ADVENT Medical Group

Welcome to our medical group…

Our dedicated medical providers and staff are committed to providing the highest quality medical care for each and every patient. Set forth below are guidelines for your participation in treatment. Your treatment is very important to us and we ask that you review the following to ensure that you receive the best reasonable care possible and that your visit exceeds your expectations. Please read the following carefully and ask the front desk staff if you have any questions with the following.

Please bring the completed packet with you to your first appointment. Please arrive 20 minutes early to your scheduled appointment to complete the registration process.

EMERGENCIES: The office phone system lists the emergency contact number for your provider. You may reach the list by dialing 636-432-5500. You will also find the emergency contact number on your appointment card. Please note that this number is for emergency situations only. Refills, appointments, and non-emergency situations will not be handled after hours.

CALL CENTER: Our office can be reached Monday-Friday by calling 636-432-5500. We make every attempt to personally answer your call. At times, you may be required to leave a message. We check the system frequently to ensure that all calls are answered promptly by the staff. Please note that providers must often times be contacted in order for the staff to respond to your request.

APPOINTMENTS: Upon being seen, you will be given a follow up appointment. It is very important that you keep this appointment. Should you need to reschedule your appointment, please notify the office as soon as possible so that we may make you another appointment as close to your recommended follow up visit as possible. Patients arriving more than 10 minutes late may be asked to reschedule.

Patients who are minors will not be seen without his/her legal guardian present.

We kindly ask that you limit the people that accompany you to your appointment. Our office is very busy and space is limited. Please note that we cannot have children waiting in our waiting area without the supervision of a parent, guardian, or care taker.

Medication refills may not be approved for patients who do not keep their scheduled appointment or have a scheduled appointment. You may reach the appointment desk by calling 636-432-5500.

PROBLEMS: At times you may experience situational difficulties or require a medication adjustment before your scheduled appointment. Please contact the office during office hours at 636-432-5500 for an earlier appointment. Although appointments are preferred, in some cases your situation may be handled over the telephone. You may leave a message with the receptionist by calling 636-432-5500. Please allow time for the receptionist to review your call with your physician and contact you with his/her recommendations.

MEDICATIONS: Our office uses an electronic prescription system. In most cases you will receive enough medication with refills until your next appointment. For medication refills prior to your scheduled appointment, please contact your pharmacy and provide them with your prescription number along with any changes in your medication since your last refill. Some medications require a written prescription. For these medications you will receive a prescription at your

appointment. That prescription will need to be taken to your pharmacy, as the refills on your previous prescriptions will not be valid once a new prescription is written. Patients requiring written prescriptions for controlled substances or stock bottles, please contact the office at 636-432-5500, and follow the instructions for obtaining your request. Please allow 48 hours for pickup. Medication can be refilled no more than 5 days early.

MEDICATION PRIOR AUTHORIZATION:

The company that provides you with prescription coverage may request that a prior authorization be completed on a specific medication before agreeing to pay for the medication.

Once you have turned in your prescription to the pharmacy, your pharmacist will submit the charges for the medication to your insurance company. Your insurance company will let your pharmacist know if a prior authorization is needed for the medication. Your pharmacist will notify our office that a prior authorization is required for your insurance to cover their cost of the medication. The pharmacist will provide our office with the information needed to initiate the prior authorization process. Your provider will review the request for prior authorization and either recommend a different medication or request the office to proceed with the prior authorization. Prior authorizations typically take 3-5 days to fully process. An approval of coverage is not guaranteed.

If the medication requiring a prior authorization is a current medication that you have been taking and you are out of medication, please discuss your options with your pharmacy for a 3-5 day supply.

Please contact your insurance company with questions regarding insurance coverage of your medication.

CHARGES

We will gladly file your insurance claim for you, please provide us with your insurance card and information. Any portion of the professional fee that is not covered by your insurance company is your responsibility. We cannot accept responsibility for collecting your insurance benefits or for negotiating a settlement on a disputed claim. Any portion of the bill the insurance company has not paid within 45 days, or has been denied will be the patient's responsibility. Payment of co pays, coinsurances and balances are required at the time of your visit. It is your responsibility to notify our office of any insurance changes as well as obtaining authorization for your care. You may reach the billing department by calling 636-939-2550 option 5.

CONFIRMATION, CANCELLATION, or UN-KEPT APPOINTMENTS:

Our automated confirmation system will call 1-2 days prior to your appointment with a courtesy reminder of your scheduled appointment. We ask that you kindly give 24 HOUR notice if you are unable to keep your scheduled appointment. Patients who DO NOT GIVE 24 HOUR NOTICE of CANCELLATION will be CHARGED. Insurance companies will not pay for these types of charges, therefore payment will be due by you. After a patient has cancelled or not attended three appointments without a 24 hour notice, the office will no longer schedule appointments or refill medications for that patient.

Please notify the receptionist if you do not wish to receive the automated confirmation call.

Directions to Advent Medical Group – Washington Office

Coming from the North (Warren and St. Charles County)

- Take I-70 to Foristell (MO-T) exit #203
- Turn south on MO-W
- Turn right on S Service Rd
- Turn left on Hwy T for 12.6 miles
- Turn right on Hwy TT for 3.6 miles
- Continue on Hwy 94 for 0.7 miles
- Take Hwy 47 South towards Washington
- Cross the Missouri River Bridge
- Turn right on E 5th Street
- Parking for the Mercy Medical Building is immediately to the right

Coming from the South / East

- Take I-44 (East from Sullivan / West from St. Louis) to Washington exit #251
- Turn north/west on Hwy 100 for 10 miles
- Turn right on Hwy 47
- Turn left on E 5th Street
- Parking for the Mercy Medical Building is immediately to the right

Coming from the West (Gasconade County):

- Take Hwy 94 East
- Turn right on Hwy 19
- Turn left on Hwy 100 for 28.4 miles
- Turn left on Hwy 47
- Turn left on E 5th Street
- Parking for the Mercy Medical Building is immediately to the right

851 E 5th Street, Suite 308 | Washington, Missouri 63090 | Voice: 636-432-5500 | Fax: 636-432-5501

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Please sign below to indicate that you have reviewed and are aware of the office guidelines.

_____

Patient Signature Date

_____

Print Patient Name

ADVENT Medical Group

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, among other reasons, to:

* Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

* Obtain payment from designated third-party payers.

* Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by Advent Medical Group of its Notice of Privacy Practices. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. The Notice of Privacy Practices is posted on our website at adventmedicalgroup-mo.com, at all office locations and is available in handout form at the receptionist desk. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____

Patient's Name Date of Birth (MM/DD/YYYY)

_____

Signed (Patient or Legal Representative for Patient) Date

_____

Legal Representative's Relationship to Patient

ADVENT Medical Group

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.

- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at Advent Medical Group, as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS.
***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information*.**

Consent

By signing this consent form you are agreeing that your provider at Advent Medical Group may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

By signing this consent form you are agreeing that Advent Medical Group can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Advent Medical Group to prescribe medication to me using the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name _____ **Patient DOB**_____

Signature of Patient or Guardian _____

Relationship to Patient _____

Today's Date _____

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Medical Group

SIGNATURE ON FILE

- **I authorize use of this form on all my insurance submissions.**
- **I authorize the release of information to all my Insurance Companies, Managed Care Companies, and PCP, including substance abuse/dependency information, if applicable.**
- **I authorize Advent Medical Group as well as the staff to act as my agent in obtaining payment from the Insurance Companies.**
- **I authorize payment direct to a provider of Advent Medical Group.**
- **I authorized information regarding my care to be released to my Residential Care giver/ POA/ or others responsible for my well being.**
- **I permit a copy of this authorization to be used in place of the original.**
- **I understand that this consent form will be valid and remain in effect until revoked in writing and delivered to Advent Medical Group.**
- **I understand that I am responsible for the charges for services rendered.**

_____

Print patient's name

_____

Patient's/Insured/Authorized signature **Date**

AUTHORIZATION FOR TREATMENT

I authorized treatment for _____to be performed by a provider of Advent Medical Group.

Patient's or Authorized signature _____ Date: _____

SIGNATURE ON FILE
MEDICARE PATIENTS ONLY

Name of patient: _____ HIC#: _____

Medigap Insurer: _____ Policy#: _____

I request that the payment of authorized Medicare benefits be made either to me or on my behalf to a provider of Advent Medical Group for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

Patient's Signature: _____ Date: _____

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PATIENT INFORMATION FORM

PATIENT

This section refers to PATIENT ONLY (make corrections as necessary)

Name: Marital Status:

Address:

City, State, Zip:

Sex: DOB: Preferred Contact #:

Home Phone: Cell Phone:

SS#: Email:

Employer: Work Phone:

Race:

Ethnicity: Preferred Language:

Emergency Contact: Emergency Contact Phone:

RESPONSIBLE PARTY

Review/complete if person responsible for the bills is NOT the patient! (Must fill out if under age 18.)

Name:

Address:

City, State, Zip:

Sex: DOB: SS#:

Home Phone: Work Phone: Employer:

Spouse or Parent (if minor):

INSURANCE

Primary Carrier:	Secondary Carrier:
Insured:	Insured:
Patient relationship:	Patient relationship:
Insured ID #:	Insured ID #:
DOB:	DOB:
SSN:	SSN:
Group No.:	Group No.:
Insurance Address:	Insurance Address:
Copay $:	Copay $:

Our computer system gererates calls to remind you of your scheduled appointments. Do you wish to opt out of this service? ___Yes ___No

AUTHORIZATION

I hereby authorize release of information necessary for my insurance company to process my claim. The above information is correct to the best of my knowledge.

Signed: _____ Date: _____

I hereby authorize payment directly to my Provider any insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid in a timely manner by my insurance.

Signed: _____ Date: _____

Who are you scheduled to see today?_____

ADVENT Medical Group

Initial Visit Questionnaire

Patient Name:_____ **Date:** _____

Reason for today's visit:_____

_____

Are you currently, or have you recently experienced any of the following: (Please circle YES or NO)

- Depressed mood Y N
- Loss of interest Y N
- Feelings of helplessness or hopelessness Y N
- Irritability Y N
- Appetite problems Y N
- Weight loss or gain Y N
  - If so, how much have you gained/ lost? _____
- Sleep Problems Y N
- Sleeping more or less than usual Y N
  - If so, how many hours of sleep a night? _____
- Anxiety or agitation Y N
- Lack of energy Y N
- Concentration/ memory problems Y N
- Death wishes Y N
- Suicidal thoughts, intentions or plans Y N
- Thoughts of harming others Y N

- Racing thoughts Y N
- Excessive money spending Y N
- Increased alcohol use Y N
- Increased use of over-the-counter medications Y N
- Loss of sexual desire Y N

- Heard "voices"? Y N
- Seen "visions"? Y N
- Had feelings of paranoia, as if someone was watching you or is after you? Y N
- Had any unusual body experiences? Y N
- Had any unusual thoughts? Y N
- Has anyone every told you, "You aren't doing well."? Y N

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Review of Systems Questionnaire

Constitutional Symptoms

Fever	O No O Yes
Malaise	O No O Yes
Fatigue	O No O Yes
Headaches	O No O Yes
Recent weight change	O No O Yes
Sleep disturbance	O No O Yes
Lightheaded/dizziness	O No O Yes
Appetite changes	O No O Yes
Sedation	O No O Yes
Pain	O No O Yes

Allergies / Immunologic

Difficulty breathing	O No O Yes
Unusual sneezing	O No O Yes
Runny nose	O No O Yes
Itchy/teary eyes	O No O Yes
Allergic response to materials/food/animals	O No O Yes

Integumentary

Rash or itching	O No O Yes
Change in skin color	O No O Yes
Change in hair or nails	O No O Yes
Varicose veins	O No O Yes

Neurological

Convulsions or seizures	O No O Yes
Numbness or tingling Sensations	O No O Yes
Local weakness	O No O Yes
Head injury	O No O Yes
Tremors	O No O Yes

Eyes

Blurred vision	O No O Yes
Double vision	O No O Yes
Loss of vision	O No O Yes
Glaucoma	O No O Yes

Ear Nose Mouth and Throat

Tinnitus	O No O Yes
Hearing Loss	O No O Yes
Chronic sinus problem or rhinitis	O No O Yes
Sore throat or voice change	O No O Yes
Swollen glands in neck	O No O Yes

Gastrointestinal

Polyps	O No O Yes
Dysphagia	O No O Yes
Nausea	O No O Yes
Diarrhea	O No O Yes
Dyspepsia	O No O Yes
Constipation	O No O Yes
Abdominal pain	O No O Yes
Rectal bleeding or blood in stool	O No O Yes
Black tarry stools	O No O Yes
Stomach ulcers	O No O Yes

Musculoskeletal

Joint pain	O No O Yes
Muscle pain	O No O Yes
Back pain	O No O Yes
Difficulty in walking	O No O Yes

Hematologic/Lymphatic

Anemia	O No O Yes
Enlarged glands	O No O Yes
Bleeding or bruising tendency	O No O Yes
Slow healing after cuts	O No O Yes
Phlebitis	O No O Yes

Respiratory

Cough	O No O Yes
Difficulty breathing	O No O Yes
Wheezing	O No O Yes

Cardiovascular

Chest pain or pressure	O No O Yes
Heart murmur	O No O Yes
Swelling of legs or feet	O No O Yes
Arrhythmias	O No O Yes
Palpitations	O No O Yes
Shortness of breath	O No O Yes
High blood pressure	O No O Yes

Female Only

Date of last menstrual period_____

Currently pregnant	O No O Yes

Genitourinary

Frequent urination	O No O Yes
Burning or painful urination	O No O Yes
Incontinence	O No O Yes
Kidney stones	O No O Yes

Endocrine

Intolerance to heat or cold	O No O Yes
Excessive thirst or urination	O No O Yes
Dryness of skin	O No O Yes
Thyroid problem	O No O Yes
Glandular or hormone problem	O No O Yes

Pain Scale

Pain on scale of 0 - 10 _____

ADVENT Medical Group

REGISTRATION FORM

Name_____ **Date of Birth** _____

Preferred Pharmacy: Name_____

Address_____

Phone_____ Fax_____

Medications Prescribed by another physician / Over the Counter Medications: *use back of page if needed*

Medication_____ Dose_____ Directions_____

Medication_____ Dose_____ Directions_____

Medication_____ Dose_____ Directions_____

Medication_____ Dose_____ Directions_____

Medication_____ Dose_____ Directions_____

Medication Allergies: __No __Yes *please specify*_____

Primary Care Physician:_____

Therapist/Counselor:_____

Current Medical problems:

Past Medical History: *surgery or problems*

Family Psychiatric History: *Please circle all that apply*

Major Depression	Mother	Father	Brother	Sister
Bipolar Disorder	Mother	Father	Brother	Sister
Anxiety Disorder	Mother	Father	Brother	Sister
Attention Deficit Disorder	Mother	Father	Brother	Sister
Schizophrenia	Mother	Father	Brother	Sister

Social History: 16 years and above. *Please circle your response*

Current Living Arrangements	Alone	With others	Facility	Homeless
Marital Status	Single	Married	Separated	Divorced
	Widowed	Same sex partner		
Children	None	Living inside home		Living outside home
Support Systems	Family	Support group	Church	
Employment History	Full-time	Part-time	Disabled	Retired
Identified Stressors	Transportation	Family	Medical	Finances
	Work	Recent Death	Lifestyle changes	
Legal History	None	Past	Current	
History of Abuse	Yes	No		
Domestice Violence History	Yes	No		
Access to guns?	Yes	No		
Do you smoke?	No	Everyday	Occasional	Former
Do you drink Alcohol?	No	Everday	Occasional	Alcohol abuse
Do you use recreational drugs?	No	Currently	Past	

****

Social History: Below 16 years. *Please circle your response*

Lives with	Mom & Dad	Mom	Dad	Guardian	Other
Siblings	Yes	No			
Developmental Milestones	Reached	Not reached			
Education History	Homeschool	At grade level	Below grade level	Learning Disability	
Interests/Activities	Sports	Music	Reading	Church	
Identified Stressors	Medical Issues	Family conflict	School	Recent Death	Lifestyle changes
Legal History	None	Past	Current		
Does child smoke?	Yes	No			
Access to guns?	Yes	No			
Exposure to abuse and trauma?	Yes	No			
Exposure to violence?	Yes	No			
Exposure to substance abuse?	Yes	No			