

DR. SCAFURI & ASSOCIATES

WELCOME TO YOUR MEDICAL HOME

A Medical Home is all about you. Caring about you is the most important job of your Patient Centered Medical Home. In this personal model of health care, your primary provider leads the team of health care professionals that collectively takes responsibility for your care. They make sure you get the care you need in wellness and illness to heal your body, mind and spirit.

Your personal provider and an extended team of health professionals build a relationship in which they know you, your family situation, your medical history and health issues. In turn, you come to trust and rely on them for expert, evidence-based health care answers that are suited entirely to you or your family.

THE MEDICAL HOME ADVANTAGE

There are many benefits to being in a Medical Home:

- Comprehensive care means your medical home helps you address any health issue at any given stage of your life
- Coordination of care occurs when any combination of services you and your provider decide you need are connected and ordered in a rational way, including the use of resources in your community
- Continuous care occurs over time and you can expect continuity in accurate, effective and timely communication from any member of your health care team.
- Accessible care allows you to initiate the interaction you need for any health issue with a physician or other team member through your desired method (office visit, phone call, or electronically) and you can expect elimination of barriers to the access of care and instructions on obtaining care during and after hours.
- Proactive care ensures you and your provider will build a care plan to address your health care goals to keep you well, plus be available for you when you get sick.

WHO IS YOUR MEDICAL HOME TEAM?

Your team may include a doctor, physician assistant, nurse practitioner, licensed practice nurse, medical assistant or health educator, as well as other health professionals. These professionals work together to help you get healthy, stay healthy, and get the care and services that are right for you. When needed, your personal doctor arranges for appropriate care with qualified specialists.

WE WANT TO LEARN ABOUT YOU

- We want to get to know you, your family, your life situation, and preferences, and suggest treatments that make sense for you.
- We want to treat you as a full partner in your care
- We want to communicate effectively with you
- We want to give you time to ask questions and we want to answer them in a way you understand
- We want to make sure you know and understand all of your options for care
- We want to help you decide what care is best for you. Sometimes more care is not better care. We want to ask you for feedback about your care experience.

WE WANT TO SUPPORT YOU IN CARING FOR YOURSELF

- We want to make sure you develop a clear idea of how to care for yourself.
- We want to help you set goals for your care and help you meet your goals one step at a time
- We want to encourage you to fully participate in recommended preventive screenings and services
- We want to give you information about classes, support groups, or other types of services to help you learn more about your condition and stay healthy

HERE IS WHAT YOU CAN DO

ACTIVELY PARTICIPATE IN YOUR CARE

You are the most important member of the medical home team.

- Understand that you are a full partner in your own health care.
- Learn about your condition and what you can do to stay as healthy as possible.
- As best you can, follow the care plan that you and your medical team have agreed is important for your health.

COMMUNICATE WITH YOUR MEDICAL HOME TEAM

- Bring a list of questions to each appointment. Also, bring a list of any medicines, vitamins, or remedies you use.
- If you don't understand something your doctor or other member of your medical home team says, ask them to explain it in a different way.
- If you get care from other health professionals, always tell your medical home team so they can help coordinate for the best care possible
- Talk openly with your care team about your experience in getting care from the medical home so they can keep making your care better.

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE: _____ ZIP CODE: _____

TELEPHONE NUMBERS-HOME: _____ WORK: _____ CELL: _____

E-MAIL ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

INSURANCE COMPANY: _____ NAME OF INSURED (IF DIFFERENT): _____

RELATIONSHIP TO INSURED: _____ DATE OF BIRTH OF INSURED: _____

EMERGENCY CONTACT NAME AND TELEPHONE NUMBER: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the above referenced practitioners to furnish information to insurance carriers concerning my illness and treatment and I assign to the practitioners all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

PATIENT'S FORMS:

I hereby acknowledge that I was given an opportunity to review the following forms for the practice:

Financial Policies	Vaccine Policy
Office Policies	Documentation Preparation Fees
Physician Participation and Affiliation Information	Referrals to Other Providers
Sleep Screening	

MEDICAL HISTORY AND CURRENT MEDICATION UPDATE:

The following information regarding my medical history and current medications should be added to my chart:



PATIENT'S SIGNATURE

DATE

ADDITIONAL INFORMATION:

Language Spoken <input type="radio"/> English <input type="radio"/> Spanish <input type="radio"/> Korean <input type="radio"/> Other Language: _____	Ethnicity: <input type="radio"/> Decline to State <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Unknown
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Race:	<input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Native Hawaiian or Other Pacific Islander <input type="radio"/> White <input type="radio"/> Other Race: _____	Marital Status:	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Other: _____
		Student Status	<input type="radio"/> Not a Student <input type="radio"/> Full Time <input type="radio"/> Part Time

Do you have an **ADVANCED HEALTHCARE DIRECTIVE?** (a legal document in which a you specify what actions should be taken for your health if you are no longer able to make decisions for yourself because of illness or incapacity)

- Health Care Proxy
- Living Will
- Other: _____

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (“HIPAA”):

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read, if I so choose) and understood the Notice. The following is a list of the names of people who I wish to receive my medical information which includes test results:



PATIENT’S SIGNATURE

DATE

CREDIT CARD POLICY:

To our valued patients:

Thank you for your patronage and we appreciate that you have entrusted us with your health care needs. This is to inform you that your insurance policy is an agreement between you and your insurance company. If the insurance company does not pay for your visit, you will be responsible for the bill. You are responsible for deductibles, co-insurances, and copays. If you do not provide us with the correct information to process your claim, such as your insurance card, and the claim is denied, you will be responsible for these charges.

Effective January 1, 2018, Dr. Scafuri & Associates require a credit card or FSA card on file. This is NOT for copays on the actual date of service you are being seen.

According to your insurance plan, we are required to collect your copays, deductibles, and/or coinsurance. In providing the credit card information below, you authorize payment for services rendered, including copays, co-insurance, deductibles, and/or uncovered services. Once your insurance settles the claim and notifies us of your patient responsibility, balances under **\$200.00** will be charged **AUTOMATICALLY**. For patient balances exceeding \$200.00, you will be notified by us, prior to your credit card being charged. A receipt for the amount charged will be automatically mailed to your home.

The safety of your personal information is of the utmost importance to us. Please feel confident that all information provided is highly confidential and secure. By signing below, you acknowledge that you have read the Credit Card Policy above, you understand its terms and you accept full responsibility for all services rendered.



PATIENT'S SIGNATURE

DATE

Name on Card: _____ Card Number: _____

Visa _____ Master Card _____ Amex _____ Discover _____

3-4 Digit Security Code: _____ Billing Zip Code: _____ Expiration Date: _____