
We at Glendale Area Medical Association understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that time slot.

Patients who do not show up for their appointment without a call to cancel will be considered a "No-Show." Patients who No-Show two (2) times within a 12 month period will be placed on a "No-Show List" and will not be able to freely schedule their appointments, but will be offered a next available appointment. Patients who No-Show three (3) times within a 12 month period will be discharged from the practice.

We understand unavoidable circumstances may cause you to cancel within 24 hours and in this instance the cancellation/no-show may be waived, but only with the Administrator/Provider approval.

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.

Patient Name (Print): _____ DOB: _____

Patient Signature: _____ Date: _____

# Patient Profile

**Glendale Area Medical Center**
**850 Main Street PO Box 375**
**Coalport, PA 16627**

**[ ] HIPAA**
**[ ] Rx**
**[ ] Photo ID**
**[ ] Insurance Card**

OFFICE USE ONLY - Doctor: _____ Patient ID# _____ Chart # _____

***PATIENT INFORMATION***

**Name:** _____

**Preferred Name**: _____ □ NA

**Address:** _____

_____

**City, ST, Zip:** _____

**Primary Phone:** _____[ ] Home [ ] Work [ ] Other

**Additional Phone:**_____[ ] Home [ ] Work [ ] Other

**Primary Language:** _____

**Veteran:** [ ] Yes [ ] No

**Date of Birth:** _____

**Social Security #:** _____

**Marital Status**: [ ] Married [ ] Single [ ] Divorced [ ] Other

**Living Situation:** [ ] Own/Rent/Lease [ ] Temporary Family/ Friends [ ] Transitional (recovery/sober living) [ ] Temporary Shelter [ ] Released from institution with no stable living [ ] Foster care [ ] Doubling up [ ] Other

**Today's Date:** _____

**Preferred Pronoun:** □ He/Him □ She/Her □ They/Them

**Gender at Birth:** [ ] Male [ ] Female

**Gender Identity:** [ ] Male [ ] Female [ ] Transgender Male [ ] Transgender Female [ ] Refuse to disclose [ ] Non-binary [ ] Other (specify)_____

**Sexual Orientation:** [ ] Straight [ ] Gay/Lesbian [ ] Bisexual [ ] Something Else _____ [ ] Don't know [ ] Refuse to disclose

**Race**: (Circle One) White / Black-African American / Asian American Indian-Alaska Native / Native Hawaiian More than one race / Other Pacific Islander

**Hispanic Origin**: (Circle One) Hispanic/Latino Not Hispanic/Latino

**Tobacco Use:** [ ] Yes [ ] No

**PATIENT EMPLOYMENT:**

[ ] Employed [ ] Unemployed [ ] Student[ ] Retired [ ] Other

**Employer:** _____ **Occupation:**_____

## PATIENT'S INSURANCE INFO: PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST

***PRIMARY INSURANCE*: [ ] Same as Patient [ ] Same as Guarantor [ ] Other _____**

Insurance Company: _____ Insured ID: _____

Insured Party: _____ Policy Group #: _____

Relationship to the patient: _____ Group Name: _____

Insured Sex: [ ] Male [ ] Female Insured SS #: _____

Effective Date of Insurance: _____ Insured Date of Birth: _____

***SECONDARY INSURANCE*: [ ] Same as Patient [ ] Same as Guarantor [ ] Other _____**

Insurance Company: _____ Insured ID: _____

Insured Party: _____ Policy Group #: _____

Relationship to the patient: _____ Group Name: _____

Insured Sex: [ ] Male [ ] Female Insured SS #: _____

Effective Date of Insurance: _____ Insured Date of Birth: _____

***GUARANTOR*: *MUST be completed for patients less than 18 years of age.**

**[ ] Same as Patient *(See Above)* [ ] Same as Guarantor *(See Above)* [ ] Other *(List Below)***

Name: _____ Guarantor's Date of Birth: _____

Address: _____ Guarantor's SS #: _____

_____ Relationship to the Patient: _____

City, ST, Zip: _____

***HOUSEHOLD INFORMATION: (Must be completed for reporting purposes)***

Family Members (Name/Relationship to Patient): # in Household: _____ Head of Household: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

For statistical reporting purposes, please circle your annual household income:

$0-$15,000 $15,001-$30,000 $30,001-$45,000 $45,001-$60,000 $60,001-$75,000 $75,001 &up Refuse to provide

OFFICE USE ONLY - Sliding Fee Form [ ] Sliding Fee Discount % _____ Effective Date: _____

**GLENDALE AREA MEDICAL CENTER**
**850 Main Street**
**PO Box 375**
**Coalport, PA 16627**
**Phone: 814-672-5141**

**Fax: 866-607-8598**

## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

**PATIENT NAME** _____ **BIRTHDATE:** _____

**ADDRESS:** _____ **SS#:** _____

_____

I hereby authorize _____ to release to

Glendale Medical Center, 850 Main Street, P.O. Box 375, Coalport, PA 16627

the following medical records, which I understand may include psychiatric information, drug and alcohol information, and/or HIV information.

The extent or nature of information to be released is indicated below:

___ Complete medical record
___ Immunizations
___ Admission/Discharge summary
___ Operative reports
___ Emergency Room reports
___ X-Rays
___ Other_____

___ Laboratory reports
___ Medication sheets
___ Colonoscopy
___ Mammogram
___ PAP Smear
___ Dental Exam (most recent)
___ Eye Exam (most recent)

The purpose for release of the above information is indicated below:

___ Continued care ___ Insurance ___Legal ___ Other_____
(specify)

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to the facility. This consent will expire in one year from the date signed, unless otherwise stated as follows: _____.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

_____ _____

Signature of patient Date signed

_____ _____

Signature of parent, guardian or legal Representative Witness

If signed by other than patient, state relationship and reason for patient's inability to sign.

_____

_____

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Verbal consent requires signature of two witnesses:

_____ _____

Signature of witness Date Signature of witness Date

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act.

A copy of this authorization has been ___ accepted ___ rejected by the patient/representative.

# HIPPA Questionnaire

Glendale Area Medical Center
850 Main Street, PO Box 375, Coalport, PA 16627  814-672-5141

Patient Name: _____ DOB: _____

Form Completed By:  Patient  Other: _____ Relationship: _____

**Purposes Approved for Release- This will be reviewed at each visit**
_____ Continued Care  _____ Legal  _____ Other: _____

_____ Insurance (note that any insurance billing request is automatically approved for release)

**I approve the release of this information beginning _____ and ending _____.**

**In the case of an emergency, GAMA may contact: (Please place these contacts in the order you wish for them to be reached).**

1. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding my health care or can call on my behalf regarding my healthcare, medications, referrals, etc.  YES  NO

2. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding my health care or can call on my behalf regarding my healthcare, medications, referrals, etc.  YES  NO

3. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding my health care or can call on my behalf regarding my healthcare, medications, referrals, etc.  YES  NO

**Can we leave a voice message for you and if so at what phone # _____.**

**Email Address: _____**

**May we reach you via email? (only after secured portal is activated)  Yes  or  No**

***Changes can be made upon written request. GAMA staff will ask you at every visit to confirm or update this information.**

**Patient/Representative Signature: _____ Date: _____**

# HIPPA & Visit Authorization Form for Minors

Glendale Area Medical Center
850 Main Street, PO Box 375, Coalport, PA 16627
814-672-5141

Patient Name: _____ DOB: _____

The above child has my permission to be seen by a GAMA provider in my absence if he/she is accompanied by the following adult person(s):

Only the person(s) listed below will be permitted to bring the child to an appointment at GAMA. If someone other than a person on the list below brings the child, GAMA will NOT be able to treat your child at that time and you will have to reschedule the appointment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**In the case of an emergency, GAMA may contact: (Please place these contacts in the order you wish for them to be reached).**

1. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding this child's health care or can call on behalf of this child regarding healthcare, medications, referrals, etc. YES NO

2. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding this child's health care or can call on behalf of this child regarding healthcare, medications, referrals, etc. YES NO

3. Name: _____ Relationship: _____ Phone Number: _____
   This person is authorized to call and ask questions regarding this child's health care or can call on behalf of this child regarding healthcare, medications, referrals, etc. YES NO

**I approve the release of this information beginning _____ and ending _____.**

Form Completed By: _____ Relationship: _____

**Signature: _____ Date: _____**

**Staff initials updated in computer: _____ Date: _____**

**GLENDALE AREA MEDICAL CENTER**
**850 Main Street**
**PO Box 375**
**Coalport, PA 16627**

## Sliding Fee Application

Applicants Name: _____ Todays Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone 1: _____ Phone 2: _____

***Before approval can be given, the following MUST be received at time of or within 30 days of application.***

- Current photo ID along with 1 proof of income for applicant and other household members over age 19.
- Proof of identity for all household dependents listed under the age of 19.

Proof of income: Copy of 2 or more checks/paystubs, recent tax return or W2, Medical/Public Assistance letter, Social Security Letter, Bank Statements, Child Support Alimony, Unemployment, Depart of Social Services Certification Letter. (INCLUDE **ALL HOUSEHOLD INCOME**.)

- Must be current within 30 days of application
- If unable to provide documentation of income (Complete Declaration of Income Form)
- Note: Total Gross Income will be calculated to determine approval

***List yourself on Line 1, spouse/significant other on Line 2 and all dependents under the age of 19 on Lines 3-7.***

| Household Members | Names | DOB | Monthly Gross Income | Student (S) | Employed (E) | Other (O) | Office Use Only Patient/Chart # |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| | Dependents under age 19 | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| | Total | | | | | | |

Documentation of No Income: If you report $0 income, please explain how you are surviving.

_____
_____
_____
_____

_____ _____

Signature of patient Date signed

Certification: I certify that the household size and income information shown above to be correct. **I understand that documentation supporting my household financial position is required before my discount can be approved and that I must provide this information within 30 days or prior to my next visit if sooner.**

I understand that I must update this information if my situation changes and that a new Sliding Fee Application must be completed at least every 12 months. I have received information explaining the program and I understand and agree to abide by the terms. I understand that if I am a self-pay patient, I will be responsible to pay at least a minimum of $15 for healthcare services. If an unpaid balance exists on my account after applying my sliding fee discount, I agree to make payment agreements and honor the terms. I understand that if I am unable to make a payment in any given month, I must contact the Billing Office prior to the due date to discuss my need to modify my payment arrangement.

_____

Patients Name (Print)

_____

Signature of Patient of Guarantor

_____

Date of Signature

| | |
|---|---|
| Application Reviewed By: | Date: |
| Documentation Received By: | Date: |
| Sliding Fee Approved | Date: |
| | |

Glendale Area Medical Center-Patient Current Medication List

Patient Name: _____ DOB: _____

Allergies: _____

Pharmacy: _____

| Medication Name | Dose | Directions |
|---|---|---|
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| Have you ever or are you currently receiving any treatment using Methadone or Suboxone? Yes / No<br>Where are/were you receiving treatment? | | |

I understand that if more medical information, other than that disclosed is discussed, GAMA has the right to terminate my medical care.

Patient Signature: _____ Date: _____


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Patient Name (Print): _____ DOB: _____

Patient Signature: _____ Date: _____

**NOTICE OF PRIVACY PRACTICES**

***GLENDALE AREA MEDICAL ASSOCIATION, INC.***
***850 Main Street***
***PO Box 375***
**Coalport, PA 16627**
**814-672-5141**

*Effective Date:* April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO YOUR MEDICAL INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice describes the practices of **GLENDALE AREA MEDICAL ASSOCIATION, INC.** in connection with the use and disclosure of your medical information and your rights and certain obligations we have regarding the use and disclosure your medical information. It applies to the physicians and other health care professionals within our center who are involved in your care and/or are authorized to enter information into your medical records, and all of our employees, staff, and other personnel working in our offices. We are required by law to maintain the privacy of your medical information and to provide you with this Notice describing our privacy practices. We are required to abide by the terms of this Notice, as it is modified from time to time.

**WE MAY MAKE CHANGES TO THIS NOTICE IN THE FUTURE, AND ANY OF THE TERMS OF THIS NOTICE THAT ARE CHANGED WILL APPLY TO ALL OF YOUR MEDICAL INFORMATION. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A COPY OF THE REVISED NOTICE BY REQUESTING IT IN PERSON AT OUR SITE OR BY SENDING A WRITTEN REQUEST FOR A COPY TO OUR PRIVACY OFFICER AT THE ABOVE ADDRESS.**

## HOW WE MAY USE OR DISCLOSE YOUR MEDICAL INFORMATION

We are permitted or required to use your medical information for various purposes. We cannot describe every possible use or disclosure of your medical information in this Notice. However, uses or disclosures that we are permitted or required to make will generally fall within one of the following categories:

**For Treatment**. We may use and disclose medical information about you in order to ensure that you receive proper medical treatment. For example, we may disclose your health information to another health care provider involved in your care.

**For Payment**. We may use and disclose medical information about you so that we obtain payment for the treatment and services we provide to you from you, an insurance company or another third party. For example, we may need to give your health insurance plan information about your diagnosis and a description of the care that we provided to you in order to receive payment for your care.

**For Health Care Operations**. We may use and disclose medical information about you for our healthcare operations. Healthcare operations are activities that are necessary to run our offices, maintain licensure, and to make sure that our patients receive quality care. For example, we may use your medical information to review our treatment of you and the services we provided and to evaluate the performance of our staff in caring for you.

**Appointment Reminders**. We may contact you or your personal representative with a reminder that you have an appointment with us.

**Treatment Alternatives**. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services**. We may tell you about health-related benefits or services that we provide that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care**. We may discuss your medical care with family members or close personal friends who are involved in your medical care or payment for that care. You have the right to restrict or refuse any of these uses or disclosures.

**As Required By Law**. We will disclose medical information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety**. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threatened harm.

**Organ and Tissue Donation**. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Workers' Compensation**. We may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness as required or permitted by law if you are injured at work.

**Health Oversight Activities**. We may disclose your medical information to a health oversight agency such as licensing boards for activities authorized by law.

**Lawsuits and Disputes**. We may disclose medical information about you in response to a court or administrative order, a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement**. Under certain circumstances, we may release information about you if asked to do so by a law enforcement official

**Coroners, Medical Examiners and Funeral Directors**. Under certain circumstances, we may release medical information to a coroner, medical examiner or funeral director.

**Government Purposes**. We may release your medical information under limited circumstances if you are a member of the armed forces or foreign military personnel, or for intelligence, counterintelligence and other national security activities authorized by law.

**Incidental Uses and Disclosures.** We may use or disclose your medical information if it is a by-product of any of the uses or disclosures described above and it could not be reasonably prevented.

**Limited Data Sets**. We may use or disclose certain information that does not directly identify you for research, public health or health care operations if the recipient of that information agrees to protect the information.

Certain types of health information are subject to more stringent protections under state law than those described above. For example, mental health records, HIV related information and drug and/or alcohol abuse or dependence information is subject to special protections.

## DISCLOSURES WITH YOUR AUTHORIZATION

We must obtain your authorization before we release psychotherapy notes prior to engaging in certain marketing activities. We are also required to obtain your authorization to use or disclose health information in those situations not otherwise described in this Notice. If you do authorize us to use or disclose your medical information, you have the right to revoke that authorization at any time.

## YOUR RIGHTS IN CONNECTION WITH YOUR MEDICAL INFORMATION.

You have the following rights in connection with the medical information we maintain about you:

**Right to Inspect and Copy**. You have the right to inspect and copy your medical information that is in our possession. You may not, however, have access to psychotherapy notes or information that is put together for use in a civil, criminal or administrative proceeding.

To inspect or copy your medical information, you must submit your request in writing to our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect or copy your health information in certain very limited circumstances. If you are denied access to your medical information, you may be able to request that the denial be reviewed.

**Right to Request Amendment**. If you feel that your medical information is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, your request must be made in writing and submitted to our office.
You must explain why you believe that the medical information is incorrect or incomplete. If we deny your request, you have a right to give us a short statement to be placed with your medical information or to have us include your request for amendment with your medical information.

**Right to an Accounting of Disclosures**. You have the right to request, and we must provide you with, a list of certain of our disclosures of your medical information. We are not required to include on that list disclosures to carry out your treatment, payment for your care, and our health care operations and certain other disclosures. To request this list or accounting of disclosures, you must submit your request in writing to our office.

Your request must state a time period covered by your request. That time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**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 or health care operations. 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 or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** To request restrictions, you must make your request in writing to our office.

**Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. To request confidential communications, you must make your request in writing to our office. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

**Right to a Paper Copy of This Notice**. You may ask us to give you a copy of this notice at any time by asking for in person or in writing. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a compliant with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, contact our office in writing.
**You will not be penalized for filing a complaint.**

**If you have any questions about this notice, please contact our Privacy Officer at the address listed above.**

*******************************

# PATIENT ACKNOWLEDGEMENT

## I hereby acknowledge that I have received a copy of Glendale Area Medical Association, Inc's Notice of Privacy Practices.

**Patient/legal representatives signature:**

_____

**Date:** _____