Manzer Family Medicine
3071 S Grand Ave.
Carthage, MO 64836

Patient Information:

Please Print Legibly:

Patient Name: _____ **Date of Birth:** _____

Address/City/State/Zip Code: _____

Home Phone: _____ **Mobile:** _____ **Work:** _____

Marital Status: _____ **Social Security #:** ___-___-____ **Email Address:** _____

Current Work Status(circle one): Full Time/Part Time/ Self-Employed/ Retired/ Unemployed

Previous Primary Physician: _____ **Location:** _____ **Phone:** _____

Primary Pharmacy: _____ **Location:** _____ **Phone:** _____

Employer Name: _____ **Occupation:** _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Authorization:

I _____ **authorize *Manzer Family Medicine* to perform treatments on me as appropriate for my condition.**

Patient Signature: _____ **Date:** _____

Relationship to patient: _____

Insurance Information:

If you are covered under the policy of a spouse, partner, or legal guardian, please tell us about them:

Subscriber/Policy Holder: _____

Date of Birth: __/___/_____ **Social Security #:** ___-____-____ **Relationship:**_____

Address/ City/ State/ Zip code: _____

Phone number: _____ **Work Phone:** _____

Email Address: _____ **Employer:** _____

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Patient Medical History:

Circle the conditions you have now or have had in the past:

Anemia	Chest Pain/ Angina	Difficulty Walking	Peripheral Vasc. Disease
Asthma	Colostomy	Herniated Disc	Sciatica
Back/Neck Injuries	Congestive Heart Failure	High Blood Pressure	Scoliosis
Balance problems	COPD	HIV/AIDS	Sleep Apnea
Cancer	Diabetes	Parkinson's Disease	Stroke/TIA

Other Medical Conditions:

_____

_____

Surgeries (please include dates):

_____

_____

Medication Allergies:

_____

_____

Current Medications:

_____

_____

Family History:

_____

_____

_____

Social History:

Tobacco use: Yes or No if so, how many packs a day: _____

Alcohol use: Yes or No if so, how many drinks a day: _____

Drug use: Yes or No if so, describe: _____

Exercise: Yes or No, if so, describe

Sexually Active: Yes or No

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Office / Appointment Policies

Cancellation of an Appointment:

Our goal is to provider quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to to better utilize availabl appointments for our patients in need of medical care.

If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. To cancel appointments, please call 417-310-9286. If you do not reach the receptionist you may leave a detailed message on the voicemail. If you would like to reschedule, please be sure to leave s your name, date of birth, phone number, and the best time to return your call.

No-Show Policy:

Please be advised we a have a No Show policy, if you miss more than 3 appointments without calling our office in advance we have the right to dismiss you as a patient.

Information / Insurance Changes:

It is your responsibility to notify our office of any changes to your account (address, phone number,insurance coverage).

_____	_____	_____
Date	Signature	Printed Name

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Authorizations

Insurance Assignment & Release:

I certify that I have insurance coverage with _____

And assign directly to Dr. Jonathan Manzer, M.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am finacially responsible for all charges wheter or not paid by insurance submissions.

The above named doctor may use my health care information and disclose such information to the above names Insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare/Medigap Authorization:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to Dr. Jonathan Manzer, M.D. for any services furnished to me by that provider.

HIPAA (Health Insurance Portability & Accountability Act):

I acknowledge that on this day I have received and read the Notice of Privacy Brochure given to me.

_____ _____

Signature Date

_____ _____

Printed Name Relationship

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Notice of Privacy Practices

Patient Acknowledgment

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in details the uses and disclosures of my protected health information that may be made by this practice, my indiviual rights, how I may excercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____ **Date:** _____

Relationship to patient (if signed by a personal representative of patient): _____

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I, _____ do hereby authorize and request
(Name ofindividual, guardian, legal or personal representative)

that _____ release or disclose to
(Name of Entity, Agency, Individual Holding the Records)

_____ the health information specified
(Name of Entity, Agency, Individual or Class intended to receive the information)

below that relates to the following individual:

Name	Date of Birth	Social Security Number
Address, City, State		Other ID

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

__ Entire Record __ Medical History, Examination, Diagnosis __ Prescriptions

__ Treatment /Tests __ Hospital Records Including Reports __ X-ray Reports

__ Lab Reports __ Immunizations/ Allergy Records __ Healthcare Payments

__ Mental Health Records/Reports __ Other (Specify): _____

INCLUDE INFORMATION WITHIN THE FOLLOWING DATE(S): _____

This authorization is good until the date(s) _____, or for one year.

PURPOSE OF REQUEST FOR DISCLOSURE:
__ At the request of the individual or the individual's legal representative
__ Other (Specify): _____

I understand the potential for PHI to be disclosed by the recipient and is no longer protected. I understand that I may revoke this authorization at any time by delivering a written revocation to Manzer Family Medicine, LLC. I understand that I may refuse to sign this form. If I do not sign this form, my health care or payment for health care will not be affected. If i revoke this authortization, it will have no effect on actions already taken in reliance of this form. I authorize the use or disclosure of the records/information described. I have read and understand this form. I have received a copy of this form. I am the patient listed or I am authorized to "Act on behalf" of the patient as the patient's personal representative.

_____ _____
Signature Printed Name

_____ _____
Relationship Date

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HIPAA Release Form

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:	Relationship:	Phone Number:
_____	_____	_____
Name:	Relationship:	Phone Number:
_____	_____	_____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

[ ] A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

[ ] B. **Disclose** my health record, as above, but do **NOT** disclose the following (check as appropriate):

- [ ] Mental health records
- [ ] Communicable diseases (including HIV and AIDS)
- [ ] Alcohol/drug abuse treatment
- [ ] Other (please specify): _____
  _____

Form of Disclosure:

[ ] An electronic record (Email or Fax)

Email: _____@_____.com **OR**

Fax: _____-_____-_____

[ ] Hard copy

This authorization shall be effective until (Check one):

[ ] All past, present, and future periods, OR

[ ] Date or event: _____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Messages

Please call:	[ ] Home	[ ] Work	[ ] Cell
Number:	_____	_____	_____

If unable to reach me, you may:

- [ ] Leave a detailed message
- [ ] Leave a message for a return call
- [ ] _____

The best time of day to reach me is between _____ to _____

_____ _____
Name of the Individual Giving this Authorization Date of birth

_____ _____
Signature of the Individual Giving this Authorization Date