ELIZABETH L. BROWN, MD
4607 MacCorkle Ave SW, Suite 200
South Charleston, WV 25309
Phone# (304) 414-2140 Fax# (304) 250-9941

PATIENT WELCOME PACKET

Welcome to the office of Elizabeth Lantz Brown, MD! Our office is very patient friendly and committed to providing the highest quality and up to date medical care. Dr. Brown is Board Certified in Internal Medicine and sees patients ages 14 and over. Our staff is here to ensure that you receive the best care in a compassionate and efficient manner. In order to better serve all of our patients, we have established a few office guidelines. We urge you to take time to read the information that follows and keep a copy for your future reference.

Office Hours: Monday – Thursday: 8:30am-4:00pm
Friday: 8:30am-3:00 pm

Location: 4607 MacCorkle Ave SW, Suite 200
South Charleston, WV 25309

Phone: 304-414-2140

Fax: 304-250-9941

Appointments: Office visits are by appointment only. Routine and acute care visits are usually 15 minutes in length. Gynecologic exams, preventative exams and special procedure visits are scheduled separately and are typically 30 minutes. New patient appointments are also 30 minutes. We ask that new patients arrive 15 minutes prior to their scheduled visit. It is important for all patients to bring a valid photo identification and current copy of your insurance card for billing purposes. Also be prepared to pay any fees required by the insurance company (e.g. Copay), at the time of service. Every effort will be made to be punctual and to see you at your scheduled time. Please understand that emergencies do arise and may occasionally cause a brief delay. In order to ensure that your visit and those of all patients occur in a timely fashion, please arrive promptly for your visit, otherwise you may be asked to reschedule.

Cancellations/No Shows: Should the need to cancel your scheduled appointment arise, we request at least 24 hours notice, if at all possible. This permits us to reschedule you at your convenience and may allow another patient to fill your appointment time. While we understand that emergencies do arise, please be advised that you may be charged a $25.00 fee for each missed appointment for which timely notice has not been given. Multiple missed appointments for any reason may result in discharge from the practice.

Sick/Acute Care Visits: Whenever possible, every effort will be made to see sick patients as quickly as possible. Often, an appointment can be arranged for the same or the following day. In order to facilitate this process, we ask that you call the office in advance, so we can allot a time for you. Walk-in patients are not guaranteed an appointment, and are highly discouraged. True emergencies should proceed immediately to the nearest Emergency Room for timely evaluation and treatment.

Worker's Compensation and Auto Accident Visits: It is the policy of this office not to treat patients for worker's compensation claims or automobile accidents. We recommend that you go to the nearest Emergency Room or Med Express for these incidents.

After Hours Care: If you require emergent care after the office is closed, Dr. Brown may be contacted through our 24-hour answering service. Please note that this service is for emergencies ONLY, and should be respected as such. Routine prescription refills should be requested during regular business hours ONLY.

Prescription Refills: Please allow yourself adequate time to inform the office of any need for prescription refills. It is advisable to call at least one week prior to the end of your medication supply, to ensure that you do not run out of medicine. Mail Order Pharmacies WILL NOT be called by our office. We will fax these prescriptions or give the prescription to the patient to be mailed. Refills will be called in by phone if adequate notice is given TO LOCAL PHARMACIES ONLY, and can be expected at the pharmacy after 5:00pm. Narcotic medications are an exception: You will be asked to come to the office to pick up any narcotic prescription and sign a written contract with the physician for such controlled substances.

Sample Medications: At times, samples of medication may be given to you to take home. However, please do not rely on samples as your mainstay of treatment or to expect a guaranteed supply of samples at each visit.

Outside Medical Care: While we understand that at times, it may be convenient to obtain medical care from an outside source (VA Hospital, Health Right, etc.), it makes it difficult for us to ensure the best and most consistent treatment for you. Please be advised that if you choose to visit another primary care facility intermittently, you may be discharged from the practice. Visits to specialist physicians, including Gynecology for women or Urology for men, are not included in this policy. However, we request that all test results and any medication changes made by these physicians be forwarded to us to become part of your record.

Testing: Dr. Brown may order laboratory testing, X-Rays, or other special tests as part of your evaluation or treatment. Urinalysis, pregnancy testing and rapid strep testing are performed on site at our office. For all other testing, you will be provided with an order to take to the lab or your choice. Any tests requiring scheduling will be done by our office staff and you will be notified of your appointment time. Our policy is to notify patients by email of all normal result labs/tests to your patient portal. You will be contacted direct with abnormal results. If for any reason, you do not receive a result within one week of your test, please call the office to inquire as to its status.

Hospital Admissions: Should the need arise for you to be admitted to the hospital, one of our hospitalist physicians will oversee your care. These are board certified physicians whose practices are limited to hospital medicine, and are available for 24 hour care during your stay. They will provide timely feedback to Dr. Brown as to your status and any changes made to your existing medications. Outpatient follow-up will be arranged with Dr. Brown at the time of your discharge.

Special Forms/Paperwork: Any paperwork related to your medical condition should be presented at the time of your appointment. Please allow one week for completion of these forms, and note that there is a charge per form. Exceptions are for visits specifically scheduled to complete paperwork, such as exams for school physicals, sports participation, occupational requirements, etc. Please note: this office does not complete forms for Disability Determination. These forms should be directed to an independent medical examiner.

Privacy Policy: In accordance with HIPPA regulations, all care and medical records pertaining to a patient are personal and confidential. Prior to your initial visit, you will be asked to complete a series of

papers regarding your privacy and access to records. No information may be disclosed to anyone other than the patient without express written permission of the patient.

Medical Records: Our office maintains a system of Electronic Medical Records (EMR). This is the most up-to-date system, which allows us to most efficiently keep track of all your medical information. As a patient, you may obtain access to your medical records at any time. However, we request at least 7 business days to obtain copies of the information for you. If referral to a specialist is made, we may send the pertinent medical information to that physician so he or she may serve you better.

Conduct: Our office maintains the highest standard of excellence regarding the conduct of our physicians and staff. Likewise, we expect our patients to behave appropriately and maintain good personal hygiene. Any acts of physical, mental, verbal or sexual misconduct will not be tolerated and may be grounds for termination from the practice, as well as any appropriate legal action.

Termination From The Practice: We hope to maintain excellent relationships with all of our patients. However, circumstances occasionally arise which necessitate termination of care. These events include, but are not limited to: any acts of physical, mental, verbal, or sexual misconduct, falsification of medical information or prescriptions, failing to keep three or more office visits or referral appointments, use of foul-language, or breach of contracts agreed upon by you and your physician. As a patient, you are likewise entitled to terminate your care at any time for any reason. Should such an occasion arise, the office will be available to you for 30 days for emergency services as you attempt to locate another physician.

Non-Discrimination Policy: All patients are treated equally, without regard to race, sex, religion, political affiliation, sexual orientation, or creed. Our office policy is that all patients, physicians, and staff be respectful of others and refrain from actions or commentary reflective of any such personal bias.

We welcome you to our office and expect to develop a meaningful and healthy relationship, which will last for many years to come.

Sincerely,

Dr. Elizabeth L. Brown

Registration Form

Elizabeth L. Brown, MD, PLLC

Patient Information:

Patient name: (Last) ____________________ (First) ____________________(MI)_____

Address: __________________________ Phone# (home): ___________________

__________________________________ Phone# (cell): _____________________

Gender: __________ Marital Status: __________

Date of Birth: __________ Social Security Number: ________________________

Email Address: ____

Employer Name: ____

Employer Telephone Number: ____

Emergency Contact Person: ____

Relation to Emergency Contact: _____________________ Phone#:________________

You will find a copy of our Privacy Policy located on both our website and posted in our office waiting area. This notice describes how your medical information may be used and disclosed, and how you can maintain access to your own information. If you have any questions, please ask the receptionist or you may request to speak with the Nursing Supervisor directly. A copy of our Privacy Policy will be made available to you upon request.

I authorize that I have read and reviewed the Privacy Policy for Elizabeth L. Brown, MD, PLLC, and have been offered a copy for my personal record.

Name: (print) ________________________ Date: ________________

Signature: ____

Insurance Information

Patient name: ________________________________ Date of birth: ____________

Who is your primary health insurance provider? ___________________________________

ID#: ___________________________ **Policy Holder Information**:

Group# ________________________ Name: _______________________________

Effective Date: __________________ Date of birth: _________________________

Phone# ________________________ Social Security#: ______________________

Who is your secondary health insurance provider? ___________________________

ID#: ___________________________ **Policy Holder Information**:

Group# ________________________ Name: _______________________________

Effective Date: __________________ Date of birth: _________________________

Phone# ________________________ Social Security#: ______________________

It is necessary for our office to verify your insurance eligibility before your appointment to determine your co-payments, deductibles, and other out of pocket expenses. We will strictly abide by your contract with your insurance carrier by collecting all patient responsibilities at the time of service. For questions about your insurance contract, you may contact your plan administrator.

I authorize the office of Elizabeth L. Brown, MD, PLLC to contact my insurance carrier to verify my eligibility, co-payments, deductibles, and other out of pocket expenses.

Name: (print) ______________________________ Date: _________________

Signature: ____

Authorizations

Patient name: ____________________________________ Date of birth: _____________

How may we contact you? _____Phone _____Email _____**Both**

Primary Phone#: ______________________ ___Home ___Work ___ Cell

Secondary Phone#: ___________________ ___Home ___Work ___Cell

Is it ok leave a detailed message at the numbers you've provided? ___Yes ___No

Who do you give us permission to talk to about your health care in the event that you are unavailable?

1) Name: ______________________________ Relationship:_________________

   Phone#: _____________________________

2) Name: ______________________________ Relationship: ________________

   Phone#: _____________________________

3) Name: _______________________________ Relationship: ________________

   Phone#: _____________________________

THIS AUTHORIZATION IS VALID FOR ONE (1) YEAR

Patient Signature: ______________________________________ Date: ____________

Witness Signature: _____________________________________ Date: ____________

** Should you choose to void this agreement, you must do so in writing directly to Elizabeth Hanna RN, BSN, Nursing Supervisor. **

Initial History & Physical

Patient name: ______________________________________ Date of birth: __________

Reason for visit: ____

____

Social History:

Tobacco Use: ________ Alcohol Use ________ Recreational Drug Use: __________

Immunization History: Please provide date.

______ Pneumonia _______ Influenza _______ Tetanus _______ PPD

_______ Hepatitis _______ Other

Surgical History:

____________________________________ Date: ___________ Doctor: _________________

____________________________________ Date: ___________ Doctor: _________________

____________________________________ Date: ___________ Doctor: _________________

____________________________________ Date: ___________ Doctor: _________________

Medication Allergies:

____ Reaction: _________________________

____ Reaction: _________________________

____ Reaction: _________________________

____ Reaction: _________________________

Review of Systems

Patient name: ______________________________________ Date of birth: ___________

Personal History of Illness: Please check all that apply.

__ Asthma
__ Liver Disease
__ Heart Murmur
__ Diabetes
__ Genital Disease
__ Arthritis
__ Heart Disease
__ Pneumonia
__ Lung Disease
__ Thyroid Disease
__ Migraine
__ Gonorrhea
__ Kidney Disease
__ Bursitis
__ High Blood Pressure
__ Cancer:_____________

__ Other: ____

Please check if you have experienced the following:

__Decreased Hearing
__Ringing in Ears
__Ear Infections
__Dizzy Spells
__Fainting Spells
__Eye Pain
__Headache
__Double/Blur Vision
__Nose Bleeds
__Sore Throat
__Hoarseness
__Sinus Trouble
__Hay Fever
__Bronchitis
__Urgency to Urinate
__Moodiness
__Suicidal Thoughts
__Phobias
__Irregular Pulse
__Leg Pain (walking)
__Varicose Veins
__Cold Numb Feet
__Loss of Appetite
__Difficulty Swallowing
__Heartburn
__Persistent Nausea
__Abdominal Pain
__Jaundice/Hepatitis
__Diarrhea
__Constipation
__Bloody Stools
__Hemorrhoids
__Difficulty Concentrating
__Urination Problems
__Overactive Bladder
__Nervousness
__Agitation
__Chest Pain
__High Blood Pressure
__Swollen Ankles
__Urine Infections
__Weight Loss-Recurrent
__Weight Gain-Recurrent
__Anemia
__Blood Transfusion
__Fatigue
__Tremor/Shaking
__Numbness/Tingling
__Back Pain
__Gout
__Rashes
__Hives
__Psoriasis
__Eczema
__Sleeping Difficulty
__Depression
__Hernia
__Wheezing
__Shortness of Breath
__Painful Urination
__Stress Incontinence
__Mental Illness
__Exercise
__Acupuncture
__Hair Loss
__Bruise Easily

Date of most recent:

Colonoscopy: ________ Lipid Profile: ________ Bone Density Test: ________

Females: Please list most recent date.

PAP: ________ Normal: ________ Abnormal: ________ Doctor: ________
Mammogram: ________ Normal: ________ Abnormal: ________
Physical Exam: ________ Doctor: ____________________________________

Males:
Problem with starting stream: ________ Bumps or nodule in groin: ________
Pain in scrotal region: ________ Problems with erections: ________
Last testicular exam: ________ Last prostate exam: ________ PSA: ________
Physical Exam: ________ Doctor: ____________________________________

Current Medical Problems:

1) ____

How long: ____
Symptoms: ____
Treatment: ____
Medication: ____
Specialist: ____

2) ____

How long: ____
Symptoms: ____
Treatment: ____
Medication: ____
Specialist: ____

3) ____

How long: ____
Symptoms: ____
Treatment: ____
Medication: ____
Specialist: ____

4) ____

How long: ____
Symptoms: ____
Treatment: ____
Medication: ____
Specialist: ____

Medication List

Patient name: ____________________________________ Date of birth: _____________

Medication:

Name: _________________________________ Dosage: _____________________________

How Often: _____________________________ Next Refill Due: ______________________

Medication:

Name: _________________________________ Dosage: _____________________________

How Often: _____________________________ Next Refill Due: ______________________

Medication:

Name: _________________________________ Dosage: _____________________________

How Often: _____________________________ Next Refill Due: ______________________

Medication:

Name: _________________________________ Dosage: _____________________________

How Often: _____________________________ Next Refill Due: ______________________

Medication:

Name: _________________________________ Dosage: _____________________________

How Often: _____________________________ Next Refill Due: ______________________

Medication:

Name: _________________________________ Dosage: _____________________________

How Often: _____________________________ Next Refill Due: ______________________

Please continue on the back if this page if you need additional room to complete your medication list

Family History

Patient name: ______________________________________ Date of birth: ____________

	MOTHER	FATHER	SIBLINGS	CHILDREN	MATERNAL GRANDPARENTS	PATERNAL GRANDPARENTS
CANCER						
HYPERTENSION						
HEART DISEASE						
STROKE						
OSTEOPOROSIS						
KIDNEY DISEASE						
ARTHRITIS						
MENTAL ILLNESS						
TUBERCULOSIS						
MIGRAINE						
OTHER						

What other important information should we know about your family history?

____

____

____

____

____

Authorization for Use & Disclosure of Protected Health Information

Elizabeth L. Brown, MD, PLLC
4607 MacCorkle Ave SW, Suite 200, South Charleston, WV 25309
Phone# (304) 414-2140 Fax# (304) 250-9941

Patient name: ___________________________________ Date of birth: _____________

Address: ____ SSN: _________________

Telephone#: __________________________

Information to be released (covering the periods of health care indicated):

Beginning Date: ______________________ Ending Date: _______________________

____Entire Medical Record ____Other (specify): _____________________________

Previous Primary Care Physician or Treatment Facility:

Name: ___________________________________ Phone#: _____________________

Address: ____

Signature: _______________________________________ Date: _____________________
Relationship to Patient: _____Self _____Parent/Guardian _____MPOA _____Other

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Drug and or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Record Release

~ I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing and/or other sensitive information, I agree to its release.
~ I understand that if my medical or billing record contains information in reference to HIV/AIDS testing and/or treatment, I agree to its release.
(I understand that not fully disclosing my medical record for reasons of privacy or to avoid embarrassment may impede my physician's ability to appropriately treat my health problems. The Physician is hereby released from any legal action, responsibility and/or liability of actions that have a negative effect as a direct result of withholding pertinent health information)

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Facility Privacy Officer, Jamie N. Frazier-Office Manager. Unless revoked, this authorization will expire thirty (30) days from the date being signed by the patient. If the patient requests the records and wants to pick up the copied records, the patient is required to do so within thirty (30) days of being notified that the records are available.
Re-Disclosure: I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility of liability for disclosure of the above information o the extent indicated and authorized herein.
Signature of Patient or Personal Representative Who May Request Disclosure: I understand that Elizabeth L Brown, MD, PLLC may not condition my treatment on whether I sign this authorization form unless specified under "Purpose of Request". I can inspect or copy the protected health information to be used or disclosed, but the original copies are the property of the facility and may not be removed from the physical location.

Signature: ____ **Date:** ______________________________

Financial Policy

Welcome to the office of Dr. Elizabeth L. Brown. In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDE BY SIGNING BELOW

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3. We will collect your deductibles, co-payments, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, Visa, and MasterCard and for your convenience there is an ATM in the lobby of the Medical Pavilion.
4. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent, we reserve the right to refer your account to our Collection Attorneys and to be reported to one of more credit bureau(s).
5. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all of your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of the amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charge until your Medicare deductible is met.
6. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service- no exceptions. If your plan requires you to choose a primary care physician, it is ***your*** responsibility to make sure your insurance company has the physician you are seeing in our office as your PCP. If your plan requires you to have an authorization to see a specialist, you still need to obtain that from our office prior to seeing the specialist. No retroactive referrals will be given. If we do not participate with your plan, we will verify your out of network benefits, file your charges, and will expect payment of your portion of the charges at the time of service.
7. SELF PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our Billing Manager, Jamie F. Logan, prior to seeing the physician to make payment arrangements.
8. NO SHOW OR MISSED APPOINTMENTS: When an appointment is scheduled with the physician, time is specifically allocated for you. When an appointment is not canceled in advance, and the patient “no shows”, another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there *may* be times when you are unable to keep an appointment, but we as the courtesy of a phone call to cancel your appointment. If ***one*** or ***two*** appointments are missed without proper notification, you will be charged a $25.00 fee. If ***three*** appointments are missed, you will be dismissed from the practice for non-compliance.
9. Your insurance is a contract between you, your employer, and/or your insurance company. **We are not a party to that contract.** It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation with this practice.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our Billing Manager at (304) 414-2140.

I have read and have a full understanding of the financial policy of Dr. Elizabeth L. Brown’s office.

Name: (print) ______________________________________ Date: __________________

Signature: ____