TriHealth
Physician Partners

John J. Nolan, MD
Mary M. Rivera, MD
Robert C. Dennis, MD
Jennifer A. Fenton, CFNP

Dear _____ Today's Date_____

Welcome to Reading Family Practice. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

We will do our best to provide you with same-day office visits for all sick visits. You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your current insurance card, your appointment will need to be rescheduled. You will be asked to fill out certain forms annually so we may keep your information updated.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to reschedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all of your prescription and over-the-counter medications with you at each visit.
Our office policy for a missed appointment is:

- If it is an appointment for a new patient, the appointment will not be rescheduled;
- Three (3) no-show appointments will result in dismissal from the practice.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will be given ample refills for 30 or 90 days at a time during your office visit.

Reading Family Practice
9400 Reading Road
Cincinnati, OH 45215
Main 513 563 6934
Fax 513 769 2622
TriHealth.com

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a. When you are down to a 30 day supply of medication, we ask that you call and schedule your follow-up office visit in order to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.

2. For the safety and well-being of our patients,

   a. Requests for new medications will not be taken over the phone or through MyChart during office hours without an appointment and evaluation by the physician.

   b. No new medications will be called in over the phone after office hours by the on-call physician.

   c. We understand that unexpected situations arise, thus a small refill of a chronic medication will be granted for one or two days after office hours on an as-needed basis determined by the on-call physician. This allows patients to be seen and evaluated by the physician during office hours for all their medication refills.

Reading Family Practice is affiliated with TriHealth Hospitals. There are 3 physicians in our office on the medical staff at Bethesda North and Evendale Hospitals and they all work with the many specialty physicians there. We will be directing our patients to use TriHealth's laboratory services and imaging resources. Our electronic medical record allows us to receive patient results quickly and efficiently through our direct link with TriHealth services. This is an important resource in meeting our goal of providing high quality care in a timely manner.

Welcome to our practice and thank you for choosing Reading Family Practice for your health care needs.

Sincerely,

TriHealth Physician Partners
READING FAMILY PRACTICE
Adam Grisak, MD (*accepting New Patients*)

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TriHealth Physician Practices
READING FAMILY PRACTICE
Office Policy

Revised 2017

$10.00 Charge on Unpaid Copay's

It is the Policy of Reading Family Practice and is your Agreement with your chosen insurance company to collect any copay that is due on the Date of Service. Therefore, any Copay unpaid on the Date of Service will be charged a $10.00 processing fee.

24 Hour Cancellation Notice

Any appointment not canceled within 24 hours prior to the scheduled appointment time may be billed a $25.00 Charge.

Late Arrivals

Due to the Electronic Health Records process of gathering patient information, co-payments, etc. at the front desk and the rooming process for the Medical Assistants your appointment time given is the time you should be available to see the physician. Patients should always arrive at least 10-15 minutes prior to the appointment time given. If you arrive 15 minutes later than the time of your arrival expectancy of your scheduled appointment you will be asked to reschedule your appointment and may be charged $25.

Uninsured Patients and Those with High Deductibles

Reading Family Practice may discount your office visits by 25% with full payment on the same day of your visit.

Notice of Termination due to NO SHOW

After 3 missed scheduled appointments without appropriate notification to Reading Family Practice termination may result. This applies to an individual account.

Notice of Termination by Physician's /Provider's

Provider's and/or Management reserve the right to terminate any patient at any anytime. Patients suspected of drug abuse shall be terminated. Rudeness, Foul Language, or Abuse in any form will not be tolerated towards Physicians, Providers, Management and Staff.

TriHealth

READING FAMILY PRACTICE

Authorization for the Release of Protected Health Information (PHI)

Healthcare Provider/Organization Information Today's Date ___ /____ / 20____

Mail / Fax Request To:

_____ _____

Name of *Healthcare Provider / Organization* (Please Print) Phone # of *Provider / Organization*

_____

Street Address *City* *State* *Zip*

AUTHORIZED BY,

Patient Information _____ ___/____ /_____

Name of Patient (Please Print) *Date of Birth*

_____ _____

Street Address *Patient's Phone #*

_____

City *State* *Zip*

Protected Health Information (PHI)

This authorization shall include release of my complete medical and history records retained by the above named Healthcare Provider / Organization.

TO RELEASE PHI TO: **READING FAMILY PRACTICE**
9400 READING ROAD
CINCINNATI, OH 45215

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Expiration Date:

This authorization will expire in (60) sixty days from the above date, or sooner by my choice, shall be valid until the following date(s) _____.

I have reviewed this authorization in its entirety and understand the content included herein. By signing this authorization, I am confirming that it accurately reflects my wishes.

***Signature* of Patient:** _____ **Date:** ___ /____/_____

If Patient is a minor
Parent/Guardian: _____ _____

Print Name *Signature* Parent/Guardian

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*_____ □ M □ F **DOB:**_____

Marital status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed

Previous or referring doctor: _____ **Date of last physical exam:** _____

PERSONAL HEALTH HISTORY

Childhood illness: □ Measles □ Mumps □ Rubella □ Chickenpox □ Rheumatic Fever □ Polio

Immunizations and dates:	□ Tetanus	□ Pneumonia
	□ Hepatitis	□ Chickenpox
	□ Influenza	□ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

TriHealth

INVOLVEMENT IN CARE

Patient's Name _____ Date of Birth ____ / ____ / _____

Last Four Digits of Social Security # _____ _____ _____ _____

I agree that any TriHealth Affiliated Physician Practice ("Healthcare Provider") where I am a patient may disclose my protected health information ("PHI") at any time to the following individual(s) who are involved in my care:

Name _____ Name _____

Phone # _____ Phone # _____

Relationship to Patient _____ *Relationship* to Patient _____

☐ **I DO NOT** wish to specify any individuals with whom my Healthcare Provider may share my PHI.

I acknowledge the following statements: The individual(s) named above are involved in my healthcare or its payment; All of my PHI is relevant to the specified individual(s) for my care or payment; and I agree that my Healthcare Provider may disclose my PHI to the individual(s) specified above.

I understand that disclosure of my PHI will include information on drug or alcohol treatment, abuse or conditions, and/or psychiatric or psychological conditions or treatment, and/or HIV related conditions, if any and agree to release of this information.

I understand that if at any time I no longer want Healthcare Provider to communicate with the individual(s) specified above, I will immediately notify them in writing by sending a letter to my Healthcare Provider's office.

I understand that Healthcare Provider may verify the identity of the individual(s) named above prior to disclosing any of my PHI. I also understand and agree that nothing in this request for involvement is intended to limit or alter Healthcare Provider's ability to disclose PHI to individuals not listed on this form in accordance with professional judgment and applicable law.

CONTACT INFORMATION FOR PHONE CALLS

Preferred contact number: □ Home □ Cell □ Work #_____

Check your preferences below:

You may leave PHI on my answering machine/voice mail: □Yes □No

_____ ____ / ____ / 20____

Patient / Guardian/Parent Signature Date

FOR GUARDIANS OR PARENTS OF MINORS ONLY

May we fax your child(ren)'s personal health information **(such as shot records or required medical information)** to his/her school or day care facility, **when requested**.

□Yes □No Fax number (*if known*) (____) _____