Kevin Forsythe MD

HIPPAA Notification & Insurance DME Coverage Policy

(Last update 1/1/2017)

When you visit our office it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you have entrusted to us.

On April 14, 2003, new regulations became effective under a federal law called the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to establish national standards to:

Give patients more control over their health information; · Set boundaries for the use and release of health records; · Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information; · Hold violators accountable, with civil & criminal penalties; and · Try to balance need for individual privacy with requirement for public responsibility that requires disclosures to protect the public health.

The HIPAA rules require that we provide all of our patients that we see with a Notice of Privacy Practices. More information can be found at:
http://www.hhs.gov/ocr/privacy/hipaa/administrative/combined/index.html

Please sign below that we have given you the opportunity to review the privacy policy. You are entitled to a personal copy of the Notice at any time to review and keep for your records.

By signing below, you also understand that you will be responsible for any dispensed durable medical equipment (DME) charges that are not covered by your health insurance policy.

I acknowledge that I have received a copy of Kevin Forsythe, M.D., Inc. Notice of Privacy Practices, as well as DME financial responsibility, and have been given an opportunity to ask questions.

Patient Name:_____

Signature of Patient or Personal Representative (indicate relationship):

_____ **Date:**
_____

You may check the box below to indicate that you understand the above and do not wish to sign the form: ☐

Phone (805) 286-4416
Fax (888) 216-9538
1111 Las Tablas Road Suite R, Templeton CA 93465

Patient Information

Patient Birthdate: _____

Current Phone Number(s) for patient:

(W) _____ **(H)** _____ **(C)** _____

Marital Status

☐ **SINGLE** ☐ **MARRIED** ☐ **OTHER**

Do you smoke?

☐ **YES** ☐ **NO**

Primary Care Physician Name: _____

Primary Care Physician Address:

_____

City:_____ State:_____ Zip:_____

Social Security #: _____
(It is our office policy to have the patient's Social Security number on file as a patient identifier. If you have any questions please ask the front desk.)

Physical Address:

_____

City:_____ State:_____ Zip:_____

If physical address is different from mailing address, please indicate mailing address below:

_____

City:_____ State:_____ Zip:_____

Email Address: _____

Patient Employment Information:

Employer/Company Name: _____

Employee Title: _____

Phone: _____ Fax: _____

Employer/Company Address:_____

City:_____ State:_____ Zip:_____

Which local pharmacy do you prefer? (Please specify a street if there is more than one of that pharmacy – Example: Rite Aid on Spring St. or Rite Aid on Creston in Paso Robles)

_____

Emergency Contact:

Name: _____ Phone Number:_____

Guarantor Information (If the insurance for the patient is under a spouse or parent, please fill in the following for our records.)

Relationship to patient: _____

Guarantor's Full Name: _____

Date of Birth: _____

Social Security Number: _____

Phone Number: _____

Address:_____

City:_____ State:_____ Zip:_____

Insurance Information:

Primary:

Provider: _____

ID Number: _____ Group #: _____

Secondary:

Provider: _____

ID Number: _____ Group #: _____

Tertiary:

Provider: _____

ID Number: _____ Group #: _____

Kevin Forsythe MD
Orthopedic Surgery & Sports Medicine
1111 Las Tablas Road. Suite R, Templeton, CA 93465
Phone: (805) 286-4416
Fax: 888-216-9538
E-mail: docforsythe@icloud.com

Narcotic Policy:

(Please check or initial each paragraph as you read it)

---I understand that narcotic medications come with serious side effects, including but not limited to: **Addiction,** increased tolerance, **hyperalgesia,** constipation, sexual side effects, dizziness, nausea, vomiting, impaired judgment, short term memory loss and inability to drive or operate machinery. I understand that driving under the influence of narcotics can lead to car accidents and arrest for DUI.

---I understand, and agree to the fact, that Kevin Forsythe, M.D., Inc. is not a pain management clinic and does not prescribe narcotics on an ongoing basis.

---It is *my job* as a patient to schedule myself an appointment *before* running out of medications. There are *no* evening or weekend refills of pain medications.

---I understand that narcotics are to be taken exactly as prescribed and only on an as needed basis. I will not take them more frequently than prescribed, nor will I combine them with other medications without expressed consent from the provider or pharmacist.

---I understand that carrying pills or a prescription for narcotics is a large responsibility. If anything happens to my prescription or pills, including but not limited to theft, loss or damage, I will under no circumstances be written a replacement script.

---I will not fill a narcotic prescription from another physician while receiving pain medication from Dr. Forsythe. I will only fill my prescriptions at one pharmacy. I give permission to Dr. Forsythe's office to inquire with federal/state/local agencies about my narcotic prescription history

---I understand that Doctor Forsythe's office has 24 to 48 hours to fill a prescription refill request. If a refill is requested on a Friday, I understand that it will not be filled until the following Monday.

---I understand that violations of the above terms will result in my discharge from the clinic.

Patient Name (Printed): _____

Patient Signature: _____

Kevin Forsythe MD
Orthopedic Surgery & Sports Medicine

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Effective January 1st 2017

Dear patients:

Our doctor is extremely busy with scheduled appointments and surgeries that are booked weeks in advance. Recently we have experienced a high volume of patients who are not cancelling in a timely manner. If we have a cancellation on the doctor's schedule, we like to offer the time slot to patients on our waiting lists. Without timely notice of cancellation, we are unable to do this.

We have requested that all patients contact our office when they are unable to keep an appointment or surgery date. We understand that emergencies happen, however, we would appreciate **24 to 48 hours notice for appointments** and **2 to 3 weeks notice for surgery**.

Fees:

There will be a **$25.00** fee for any paperwork that needs to be filled out or filed by Doctor Forsythe and his staff. This fee will be paid up front when paper work is dropped off or called in to be filed online. Please be sure to have all necessary information available with your forms before dropping them by or calling them in.

If an appointment is missed or not cancelled in a timely manner it is our policy to charge a **$25.00** fee.

If a surgery is missed or not cancelled in a timely manner, depending on the circumstances, our policy may be to charge a **$500.00** fee.

It is our goal to provide quality care for all our patients. We greatly appreciate your help in maintaining that level of care by respecting the policies our office has put into affect.

Thank you!
Sincerely,
Dr. Kevin Forsythe M.D. Inc.

Patient Name:_____

Patient Signature:_____

Date:_____