

WELCOME TO CENTRAL OHIO PRIMARY CARE

Thank you for choosing the doctors of Dublin Internal Medicine. For your convenience we have enclosed your NEW PATIENT paperwork. Please fill out and bring with you the day of your appointment along with your insurance card (if any). You will find the back sheet is a request for medical records. Please fill out and send to your previous doctor.

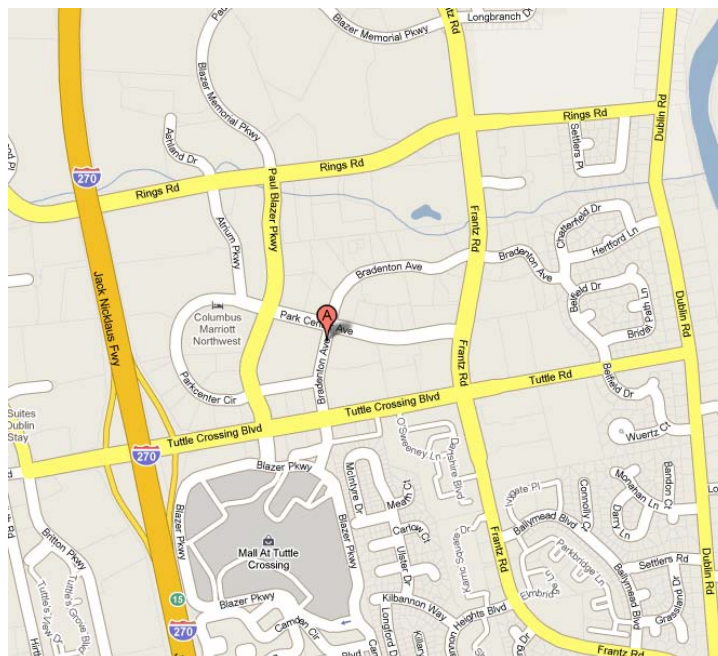
We ask that you arrive 15 minutes early so we can complete your paperwork and keep you on time for your appointment with the doctor. Attached, please find a copy of our billing policy. Should you have any questions, please call the office and we will be happy to assist you.

WE ARE LOCATED AT 5070 BRADENTON AVE. IN DUBLIN

From I-270 and Rt. 161: Head east on 161 toward Dublin to the first light, which is Frantz Road and turn right. Continue to Bradenton which is one block south of the concrete field of corn, make a right and we are on the right.

From I-270 and Tuttle Crossing: Head east towards the Mall to Bradenton Ave and turn left (there is a Boston Market on the corner). Go through the STOP sign and we will be the second drive on the left.

Again, thank you for choosing Dublin Internal Medicine. Please call us if you have any questions, comments, or concerns.





**5070 Bradenton Ave.
Dublin, Ohio 43017**
p: 614-764-1777
f: 614-764-9555
Elden A. Apling, M.D.
David D. Burnside, M.D.
Scott W. Johnson, M.D.
Susan Goodlive, M.D.

Billing Policy

In order to serve our patients to the best of our abilities, please note our billing policy as follows:

Payment is due at the time of service. For your convenience, we accept Visa, MasterCard and Discover as well as cash and personal checks.

If you are a member of a managed care insurance plan with which we are a provider, we will file your claim as long as we have a copy of your insurance card with the correct and updated information. For this reason, we require insurance cards at each visit. If you have a co-payment with your insurance, it is due at the time of service. This is a contractual obligation you have with your insurance company. Failure to pay co-pays at the time of service may affect your insurance coverage.

If we are not contracted with your insurance company, payment is due at the time of service. As a courtesy to our patients, we will file your claim with your insurance company as long as we have a current copy of your insurance card. If you have not received reimbursement from your insurance within thirty days, please contact your insurance company directly.

Dublin Internal Medicine does charge a \$25.00 fee for all missed appointments that are not cancelled within 24 hours notice. Fees will be charged for all paperwork and/or prescription requests made other than at the time of visit.

We realize that unusual circumstances arise which preclude immediate payment in full. In this event, please contact our Central Office at (614) 326-2672.



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PRIMARY CARE

Dublin
Internal Medicine

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Dear Patient:

On May 1, 2009, we began charging for the completion of various forms, letters and paperwork as well as prescription requests made other than at the time of your visit. This is necessary due to the time and expense involved in completing the volume of requests our providers must handle that are not reimbursed by insurance plans. A complete listing of the fee structure is available upon your request. These fees will be billed directly to you and will not be the responsibility of your insurance carrier.

To avoid the possible high costs, it will be in your best interest to request all of your medications at the time of your visits. You will need to make sure that you will have enough of your medication to last until your next office visit. In order to avoid fees for this service.

Sincerely,

Dublin Internal Medicine



**CENTRAL OHIO
PRIMARY CARE**

PATIENT INFORMATION Please print & complete the form and bring it to your appointment.				TODAY'S DATE	
Name	DOB:	Age:	Sex: M F	SS#	
Address:		Phone <i>primary</i> : ()		Phone <i>alternate</i> : ()	
City:	State:	Zip:		Cell # ()	
Employer:	Employer Address:		City:	State:	Ph: ()
Marital Status: S M D W		Spouse Name:		Spouse DOB:	Spouse SS #
Spouse Address if different		City:	State:	Zip:	Spouse Ph. ()

NEAREST RELATIVE (EMERGENCY CONTACT) OTHER THAN SPOUSE:

Name	Relationship:	Ph:			
Address:	City:	State:	Zip:		

Personal consent for care and treatment:

I authorize Dublin Internal Medicine and/or Central Ohio Primary Care Physicians to provide care and treatment under my physician's direction.

Patient Signature & Date

Witness (office staff) & Date

ALTERNATE CONSENT:

I hereby authorize Dublin Internal Medicine and/or Central Ohio Primary Care Physicians to provide care and treatment for _____, who is unable to give consent because he/she is a minor, is unable to comprehend, or is other wise unable to personally give consent at the time of treatment.

Relationship to patient Date alternate signature Witness (office staff)

INSURANCE INFORMATION:

In order for Central Ohio Primary Care Physicians to submit an accurate claim to your insurance company, please be prepared to present your insurance card (s) at each and every visit.

By signing below I acknowledge that I have been offered a copy of the privacy practices for COPC/Dublin Internal Medicine. Name: _____ Date: _____

I am aware that appointments not cancelled with 24 hours notice will result in a \$25.00 fee that will not be billed to insurance. Signed _____

Please present your insurance cards at every appointment. To submit a claim to your insurance company, we will need complete and accurate insurance information. Thank you.

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION

All other Insurance companies and/or third party payers: I hereby authorize Central Ohio Primary Care Physicians, Inc. and/or any of its representatives to submit a claim to my insurance carrier or its intermediaries to issue payment directly to Center Ohio Primary Care Physicians, Inc. and or physicians(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Medicare and Medicaid: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release it to the Social Security Administration, Medicare, Medicaid or its intermediaries or carriers any and all information for this or related Medicare of Medicaid claim. I authorize and request that payment be made directly to Central Ohio Primary Care Physicians, Inc. **Guarantee of Payment:** I UNDERSTAND that filing a claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by Central Ohio Primary Care Physicians, Inc to me or the patient as indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to claims filed for Worker's Compensation and/or claims due to personal injury, accidents or illnesses.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

PATIENT SIGNATURE: _____ **DATE:** _____

(If patient is 18 years or older, his/her signature is required, in addition to the "responsible party".

RESPONSIBLE PARTY: _____ **DATE:** _____

(if other than patient)

Name: _____

Medication allergies or reactions:

Medication	Reaction	Medication	Reaction
1.		3.	
2.		4.	

Family History:

Family Member	Age(s)	Living	Deceased	Diseases
Father				
Mother				
Brother (s) # _____				
Sisters (s) # _____				

Diseases in the family: Check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Addiction problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Details / Other _____ | | |

Social History:

Do you smoke? NO YES ___ packs per day for ___ years. Other tobacco products _____
Do you drink alcohol? NO YES Beer Wine Liquor. How many drinks per week? _____
How many servings of caffeine per day? _____ Coffee Tea Sodas
Any recreational drug use? NO YES Type _____
Occupation _____ Any known occupational exposures? _____
Do you exercise regularly? Yes No How many times per week? _____ Type of exercise _____

Preventative Care:

Last Colon and Rectal Cancer screening: Rectal exam Checking for blood Sigmoidoscopy
 Colonoscopy Barium Enema Date _____
Do you use your seatbelts / shoulder restraints? Yes No

Immunizations:

Immunizations:	Date	Immunizations:	Date
Tetanus		Hepatitis A	
Influenza		Hepatitis B	
Pneumonia			

For our Female Patients:

Last PAP test _____ Last mammogram _____ Do you do self-breast exams? Yes No
Menstrual or period problems: Irregular Heavy Change in frequency _____
Have you gone through menopause? Yes No
Number of pregnancies _____ Live births _____ Vaginal _____ C-section _____ Miscarriages _____
Can you think of anything else that you think we should know about your health and lifestyle that is not listed here?

Name: _____

Review of Systems (Symptom Review): Check all that apply:

Constitutional: Fever Chills Sweats Weight gain / Loss Fatigue Weakness
 Dizziness (room spinning)

Head: Headache Sores Sinus pressure or pain

Eyes: Blurred vision Double vision Eye pain "floaters"
 Excess tearing Irritation

Ears: Ear pain Decreased hearing Dizziness (light headed, room spinning) Ringing

Nose: Congestion Post nasal drip Difficulty breathing through nose Frequent nose bleeds

Throat: Sore throat Fullness or sensation of mass Difficulty swallowing

Neck: Neck pain Fullness or mass

Chest: Chest discomfort (pain, pressure, fullness squeezing) with exertion or exercise Heart pounding
 Heart racing Shortness of breath while lying down or with exertion (out of proportion to activity)
 "skipping beats"

GI: Nausea Vomiting Abdominal pain Excess belching
 Heartburn Cramps
 Diarrhea Constipation Blood in stool Change in frequency of stools

Genitourinary: Pain with urination Increased frequency of urination Getting up more than twice a night
 Blood in urine Sexual problems Difficulty with erections Vaginal pain
 Vaginal discharge

Musculoskeletal: Joint pains Muscle weakness Muscle pain Back pain

Skin: Rash Sores Moles that are changing Itching Dry skin
 Eczema

Neurological: Numbness Tingling Weakness Speech abnormalities
 Abnormal movements

Psychological: Anxiety Eating disorder Obsessive behavior Depression
 Mood swings Crying spells Lack of motivation Drug dependence
 Alcohol problems

In the last 2 weeks, have you felt down, depressed or hopeless? Yes NO

In the last 2 weeks, have you felt little interest or pleasure in doing things? Yes NO

Reviewed with patient on _____ Signature _____



Office Use Only: P#: _____

Dr. #: _____

ADULT REQUEST FOR CONFIDENTIAL COMMUNICATION

I hereby request to receive confidential communications from the practice in the following manner:

(Please Print)

Patient Name: _____ Middle Initial: _____ DOB: _____

Primary Physician: _____ **(Please Print)**

You may communicate my protected health information with the following:

(Please Print)

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

You may leave limited protected health information on a voicemail or answering machine of the names listed above (lab or test results, information about scheduling or prep for a test or procedure or information regarding follow up with a specialist)

Yes _____ No _____

Address where I would like my protected health information mailed to:

Street _____ Apt _____

City _____ State _____ Zip _____

Phone: _____

You may leave messages on voicemail or Answering Machine **Yes** _____ **No** _____

I understand COPC will notify me if COPC is unable to comply with my request. I also understand that my protected health information may be released as my physician determines appropriate in an emergency situation. I have been offered the office Notice of Privacy Practices for COPC **Yes** _____ **No** _____

Signature of patient/legal guardian: _____ Date: _____
(if over the age of 18/if under the age of 18)

(Please Print)

Name of person signing: _____ Relationship: _____

Office Use Only

Date received: _____ Entered into Mysis: _____ Entered into IC: _____

Initials: _____