PRINCETON SPORTS & FAMILY MEDICINE

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# Returning Patient Forms

## Welcome and Thank You for Choosing Princeton Sports and Family Medicine!

Before your appointment, we ask that you **fill and sign the following forms** attached in this packet, along with sending us the other mentioned items:

- ☐ Patient Demographics
- ☐ HIPAA and Patient Authorization
- ☐ Copy of the front and back of your insurance card
- ☐ Copy of your driver's license or other valid photo ID (in color)

**Other important things to do before coming to your appointment:**

☐ Review our Patient Information/ Policy webpage

☐ Go to your patient portal

- You will have to agree to the patient consent form. This will automatically pop up when you enter your portal for the first time.
- On the dashboard, you will see any upcoming appointments, current medications, lab results, billing statements, and medical records.
- On the left side of the screen will be options.
    - To update your demographics, send portal messages to your provider, request medication refills and appointments, and review your medical records

☐ Save our phone number (609-896-9190) in the event that we need to reach you

**Please send these completed forms to psfmed@gmail.com and include the patient's name, appointment time, and appointment date in the subject line.**

PRINCETON SPORTS & FAMILY MEDICINE

# 2024 PATIENT DEMOGRAPHICS

**Name** _____ **MI** _____ ☐ Female ☐ Male

**Mailing Address** _____ **Apt** _____

**City** _____ **State** _____ **Zip** _____

**Home Phone (_____)** _____ - _____ **Cell Phone (_____)** _____ - _____

**DOB** ____/_____/_____ **SS#** _____-____-_____ **E-Mail** _____

**Primary Care Physician** _____ **PCP Phone # (___)** ____ - _____

**Employer** _____ ☐ Full ☐ Part ☐ Self ☐ Retired ☐ Unemployed ☐ Active Military

**Student** ☐ Full ☐ Part ☐ N/A **School** _____

**Race** ☐ African American ☐ American Indian ☐ Asian ☐ White ☐ Decline to Specify

**Ethnicity** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Language** ☐ English ☐ Other _____

**Emergency Contact** _____ **Relation** _____ **Phone # (____)** _____-_____

## INSURANCE INFORMATION

**Primary Insurance** _____ **ID Number** _____

**Subscriber Name** _____ **Subscriber DOB** ___/___/_____ **Relation** _____

**Insurance Address** _____ **City** _____ **State** _____ **ZIP** _____

**Secondary Insurance** _____ **ID Number** _____

**Subscriber Name** _____ **Subscriber DOB** ___/___/_____ **Relation** _____

**Insurance Address** _____ **City** _____ **State** _____ **ZIP** _____

_____ _____/_____/_____

**PATIENT/PARENT/GUARDIAN SIGNATURE** **DATE**

# 2024 HIPAA PATIENT PRIVACY FORM

THIS IS TO NOTIFY **PRINCETON SPORTS & FAMILY MEDICINE, PC** THAT I AM RESTRICTING THE RELEASE OF MY PROTECTED HEALTH INFORMATION. **NO** INFORMATION MAY BE RELEASED WITHOUT MY EXPRESS WRITTEN CONSENT AS INDICATED BELOW.

I HEREBY GIVE PERMISSION TO **PRINCETON SPORTS & FAMILY MEDICINE, PC** TO DISCUSS ANY MEDICAL MATTERS WITH THE FOLLOWING PERSON(S):

**NAME** **RELATIONSHIP**

_____

_____

_____

I authorize Princeton Sports & Family Medicine, PC to contact me in the following manner:

☐ Home Phone (____) _____
☐ Work Phone (____) _____
☐ Cell Phone (____) _____

☐ OK to leave a detailed voicemail
☐ OK to mail my home address
☐ Leave VM with callback number only

I would like to receive my appointment reminders in the following manner:

☐ VOICE ☐ TEXT ☐ EMAIL

BY SIGNING THIS FORM, I ACKNOWLEDGE AND UNDERSTAND THAT I CAN REVOKE THIS PERMISSION AT ANY TIME BY SUBMITTING A SIGNED STATEMENT, AND THAT PERMISSION WILL REMAIN IN EFFECT UNLESS WE RECEIVE A REVOCATION IN WRITING.

PATIENT NAME: _____ DOB: ___/____/____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: ___/____/____

**PLEASE *FLIP OVER* TO REVIEW OFFICE POLICIES!**

# PATIENT AUTHORIZATION

- I grant consent to all healthcare providers of **Princeton Sports and Family Medicine, PC.** to evaluate and treat.
- I consent to release to my insurance company any information required, including the diagnosis and records in the course of my exam and treatment.
- I understand that outside Healthcare and Educational Institutes may be participating in my treatment and care.
- I understand that all forms, letters, or paperwork filled out by a provider will be charged **$10.00 per form**. Where multiple forms are necessary the charge will be **$25.00** for all paperwork related to that incident. Please allow **7-10 business days** for all forms. Payment is due when forms are submitted.
- **CANCELLATION | NO SHOW POLICY:** We understand that there are times when you must miss your scheduled appointment due to emergencies or obligations for work or family. However, when you do not call to cancel your appointment, you may be preventing another patient from getting much needed treatment.
    - We require **at least 24 hours advance notice** to cancel or reschedule your appointment. **If your appointment is NOT CANCELLED at least 24 hours in advance, you will be charged a fee of $50.00.** This fee will NOT be covered by your insurance company.
- **INCOMING REFERRAL POLICY:** If your insurance requires a referral to see one of our specialist physicians, and we **DO NOT** have the referral, you will **NOT** be seen.
- **OUTGOING REFERRAL POLICY:** If your insurance requires a referral for specialist, labs, or images, we require a **72-hour notice** to submit your referral.
- **UNPAID BALANCES POLICY:** Any unpaid balances may be sent to payment agencies for collection.
- **RETURNED CHECK POLICY:** If your check is returned by your financial institution, you will be responsible for a **$40** return check fee.

PATIENT NAME: _____ DOB: ____/_____/_____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: ____/_____/_____

# PREVENTATIVE HEALTH QUESTIONNAIRE

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

Little interested or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

**Have you had a flu shot this year?** ☐Yes ☐ No

If yes, where? _____ when? _____

**Have you ever had a mammogram?** ☐ Yes ☐ No

If yes, where? _____ when? _____

**Have you ever had a colonoscopy?** ☐ Yes ☐ No

If yes, where? _____ when? _____

**Did you know it is recommended you exercise at least 150 minutes per week?**
**How often do you exercise?**

_____ times per weeks

**Name:** _____ **DOB** _____/_____/_____