Mark Swetz, M.D., P.C.
Family Practice

3065 Southwestern Blvd.
Orchard Park, NY, 14127
Phone: 716.674.1414
Fax: 716.674.1473

PATIENT INFORMATION SHEET

Patient's Name: _____ Date of Birth: _____

Address: _____ Gender: MALE / FEMALE

City, State, Zip: _____ SSN: _____

PHONE NUMBER: Home: _____ Work: _____ Cell: _____

BLACK WHITE ASIAN PACIFIC ISLANDER

Ethnicity: HISPANIC / NON-HISPANIC Race: NATIVE AMERICAN/ESKIMO OTHER

Preferred Language: _____ Do you require assistance due to a visual impairment? _____

Do you require an interpreter due to a hearing/speech impairment or limited English proficiency? _____

Marital Status: (Circle one) Never Married MARRIED DIVORCED WIDOWED

Parent(If under 18) OR Legal Guardian/Power of Attorney: _____

Address: _____

PHONE NUMBER: Home: _____ Work: _____ Cell _____

Employer's Name: _____ Occupation: _____

Employers Address: _____ Employer's Phone: _____

PHARMACY: _____ Phone Number: _____

Address/Town: _____

E-MAIL ADDRESS: _____

PRIMARY INSURANCE: _____

ID #: _____ Group #: _____

SUBSCRIBER'S NAME: _____ Date Of Birth:

SSN: _____ Relationship to Patient: _____

Employer's Name: _____

SECONDARY INSURANCE: _____

ID #: _____ Group #: _____

SUBSCRIBER'S NAME: _____ Date of Birth: _____

SSN: _____ Relationship to Patient: _____

Employer's Name:

Do you have a: (Please circle if yes) HEALTH CARE PROXY LIVING WILL ORGAN DONATION

If yes, please bring in the completed and signed form to the office.

Mark Swetz, M.D., P.C.
Family Practice

3065 Southwestern Blvd.
Orchard Park, NY, 14127
Phone: 716.674.1414
Fax: 716.674.1473

HIPAA CONTRACT

In case of emergency, who should we contact?

Name: _____

Relationship to Patient: _____

Phone Number: HOME: _____ WORK: _____ CELL: _____

I permit Mark E. Swetz, M.D., his nurses and other personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my care:

Please list ***ALL*** family members/friends and state the person's relationship to the patient:

_____

_____

_____

_____

_____

If more room is needed, please use the back of this form.

Release of information under this document is *limited* to **verbal discussions** with my Health Care Provider and his personnel. This document does *not* permit the **release** of any **written health information** to the individuals named above. Please be aware that reports needed by other health care facilities or insurance companies for my care may be released at the doctor's discretion.

IF AT ANY TIME I DO NOT WANT VERBAL DISCUSSIONS TO BE PERMITTED BETWEEN MY HEALTH CARE PROVIDER AND ANY OF THE INDIVIDUALS NAMED ABOVE, I MUST NOTIFY MY HEATH CARE PROVIDER BY CONTACTING HIS OFFICE ***IN WRITING***.

PATIENT'S INFORMATION:

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Is it OK to leave a **GENERAL MESSAGE** on:			Is it OK to leave **MEDICAL INFORMATION** on:		
	YES	***NO***		***YES***	***NO***
Answering Machine			Answering Machine		
Cell Phone			Cell Phone		
Office Voice Mail			Office Voice Mail		
With Another Person			With Another Person		
Sent Through Mail			Sent Through Mail		
Sent via E-mail			Sent via E-mail		

Mark E. Swetz MD, PC
Family Practice

3065 Southwestern Blvd.
Orchard Park, NY, 14127
Phone: 716.674.1414
Fax: 716.674.1473

OFFICE POLICY

•Please familiarize yourself with our office policies. If you have any questions please call during office hours or feel free to speak with the office staff. Office visits are by ***appointment only*** and may vary according to the holidays or the doctor's vacation schedule.

•Because the appointment time has been especially reserved for you, we do request that you give us **AT LEAST 24 hours** notice of a cancelled appointment. If you should fail to show for your appointment with no phone call, a fee of $25 will be charged in this situation. **THESE CHARGES ARE NOT COVERED BY YOUR INSURANCE AND ARE DUE AND MUST BE PAID PRIOR TO ANY FURTHER APPOINTMENTS.**

•There is a $10 fee for **all** forms that need to be filled out by the office. This includes but is not limited to Disability forms, school physical forms, as well as any other forms that may be 3 pages or less. More complex forms may be charged up to $25, depending on the length and time involved in completing the form.

•The situation may occur where you need to be referred to an outside physician or facility for additional medical care. Due to numerous changes in benefits with many major insurance companies, I am advising ALL patients to contact their personal insurance company BEFORE seeing any outside physician or scheduling an appointment with any outside facility (including lab work & x-rays). Our office will make every effort to work with you, however, it is ultimately the responsibility of the patient to find out which physicians and/or facilities are considered "in-network" with their specific insurance company and if a referral or prior-authorization is needed. Our office will not be responsible for any charges or fees that you may acquire from an outside physician or facility.

•If your minor child (under 18) is coming into the office by themselves or with someone other than the parent/guardian they will need to provide a written release signed by a parent/guardian before we may treat the child.

INSURANCE POLICY

•Co-pays are to be paid at the time of your appointment, per your insurance contract. If they are not paid at the time of service, there will be a $10 billing fee added to the co-pay amount.

•I hereby assign all medical benefits to include major benefits to which I am entitled, including Medicare, private insurance and any other plan. I understand that it is my responsibility to name Dr. Mark Swetz as my primary care physician (PCP) with my insurance company to ensure benefits. This assignment will remain in effect until revoked by me, in writing. A photocopy of this assignment is to be considered valid as the original.

•I hereby authorize my physician to perform any medical treatment deemed necessary.

•I hereby authorize said assignee to release all information requested by said insurance company.

•I hereby authorize my physician to release my personal medical information to consulting physicians.

•I understand that I am financially responsible for all charges whether or not paid by said insurance company. I understand that it is my responsibility to provide updated and accurate insurance information as well as my original insurance card(s) to Dr. Mark Swetz's office at every visit.

I have read and understand the policies listed above.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Mark E. Swetz MD, PC
Family Practice

3065 Southwestern Blvd.
Orchard Park, NY, 14127
Phone: 716.674.1414
Fax: 716.674.1473

FINANCIAL & INSURANCE AGREEMENT

We would like you to review your financial and medical insurance responsibility for our services. Our office works very hard to avoid any insurance or billing problems. We would like you to read the following agreement to understand your responsibility to AVOID financial disputes:

- I understand that the office of Mark E. Swetz, M.D., DOES NOT BILL NEW YORK STATE MEDICAID
- If I lose my medical insurance during anytime of services provided to me by the office of Mark E. Swetz, M.D., I will notify the office of any and all insurance changes. It is MY responsibility to make certain that my new insurance carrier accepts and participates with Mark E. Swetz, M.D. If I do not obtain "other" insurance, I am personally responsible for the financial charges.
- If I receive a bill from Mark E. Swetz, M.D., and the medical insurance billing is incorrect or needs to be resubmitted, I must notify the office within 15 days from the bills date. Any unpaid balance after 90 days from the time of service will be my responsible to paid.
- If I have a Medicaid funded HMO but fail to recertify for the HMO portion and have Medicaid only, I will be responsible for all unpaid bills.

Patient Signature: _____

Date of Financial Agreement: _____ Witness: _____

Mark E. Swetz MD, PC
Family Practice

3065 Southwestern Blvd.
Orchard Park, NY, 14127
Phone 716.674.1414
Fax: 716.674.1473

If your Health Insurance has a deductible you WILL be required you pay a deposit toward services at the time of your office visit. If you are unable to make a payment, your appointment will be re-scheduled and you will be charged a $25.00 service fee.

Patient Signature: _____

Date: _____ Witness: _____

Mark E. Swetz MD, PC
Family Practice

3065 Southwestern Blvd.
Orchard Park, NY, 14127
Phone: 716.674.1414
Fax: 716.674.1473

PATIENT NAME: _____

Do you find it difficult to meet daily needs of food, housing and transportation? **YES / NO**

Barriers to Health: Check any or all that apply to you

None..... ☐

Difficulty affording transportation..... ☐
Difficulty accessing transportation..... ☐
Homelessness..... ☐
Limited access to nutritious food..... ☐
Uncertain access to nutritious food..... ☐
Unsafe housing quality..... ☐
Other (please explain)..... ☐
_____
_____
_____

Do you find it difficult to interact with others? **YES / NO**

Do you have an adequate social life? **YES / NO**

Barriers to social function: Check any or all that apply to you

None..... ☐

Absence of social engagement..... ☐
Anxiety/ Depression..... ☐
Declining health/ cognition..... ☐
Inability to maintain an adequate social life..... ☐
Isolation..... ☐
Lack of family network..... ☐
Lack of friend network..... ☐
Other (please explain)..... ☐
_____
_____
_____

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Permission for use granted by Richard Brown, MD.