WVUMedicine
CAMDEN CLARK MEDICAL CENTER

Thank you for choosing

Camden Clark Physician Corporation

for you healthcare needs.

Kindly arrive thirty minutes

early for your appointment

with your completed paperwork, bring

your insurance card(s), co-pay, photo ID and

all of your prescribed medications

in their bottles.

NOTICE TO SELF-PAY PATIENTS: you will need to pay $50.00 on the day of service and you will be billed the remainder of the balance.

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CAMDEN CLARK
PHYSICIAN CORPORATION

Dear Patient:

Welcome to Camden Clark Physician Corporation. We are glad that you have chosen our practice for your healthcare. In order to familiarize you with how our office works, we are providing this information which we hope you will find helpful.

OUR PRACTICE

Our practice is part of a large group of physicians, Camden Clark Physician Corporation, which is comprised of about 40 physicians and covers multiple specialties.

APPOINTMENTS

In order to serve you most effectively, we see patients by appointment only. Appointments can be scheduled by calling 304-865-5140. If you find that you are unable to keep your scheduled appointment, please call at least 24 hours in advance so that we may make that time available for someone else. You may be subject to a fee should you no show up for your appointment or fail to notify us in advance as stated above.

We recognize that your time is valuable, and we will make every effort to keep to our schedule. Unfortunately, the nature of our specialty is such that emergencies and complex visits arise during office hours, so delays may occur. We appreciate your patience and understanding.

OUR COMMITMENT

Our practice is committed to providing quality healthcare. During your first visit, we will address your medical history and make a plan to address any needed screening tests and disease prevention efforts. At each visit, you will receive a summary that will help you keep track of what was addressed during your visit. The summary will also contain our agreed upon plan of care.
Please be aware:

- Due to the alarming rate of narcotic pain medication abuse/dependence, Camden Clark Primary Care will not prescribe any narcotics or benzodiazepines, such as Vicodin, Hydrocodone, Percocet, Morphine, Xanax, Ativan, Adderall, Klonopin, etc. We will refer these patients in need of use of controlled substances to a pain specialist for further evaluation / treatment.
- Any aggressive behavior or misconduct towards the staff will not be tolerated and is grounds for dismissal from the practice.
- Your compliance with your treatment plan is essential to ensure a productive and continuing doctor-patient relationship.
- Any complicated psychological issues will be referred to a psychiatrist for further evaluation.

TELEPHONE CALLS

Please call during our regular office hours regarding your care or lab results. For prescription refills, please call your pharmacy. Please understand that we are unable to refill medications or provide lab results after office hours. Also, please remember that we cannot refill medications if it has been more than one year since your last annual exam.

EMERGENCY AND HOSPITAL ADMISSIONS

If you need medical attention and it is after hours, please go to the nearest ER. If you are admitted to Camden Clark Medical Center, your inpatient care will be managed by physicians specialized in hospital care. The hospitalist physicians at Camden Clark Medical Center are part of the Camden Clark Physician Corporation and are our partners. We will receive a summary of your inpatient care that will assist in your continued care after leaving the hospital.

Thank you for entrusting us with your healthcare.

Sincerely,

_____ _____

Patient Signature Date

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Patient Information

Name:	Marital Status:
Address One:	Patient Number:
Address Two:	Date of Birth:
City:	Social Security #:
State: Zip:	Sex:
Home Phone #:	Employer:
Cell Phone #	Emergency Contact:
If Retired, Previous Employer:	__ May discuss my medical condition with emergency contact
Referred by:	Emergency Phone #:
Email Address:	Emergency Relationship:
Referred By:	Primary Care Doctor:
Email Address:	Race:
Ethnicity ___Hispanic or Latino ___Not Hispanic or Latino	Language:

Guarantor Information

Name:	Date of Birth:
Address One:	Social Security Number:
Address Two:	Custom Info:
City:	Employer:
State: Zip:	Employer Address:
Home Phone #:	Employer City:
Work Phone #:	Employer State: Zip:
Cell Phone #:	Is Guarantor a Patient Here?

Insurance Information

Primary Insurance:	Secondary Insurance:
Certificate #	Certificate #:
Group Number:	Group Number:
Group Name:	Group Name:
Copay Amount:	Copay Amount:
Subscriber Name:	Subscriber Name:
Subscriber 1 Date of Birth:	Subscriber 2 Date of Birth:

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to me or to my Provider at Camden Clark Physician Corporation when assigned is accepted. I realize that I am responsible for non-covered services, deductibles, and copays, and that it is my responsibility to obtain information from my health plan about service coverage. If I seek coverage outside my Insurance Benefits Contract, I realize I may be responsible for all charges incurred. Acknowledgement of Receipt of NOTICE OF PRIVACY PRACTICES: I have received the Notice of Privacy Practices for Protected Health Information and understand that my protected health information may be used by the practice as described in this notice.

Pharmacy: _____Address:_____

Preferred Method of Contact: ___Home ___Cell ___Work

(Please initial) _____Yes, I authorize for messages to be left on my answering machine.

Please list names and relationships of family and/or friends that we may talk to regarding your medical condition.

_____ _____ _____

_____ _____ _____

Authorization to Release Medical Information: I hereby authorize my Provider at Camden Clark Physician Corporation to release any information necessary for my course of treatment. I also authorize the release of any of my medical records to my Provider at Camden Clark Physician Corporation.

_____ _____

Signed (Patient or Parent if minor) Date

A photocopy of this release with my signature on it may be used as an original unless marked otherwise.

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Medical History Information

Name: _____ Date of Birth: _____

Reason for today's visit: _____

Past Medical History: (Please list any medical issues/diagnosis such as Cancer (type), Diabetes, High Blood Pressure, High Cholesterol, Thyroid Problems, Alzheimer's, etc.)

_____

_____

_____

_____

Allergies (Drug, Food or Contact) _____

Immunizations (List last date or year)

Pneumonia: _____

Tetanus Booster: _____

Influenza: _____

Shingles: _____

Hepatitis A/B: _____

TDap (Tetnus, Diptheria and Pertusis): _____

Family History: (Please list any medical issues/diagnosis such as; Cancer (type), Diabetes, High Blood Pressure, High Cholesterol, Thyroid, Alzheimer's, etc.)

Mother: _____

Father: _____

Sister: _____

Brother: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

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Medical History Information

Social History

Tobacco Use (Past/Present) YES: _____ NO: _____ Packs per day: _____ Date Quit: _____

Type: _____

Alcohol Use (Past/Present) YES: _____ NO: _____ Drinks per day: _____ Type: _____

How long? _____

Status: Married_____ Single _____ Divorced _____ Widowed _____ Life Partner _____

Number of Children: _____

Work Status/Profession: _____ Retired _____ Disabled _____

Do you wear seatbelts? YES: _____ NO: _____

Current Medications: (Please include over the counter, vitamins, and supplements)

Name of Medication	Strength	How Many Time a Day

Preferred Pharmacy (Name, Street Address, and Phone Number)
Local: _____
Mail In: _____

Signature: _____ Date: _____

Past Surgical History (Please write in the date. If you are unsure of the exact date, please write in the year. Examples: Gallbladder, Tonsils, Joint Replacements, Biopsies, Cataracts, Mole Removal, Oral Surgeries, etc.)

_____

_____

_____

_____

Diagnostic Studies

Cardiovascular Stress Test: _____

Chest X-Ray: _____

Coronary Angiogram: _____

EKG: _____

Endoscopy: _____

Carotid Ultrasound: _____

Other: _____

Health Maintenance: (List last date of any below and results if known)

Bone Density: _____

Mammogram: _____

Pap Smear: _____

Colonoscopy: _____

Testicular Exam: _____

Rectal Exam: _____

Eye Exam: _____

Glaucoma Screening: _____

Dental Exam: _____

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Please check any symptoms that may apply to your CURRENT health:

GENERAL	**RESPIRATORY**	**MUSCULOSKELETAL**
Appetite loss	Coughing up blood	Back pain
Weight gain	Low exercise tolerance	Joint swelling
Obesity	Wheezing	Muscle cramps
Weight loss	Shortness of breath	Muscle pain/weakness
Chills	Cough	Swelling of extremities
Fatigue	Snoring	Decreased range of motion
Fever	COPD	Joint pain
SKIN	**CARDIOVASCULAR**	**NEUROLOGY**
Bruising	Chest pain	Aura
Dryness	Hypertension	Decreased memory
Sweating	Palpitations	Difficulty speaking
Hair growth	Low blood pressure	Dizziness
Hair loss	Swelling	Fainting
Hives		Headaches
Itching	**NECK**	Numbness
Nail changes	Neck mass	Seizures
Sores/lesions	Neck pain	Stroke
Rash	Neck stiffness	Tremor
Skin color changes	Swollen glands	Unsteadiness
		Weakness
EAR, NOSE & THROAT	**GASTRONINTESTINAL**	**PSYCHIATRY**
Headache	Abdominal mass	Frequent crying
Head injury	Abdominal pain	Difficulty sleeping
Blurred vision	Black/tarry stools	Mania
Eye pain	Bloating	Anxiety
Eye redness	Change in bowel habits	Delusions
Hearing loss	Constipation	Depression
Ear infection	Diarrhea	Fearful
Ear pain	Difficulty swallowing	Inability to concentrate
Ear ringing	Food intolerance	Mood changes
Runny nose	Gas	Panic attacks
Nose bleeds	Heartburn	Suicidal thoughts or plans
Frequent colds	Indigestion	**ENDOCRINE**
Nasal congestion	Hemorrhoids	Cold intolerance
Seasonal allergies	Nausea	Excess thirst
Sinus pain	Rectal bleeding	Heat intolerance
Mouth sores	Vomiting	Thyroid problems
Sore throat	Vomiting blood	Hot flashes
HEMATOLOGY	**GENITOURINARY**	**GENITOURINARY**
Abnormal bleeding	Urinary hesitancy	Vaginal discharge
Easy bruising	Incontinence	Blood in urine
Frequent nose bleeds	Painful intercourse	Urinary frequency
Blood clot in past	Painful urination	Missed periods
Bleeding disorder	Pelvic pain	Urination at night
	urinary	

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My Request is to be contacted in the following manner
(Please check ALL that apply)

Home Telephone: _____

_____My approval to leave a message with detailed information

_____Leave a message with a call back number ONLY

Work Telephone: _____

_____My approval to leave a message with detailed information

_____Leave a message with a call back number only

Written Communication

_____Approval to mail to my home address

_____Approval to mail to my work/office address

_____Approval to fax to the following number

Please list name and relation of persons we are allowed to release medical information to. If no one is authorized, please write N/A below

Names Authorized on Account:

_____

_____

_____

Patient Signature _____ Date _____

Patient Name _____ DOB _____

NOTICE OF PRIVACY PRACTICES

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different way that we use and disclose health information. For each category of uses or disclosures we elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

FOR PAYMENT: We may use and disclose medical information about you so that the treatment and services you receive at our practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example: We may disclose your records to an insurance company so that we can get paid for treating you.

FOR TREATEMENT: We may use medical information about to you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or hospital. For example: We may disclose medical information about you to people outside of the practice who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

FOR HEALTH CARE OPERATORS: We may use and disclose medical information about you for health care operations. These uses are disclosures are necessary to run our practice and to make sure that all patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example: We may review your records to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE: This notice describes our practices' policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as we do all employees, staff, and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of care and the service you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or your personal doctor. The law requires us to: make sure that the medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected health care information include: appointment reminders; as required by law, for health-related benefits and services; to individuals involved in your care or payment for your care; to avert serious threat to health safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for, coroners, medical examiners, and funeral directors; health oversight activities; inmates; law enforcement; lawsuits, and disputes; military and veterans; national security and intelligence activities; organ and tissue donations; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

RIGHT TO AN ACCOUNTING OF DISCLOSURE: You have a right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. To request this listing or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

RIGHT TO AMEND: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

RIGHT TO INSPECT AND COPY: You have the right to inspect and copy medical information that may be used to make decision about your care. We may deny your request to inspect or copy in certain very limited circumstances.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment of health care operation purposes. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We will post a copy of the current notice in our practice.
COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Resources. To file a complaint with our practice, contact our Privacy Officer. All complaints must be submitted in writing. YOU WILL NOT BE PENALIZED IN ANY WAY FOR FILING A COMPLAINT.
OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you make revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I ACKNOWLEDGE BY SIGNING BELOW THAT I HAVE READ AND RECEIVED THE NOTICE OF PRIVACY PRACTICES AND NOTICE OF INDIVIDUAL RIGHTS.

_____

Patient or Patient's Personal Representative Date