Galbraith Family Medicine, LLC

44 Elm Street
Limerick, Maine 04048
Phone (207) 793-9586
Fax (207) 793-9587

Dear Patient,

Welcome, and thank you for choosing Galbraith Family Medicine, LLC, for your care. We are committed to providing quality care to the entire family, with an emphasis on treating the whole person and on promoting healthy living to prevent disease. In this packet, you are given information that describes some important aspects of our practice and some of what you can expect during your visits with us. It also includes forms to complete to help us get to know you better.

In order to help us best serve your needs, please fill out the enclosed "Registration and Consent" form (1 page) and the "Patient History" form (3 pages). Please also read and sign the "Signature on File" form. To best serve you, these forms should be completed and returned to us *before* your visit so that we may enter this information into your chart. Also enclosed is the "Acknowledgment of Receipt of Notice of Privacy Practices" form which should be brought to your appointment where we can provide you with a copy of our Notice of Privacy Practices for your review prior to signing the acknowledgment.

In this packet we have also included an "Authorization To Release Protected Health Information" form. This may be copied (if necessary), completed, and sent or hand-carried to your previous medical provider(s) so that we may obtain your records. As an alternative, you are welcome to mail the completed form to us along with your other forms and we will request the records for you. This is best done well ahead of your visit with us as it can take several weeks for records to be prepared and sent. We prefer to have your records in hand before we meet; please be aware that without your previous medical records, our first visit may be very limited in scope.

Please bring your insurance card with you to all of your appointments. Also bring your Co-Pay, if applicable, as payment is expected at the time of service. We submit a claim to your insurance for each visit as appropriate; you will be billed at a later date for any balance not covered by your insurance. For those without insurance or for those who prefer to forego the insurance claim process, we offer a 40% discount for full payment of the day's balance at the end of the visit.

We look forward to seeing you. If, however, you are unable to keep your appointment, kindly let us know within 24 hours of your visit, and we will reschedule the appointment for a time that is more convenient for you.

If you have questions, please feel free to give us a call. Thank you for placing your trust in us.

Sincerely,

Kathryn Galbraith, MD

David Galbraith, MD

Galbraith Family Medicine, LLC

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REGISTRATION AND CONSENT FORM (Please Print)

Patient Information

Primary Care Provider: Dr. David Galbraith Dr. Kathryn Galbraith

Patient Last Name First Middle	Date of Birth / /
Mailing Address	Social Security #
Street Address (if different from above)	Home Phone # ( )
City State Zip Code	Cell Phone # ( )
Marital Status Single Married Separated Divorced Widow/Widower	Gender Male Female
Employer Occupation	Work Phone # ( )
Emergency Contact Phone # ( )	Relationship
Preferred Pharmacy	Race: White Hispanic Asian Native American African American Multiracial/Other_____

Insurance Information (Please give your insurance card to the receptionist to make a copy)

Person Responsible for the Bill	Address if different from patient's	Phone # ( )
Relationship to patient	Responsible Person's Employer	This Employer's Phone # ( )
Name of Primary Insurance / CoPay $	Group #	Policy #
Subscriber's Name	Subscriber's Social Security #	Relationship to patient
Name of Secondary Insurance / CoPay $	Group #	Policy #
Subscriber's Name	Subscriber's Social Security #	Relationship to patient

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Galbraith Family Medicine, LLC. I understand that I am financially responsible for any balance and for any amounts that may not be covered by my insurance. I also authorize Galbraith Family Medicine, LLC, and/or insurance company to release any information required to process my claim.

I, or the guardian/representative of the patient, hereby give consent to Galbraith Family Medicine, LLC, and other individuals involved in this care to administer such diagnostic procedures and/or treatments as may be advisable to evaluate and treat illness or injury and promote good health.

I also understand that the provider responsible for this care has the responsibility to explain the purpose, benefits, and usual risks inherent to the diagnosis and treatment of any illness, injury or to the promotion of good health and preventative care, including alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests or treatments.

_____ _____

Patient/Guardian Signature Date

Note to minors: If you are a minor who consents to health care services on your own behalf, but utilize your parent's or guardian's insurance policy to pay for your services, please know that your parent or guardian will receive an Explanation of Benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. Please speak with our staff if you wish to pay for your services in another manner.

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Signature on File

I authorize the use of this form on all of my insurance submissions.

I authorize the release of medical and other information to all my insurance companies.

I authorize my doctor and his or her representatives to be my agents in helping me obtain payment from my insurance companies.

I authorize payment directly to my doctor and/or Galbraith Family Medicine, LLC.

I understand that I am responsible for my bill.

I understand that during the course of my treatment certain tests or consultations with specialists may be necessary and that I authorize the release of any pertinent medical information to the parties involved for these purposes.

I permit a copy of this authorization to be used in place of the original.

Signature_____

Name (printed)_____

Date_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You may refuse to sign this acknowledgment*****

Patient name: _____ Date of birth: _____

I have received a copy of the Notice of Privacy Practices, either in paper form or have had the opportunity to review a copy available in the office. I acknowledge that I have had an opportunity to ask questions about the Notice of Privacy Practices for Galbraith Family Medicine, LLC. This practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Galbraith Family Medicine, LLC.

_____ _____
Signature of Patient or Patient Representative Date

_____ _____
Printed name of person signing Relationship

FOR OFFICE USE ONLY

Patient name: _____ Date of birth: _____

Galbraith Family Medicine, LLC, attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign.
Communication barriers prohibited obtaining the acknowledgment.
An emergency situation prevented us from obtaining acknowledgment.
Other (please specify)

_____
_____

_____ _____
Employee signature Date

Galbraith Family Medicine, LLC
PATIENT HISTORY FORM

Please Print

Today's Date: _____ Name: _____ DOB: _____

Please list your ON-GOING, long-term medical problems (chronic illnesses):

_____
_____
_____
_____
_____
_____
_____

Please list PAST problems and surgeries you have had:

_____
_____
_____
_____
_____
_____
_____
_____

Please list all current medications, vitamins, herbs, and over-the-counter medications you take: (Please use the back if needed)

Name of Medication	Strength	When you take it

Please list your MEDICATION ALLERGIES and your reaction to each:

_____
_____
_____
_____

Please check the medical problems that run in your family (EXCLUDE YOURSELF) and write in who was affected:

Cancer
- Breast_____
- Colon_____
- Melanoma_____
- Ovarian_____
- Prostate_____

High blood pressure_____
Migraine headaches_____
Osteoporosis _____
Other: _____

Heart attack prior to age 50_____
Diabetes (adult onset)_____
Stroke_____
High cholesterol_____
Asthma_____
Depression or Anxiety_____
Bipolar disorder_____
Alcoholism_____
ADD/ADHD _____

Health habit history:

Occupation:_____
Marital status (circle): Single Married Divorced Widowed
Do you have children? (circle) YES NO #daughters:_____ #sons:_____
Do you use tobacco? (circle) YES(every day) YES(some days) NO(quit) NO(never)
If yes , how much per day:_____
If quit, what year did you quit:____ #years smoked:____ Ave. amount smoked:____
Do you drink alcohol? (circle) YES NO
If yes, what type:_____ How often:_____ Amount:_____
If quit, what year did you quit:____
Do you drink caffeine? (circle) YES NO
If yes, what types: _____ Amount per day:_____
What is your activity level? (circle) Sedentary "Active" Moderate or vigorous exercise
What is your birth control type?_____
Do you have a living will or advanced directive? (circle) YES NO
List your preferred language: _____
Ethnicity (circle): Hispanic Non-Hispanic Other:_____

Confidential health habit history:

Do you use recreational drugs? (circle) YES NO
If yes, what types:_____ Frequency:_____
Do you have a history of being abused as a child? (circle) YES NO
Have you ever been a victim of domestic violence? (circle) YES NO
Are you sexually active? (circle) YES NO
If so, do you engage in activity with (circle): Men Women Both
If so, do you use condoms? (circle) YES NO

Health Maintenance (list approximate dates of your last visit):

Colonoscopy:_____ Where was it done?_____
Flu shot:_____
Pneumonia shot:_____
Tetanus shot:_____
Mammogram:_____ Where was it done?_____
Pap smear:_____ Where was it done?_____
Bone density test:_____ Where was it done?_____

Review of systems--if YES circle and list details:

Constitutional
Weight gain or loss_____
Fever_____
Insomnia_____
Fatigue_____

Gastrointestinal
Abdominal pain_____
Blood in stool_____
Constipation_____
Diarrhea_____
Heartburn_____
Nausea _____

Dermatological
Acne_____
Excessive sun exposure_____
Change in mole_____
Skin lesion_____

HEENT
Headache_____
Itchy eyes_____
Visual loss_____
Ear pain_____
Ringing in ears_____
Dizziness_____
Nasal discharge_____
Nasal congestion_____
Postnasal drip_____
Snoring_____
Tooth pain_____

Genitourinary
Decreased stream_____
Painful urination_____
Urinary frequency_____
Blood in urine_____
Lots of urine_____
Urinary incontinence_____

Respiratory
Cough_____
Windedness with activity_____
Shortness of breath_____
Wheeze_____

Musculoskeletal
Joint pain_____
Muscle pain_____

Hematological_____
Easy bruising_____
Easy bleeding_____

Vascular
Cool extremity_____
Varicose veins_____

Immunological
Hives_____

Metabolic/endocrine
Hair loss_____

Neurological
Localized body weakness_____
Gait disturbance_____
Memory impairment_____
Seizures_____

Psychiatric/emotional
Difficulty concentrating_____
Anxiety_____
Depression_____
Irritability_____
Suicidal thoughts_____
Mood swings_____

Reproductive
Age when became postmenopausal_____
History of abnormal pap smear_____
Sexual dysfunction_____
Last menstrual period_____

Cardiovascular
Chest pain_____
Passing out_____
Ankle swelling_____
Irregular heart beat_____

How did you hear about us?_____

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Authorization To Release Protected Health Information

Patient Name_____ Date of Birth_____

I HEREBY AUTHORIZE GALBRAITH FAMILY MEDICINE, LLC, TO: (Please check)

Obtain my protected health information from:_____

Release my protected health information (PHI) to: _____

Share my health information with:_____

Physician/Other_____
Address_____
City_____ State_____ Zip code_____

Protected Health Information to be released: I am changing doctors

Medical records (may specify "all" or related to a specific condition):_____

Billing records

Records from time frame _____ to _____

I understand that the PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.

Purpose of disclosure: _____ (if used for marketing this will be stated and remuneration if involved will be disclosed)

I HAVE BEEN MADE AWARE THAT I MAY REFUSE TO DISCLOSE ALL OR PART OF MY HEALTH CARE INFORMATION, PARTICULARLY AS NOTED BELOW. I HAVE BEEN MADE AWARE THAT REFUSING DISCLOSURE MAY RESULT IN IMPROPER DIAGNOSIS OR TREATMENT, DENIAL OF COVERAGE FOR AN INSURANCE CLAIM, OR OTHER ADVERSE CONSEQUENCES.

(Check below any information you **do not** wish disclosed)

Psychological or psychiatric problems (Records generated at a mental health agency/facility or by a psychiatrist, clinical nurse specialist, social worker or psychologist)

Substance abuse or chemical dependency (Records generated by medical personnel whose primary function is treating this. I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.)

HIV test results or status (Maine law requires our practice to inform you that disclosing your HIV infection status may have consequences such as negative treatment in your personal life, at work, or by insurance companies, if this information is misused. Yet it can be important for providing you needed services and healthcare)

*Other*_____

CHECK ONE:

I authorize the release of the requested records **without** information relating to the conditions checked above.

I authorize the release of the requested records in their entirety directly to the party who requested this information regardless of content.

I have read this release and understand the information contained in this document. I understand that I am not required to sign this form and that Galbraith Family Medicine, LLC, will not condition treatment, payment of services, or eligibility for services on whether I sign this form. I understand that I may revoke this consent at any time except to the extent that action has been taken in reference to this request. I can revoke this consent at any time by written, signed and dated notice to this office but understand that doing so may be the basis for denial of health benefits or other insurance coverage or benefits. I understand that I have the right to access or copy the PHI described in this form by making a written request to above address to the Privacy Officer(s) of this practice, David or Kathryn Galbraith, and that a copying fee may be charged as permitted by law. I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by confidentiality laws. This release is valid for this request only. I am entitled to a copy of this form upon request.

_____ _____
Signature of Patient or Legal Guardian Date
(Signature is valid for 30 months from signature date unless specified here:_____.)