ NO

Work History:
Present Occupation or if retired previous occupation? _____

Family Medical History:

Family Member	Sex	Age	Diseases	If Deceased, Cause & Age of Death
Father				
Mother				
Siblings				
Children				
Grandparents				
Other Relatives				

_____ _____
Patient's signature Physician's signature

_____ _____
Today's date Physician Assistant

FINANCIAL POLICY AND INFORMATION

Name (first)_____ (Middle)_____ (Last)_____

Home Phone ( )_____ Wk. Phone ( )_____ Alt. Phone ( )_____

Home Address_____

Street *City* *State* *Zip Code*

Date of Birth_____ Age _____ Sex_____ Social Security #_____

Employer _____ Occupation _____

In the event of an emergency, who may we contact? _____ Phone ( )_____

Name of Referring Physician _____

Name of Primary Care Physician _____

PRIMARY INSURANCE COMPANY _____

Insurance Address _____

Street/P.O. Box *City* *State* *Zip Code*

POLICY #_____ **GROUP #**_____

Policy Holder's Name_____ Date of Birth _____

Social Security #_____ Sex_____

Responsible Party_____ Phone ( ) _____

Address_____

Relationship to Patient_____Self _____Spouse _____Child _____Other

SECONDARY INSURANCE COMPANY _____

Insurance Address _____

Street/P.O. Box *City* *State* *Zip Code*

POLICY #_____ **GROUP #**_____

Policy Holder's Name_____ Date of Birth _____

Social Security #_____ Sex_____

Responsible Party_____ Phone ( )_____

Address_____

Relationship to Patient_____Self _____Spouse _____Child _____Other

Is this visit related to an _____ Auto Accident _____ Work Injury If so, please complete below:

WORKMAN'S COMPENSATION/AUTO ACCIDENT CLAIM INFORMATION

Insurance Company Name _____

Claims Address_____

Contact Name/Agent_____ Phone ( )_____

Date of Injury _____CLAIM # _____

Signature _____ **Date** _____

FINANCIAL POLICY AND INFORMATION RECORD:

Thank you for choosing us as your healthcare provider. The following is a statement of our financial policy, which we require that you read, agree to and sign prior to treatment.

CO-PAYS:

- Co-pays are due on the day of the visit.
- We accept CASH, CHECKS, or VISA/MASTERCARD.

INSURANCES:

- Our practice charges what is usual and customary for our area. Without your insurance information, you will be billed directly for payment.

MINOR PATIENTS:

- The adult accompanying a minor (parent/guardian) is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved method of payment at the time of service.

I have read, understand and agree to the provisions of this financial policy.

_____

Responsible Party Signature

_____

Date

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NAME:_____ DOB: _____

Privacy Information

Leave appointment message on:		**Leave other medical info on:**	
Answering Machine?	☐	Answering Machine?	☐
Office Voice Mail?	☐	Office Voice Mail?	☐
w/ Another Person?	☐	w/ Another Person?	☐
Send through mail?	☐	Send through mail?	☐
Send via e-mail?	☐	Send via e-mail?	☐
Cell Phone?	☐	Cell Phone?	☐

Person (s) Authorized to Communicate With

_____

Signature of Patient or Personal Representative

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by _____ on _____.

[ ] Consent added to the patient's medical record on _____.