Dr. Molly B. Trostle DO
Internal Medicine Inc.

881 Hills Plaza Drive Suite 530 Ebensburg, PA 15931-4220 814-419-8084

PATIENT INFORMATION									
FIRST NAME		MI		LAST NAME					
ADDRESS									
ADDRESS									
CITY									
STATE		ZIP							
PHONE NUMBERS	HOME ( )	CELL ( )		WORK ( )					
DATE OF BIRTH		SEX		FEMALE		MALE			
MARITAL STATUS CHECK ONE		MARRIED		SINGLE		DIVORCED			
SOCIAL SECURITY #		EMPLOYER							
EMERGENCY CONTACT									
NAME		RELATIONSHIP		PHONE#					

EMAIL ADDRESS	

RACE (Please check)		ETHNICITY (Please check)		LANGUAGE (Please check)	
	American Indian or Alaskan Native		Hispanic or Latin American		English
	Asian		Not Hispanic or Latin American		Other (Please specify)
	Native Hawaiian or Pacific Islander		Refused to Report		
	Black or African American				
	White				
	Hispanic				
	Other Race				

We will contact our patients regarding appointments, scheduling, billing and/or payment questions, results of tests and much more. In addition, unforeseeable emergencies do sometimes arise when it may be necessary for the physician or staff to contact you. It is our office policy to leave a message at your home or cell if you are not available, or we may contact you at work if an emergency arises. Please specify where we may contact you or leave messages for you.

		Leave a message?	Text message?	Email?	Preferred order of contact.
HOME PHONE #	( ) -	Y or N			1 2 3 4
CELL PHONE #	( ) -	Y or N	Y or N		1 2 3 4
WORK PHONE #	( ) -	Y or N			1 2 3 4
EMAIL ADDRESS				Y or N	1 2 3 4

PHARMACY	NAME	LOCATION
LOCAL		
LOCAL		
MAIL ORDER PHARMACY		

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PATIENT NAME	DOB

By law we are required to get a signature to obtain your past prescription history. Signing below will give us the right to obtain that history.

Signature:_____ Date: _____ Witness: _____

INSURANCE			
PRIMARY INSURANCE CARRIER			
ID#		GROUP #	
SUBSCRIBER NAME		DATE OF BIRTH	
SECONDARY INSURANCE CARRIER			
ID#		GROUP#	
SUBSCRIBER NAME		DATE OF BIRTH	
SELF PAY-Please check ☐			

I understand that I will be held financially responsible for all charges resulting from services provided. I authorize direct payment of medical benefits from my insurance company. In addition, I authorize the release of any medical information necessary for the processing of these claims for payment including facsimile transmission of information. In accordance with the notices of privacy practices, I authorize the use and disclosure of any medical information with a third party to coordinate or manage my healthcare or any related services

Patient Signature _____ Date_____

Signature of Authorized Person
(If minor or POA exists)_____Relationship _____

This office adheres to strict policies with regard to release of confidential information. Please understand that our policy is not to disclose your personal health information to other parties, except for those directly involved in your care, without your written consent or as permitted by law. For this reason, please list any person(s) to which we are authorized to discuss and disclose your personal information to.

NAME	PHONE#	RELATIONSHIP

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular diagnosis/disease. Any such limitations must be disclosed below in writing. I understand that by leaving this section blank I am creating no limitations of disclosure.

LIMITATIONS	

Signature _____Printed Name _____ Date of Birth _____

Signature of Authorized Person
(If minor or POA exists)_____Relationship _____

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PAYMENT RESPONSIBILITY AGREEMENT

I, the guarantor, understand that I am fully responsible for all fees payable to Dr. Molly B. Trostle, D.O. Internal Medicine, Inc. for any medical care rendered by the physician or staff members to me or the patient for whom I am financially responsible. I permit the office of Dr. Molly B. Trostle Internal Medicine, Inc. to bill my insurance for services rendered.

COPAYS, DEDUCTIBLES AND COINSURANCE

I am aware that my co-pay must be paid the day of my visit. I understand it is my responsibility to know the requirements of my health insurance plan(s). By signing this agreement, I acknowledge that I am fully aware of my co-pays, deductibles and coinsurance. I acknowledge that the physician's office will bill me for balances due and that I am fully responsible for all balances billed to me. Payment may be made with cash, personal check or credit card. I understand that there will be a $40.00 fee for all checks returned for insufficient funds.

NONCOVERED SERVICES

I understand that this office may provide me with services that may not be covered by my insurance company. In the event that I require these services, I am aware that I am fully responsible for payment. This includes, but is not limited to, telephone encounters involving diagnosis and treatment and the cost for completing forms and/or sending records to a third party.

LEGAL, MOTOR VEHICLE or WORKER'S COMPENSATION CASES

I understand that if I am involved in any of these cases, I must present all relevant documentation before my appointment. I must also present my personal health insurance card. In the event that services are denied under my case, my personal insurance will be billed. If all of the appropriate information is not presented prior to my appointment, I understand and agree that all unpaid balances become my responsibility.

OUTSTANDING BALANCES AND COLLECTIONS

I understand that no further appointments will be scheduled until a payment plan has been set up or my balance has been paid in full. I understand and acknowledge that the physician's office can submit my unpaid balance due over 121 days old to a collection agency and notify the credit bureau.

APPOINTMENTS

I understand that there will be no charge for rescheduled appointments provided a 24 hour notice is given. I understand that I will be assessed a $75.00 charge if a 24 hour notice is not given or if I have missed my appointment. In the event that I have missed 2 appointments, I understand that I may be dismissed from the practice.

DIAGNOSTIC TESTING

Due to the ever changing regulations and policies in health care, the increasing burden of paperwork, and the exponential increase in confusion as a result of progressive implementation of computers in health care, we are no longer able to review diagnostic testing results with patients via phone.

Please schedule a follow up appointment to review the results of any testing that you have had done. Having a follow up appointment will ensure that all testing that you have had done is received, reviewed and addressed appropriately.

Health care has become an overwhelming entity with many opportunities for error. Our goal is to minimize and hopefully eliminate any errors in your health care.

Your understanding and cooperation in helping us to achieve our goal is greatly appreciated.

PRESCRIPTIONS

When calling in for prescription refills, you must give all prescription information for your script to be called in. This eliminates errors and assures accuracy of the prescriptions called in. The prescription information needed to call in a prescription is:

- Your name
- Medication name
- Dosage
- Frequency
- Day supply (30 days, 90 days)
- Pharmacy name and location (if appropriate)

GENERAL CONSENT FOR TREATMENT

I consent to treatment and care by Molly B. Trostle, DO Internal Medicine, Inc., and by the physicians and healthcare providers. I understand that my treatment and care may include routine care, immunizations, injections and a variety of other medical services depending on my condition. I am aware that the practice of medicine is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

My signature below acknowledges that I understand and agree to all policies as indicated above. This agreement will be effective for the calendar year indicated; however, this consent will not expire for services or claims processing for visits occurring while this consent was in effect.

_____

PATIENT NAME (Please Print) DATE: _____

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_____
PATIENT SIGNATURE (or Authorized Representative) RELATIONSHIP, if not patient: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that you information remains private.
If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	
Contact Person	Chris
Phone Number	814-419-8084

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRCTICES**. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in any way."

_____
Patient or Representative Name (please print)

_____ _____
Patient or Representative Signature Date

O Patient refused to sign
O Patient was unable to sign because _____