We at Fairfield Medical Associates, LLC would like to welcome you to our practice. We want to take the time to explain some policies and give you important phone numbers that you may need in the future.

To reach the operator, please call (740) 687-8600. The receptionist will schedule your appointments, take message for the physician's assistant, and help answer any questions that you may have. If all lines are busy at the time of your call, you will be forwarded to our voicemail system. You will need to leave your full name, date of birth, phone number, and a brief message regarding the nature of your call. Someone will return your call in a timely manner.

We also have a **Prescription Refill Line**. You can call and leave a voicemail request for refills for medications at (740) 475-0550. You **MUST** leave:

- Your full name
- Date of birth
- Phone number
- Physician's name
- Pharmacy's name and location (ie. Krogers East, Walgreens Main, and Risch's Fair).
- Name of medication, dosage, and how often you are taking it.

You must allow 24-48 hours for all prescription refills. Please call prior to running out of medication to avoid missing doses. After 48 hours please check with your pharmacy to see if your prescription is ready before calling our office.

For questions regarding your insurance or bill, please call **Billing** at (740) 455-3304.

For questions regarding the need to see a specialist or if your physician is sending you for further testing please call our **Referral Department** at (740) 475-0567.

Phone Number list:

Main Switchboard	(740) 687-8600
Prescription Refills	(740) 475-0550
Referral Department	(740) 475-0567
Billing Department	(740) 687-8643
Fax	(740) 475-0598

Fairfield Medical Associates, LLC

1781 Countryside Drive, Lancaster, Ohio 43130

FINANCIAL POLICY

In today's financial climate, we understand that patients must be efficient with their money and that you, as a patient and a consumer, have options in healthcare. In order to help keep your costs down, we are making a concerted effort to run as financially efficient of an office as we possibly can. In order to do this, we strictly abide by the following guidelines. If you have any questions please call our office at (740) 687-8600.

Patient Name: ____ DOB: ____________________

1. PAYMENT

Payment is due at the time services are rendered. Our staff will provide you with as accurate information as available to us from your insurance company regarding your copay, deductibles, and coinsurance amounts. Balances that are residual after filing with your insurance company will be expected prior to your next scheduled office visit or statement date, whichever is sooner. If the patient is unable to pay at the time of service, the appointment will be rescheduled. We accept cash, check, or credit card.

2. NO SHOW POLICY

If you are unable to keep a scheduled appointment, please let us know 24 hours in advance. A **NO SHOW** is when a patient fails to keep a scheduled appointment. A no show will generate a $25.00 fee that will **NOT** be billed to the patient's insurance company and could result in being discharged from the practice at the physician's discretion. This fee must be paid before any further appointments will be scheduled. Failure to pay the no show appointment fee will require that you seek your medical care elsewhere. We do send out reminder calls prior to each appointment You can also opt in to receive text message reminders for appointments. Please ensure we have your correct contact information.

3. FEES

No Show- $25.00
Forms- $10.00 Processing time is 7-10 business days once payment is received
Returned check- $25.00 -We do not rerun any returned checks through the bank.
Medical Records-
- First 10 pages $3.07 per page
- Pages 11-50 $0.64 per page
- Pages 51 & higher $0.26 per page

4. DEFAULT

Should you default on your balance, Fairfield Medical Associates has the right to discharge you as a patient and not accept new diagnosis. If your account qualifies for collection, you will be assessed all collection and/or legal costs. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address that you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. If you are set up on a payment plan and miss a payment we reserve the right to discharge you from the practice and turn refer the account to collections. You must pay the full designated payment amount each month to remain in the practice and avoid collections.

5. SELF-PAY/UNINSURED

Self-pay/uninsured patients do receive a discounted rate. This is calculated off of Medicare allowables. You are expected to provide a credit card, blank check or $50.00 cash deposit prior to seeing the physician in order to secure payment for the service rendered. Once the appointment is over you have the option to pay the total due at a 20% discount or the option to be billed the total amount without the discount minus the $50.00 deposit. The total must be paid at the end of the visit on that day to receive the discount.

6. INSURANCE & INSURANCE CARDS

You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, coordinator of benefits, accidents, or prior medical coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full, immediately. Our office participates with and will bill directly to Medicare and, as a courtesy to you, we will also file a claim with your secondary insurance if we are provided a copy of the secondary insurance card. It is your responsibility to inform us if your insurance changes in any way, and the effective date of the change. It is also the patient's responsibility to verify all coverage and costs with the insurance company prior to all visits. If you do not bring your insurance card to each visit you may be asked to reschedule your appointment. If you are asked to reschedule your appointment the visit will be considered a no show which may result in a $25.00 no show fee.

7. PERSONAL INJURY/AUTO ACCIDENT

It is your responsibility to inform registration that you are being seen due to a personal injury or auto accident. You must provide the date of accident and state. The bill will be your responsibility and payment is expected at the time of service. We will provide you with an itemized statement for your insurance, if needed. Please remember that you are ultimately responsible for payment of your bills, not your attorney.

8. WORKER'S COMPENSATION

Fairfield Medical Associates physicians **DO NOT** provide care for worker's compensation cases. Please contact the local BWC office at (800) 385-5607 for names of BWC providers.

9. FORMS

All FMLA forms require an appointment as well as any other forms at the physician's discretion. All other forms will that require completion need to be present during your appointment. If any form requires completion outside of your appointment there is a $10.00 fee that must be paid prior to paperwork completion. All appropriate fields must be completed by the patient before physician will complete. Processing time is 7-10 business days. Patients are responsible for providing current legal documents to input into the patient's chart or to replace existing paperwork and notifying our office of any custodial changes, etc. All legal documents must be replaced by legal documents unless that legal document has an expiration date.

10. MINORS

Individuals that are not the parent or legal guardian arriving with minors to be treated will be re-scheduled if the Designation to Consent for Treatment of a Minor form has not been completed with the adult attending the appointment listed. The patient's co-pay is also due at the time of service. These forms are available on our website or our office. Any minor arriving to his or her appointment alone must have a completed minor consent form from the parent or legal guardian giving consent for treatment. If there is no form we must receive verbal consent from the parent or legal guardian before the patient can be seen. If no contact can be made the appointment will be re-scheduled. If you are asked to reschedule your appointment the visit will be considered a no show which may result in a $25.00 no show fee.

11. DIVORCE

Payments including but not limited to copays, deductibles, coinsurance or any additional fees charged by your insurance are due at the time of service regardless of which parent is responsible for medical expenses. We are not a party to your divorce and/or separation agreement. We will first attempt to collect payment due from the parent who brings the child to the visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Both parents will be considered equally responsible for payment and will be jointly and severally liable. This will apply regardless of the terms of the parties' divorce decree. It will be up to the parent(s) to resolve divorce decree differences. Should the parents fail to pay for services rendered, the provisions of section 4 (Default) of this policy will apply.

12. PHOTO ID

A valid photo ID is required at each visit to verify the patient. The ID will be scanned into the chart until expiration but will be checked at each visit. Failure to provide a valid photo ID could result in the appointment being re-scheduled and the visit being considered a no show which may result in a $25.00 no show fee.

13. AFTER HOURS & WEEKEND APPOINTMENTS

After hours appointments begin at 5:00 p.m. and weekend appointments are available. There is an additional fee for these appointments and will be billed to your insurance. The patient is financially responsible for any remaining balance for an after-hours or weekend appointment.

14. PAYMENT PLANS

Payment plans are available at Fairfield Medical Associates and are required for any balance over $200.00 that is not being paid in full. Payment plans can only be set up for balances $200.00 and higher. These are interest free plans that allow our patients to pay down the balance each month. Payments for plans are decided by taking the balance and dividing that by how many months are required based on the tier. All payment plans require that a credit or debit card be placed on file and auto deducted each month. Patients are only permitted one payment plan per patient at one time and any balances one incur outside of the payment plan must be paid in full before any additional appointments will be made. Each patient must sign a Payment Plan Agreement which will be kept on file. If the card on file is declined Fairfield Medical Associates will make two attempts to make contact for new card information and if no contact is made the account will be turned over to collections and the patient will be dismissed from the practice. Refusing to sign up for a payment plan will require the full balance to be paid before any additional appointments can be made. All payment plans are set up at the discretion of Fairfield Medical Associates.

Balance Tiers

- Balances $200-$499 must be paid within 4 months
- Balances $500-$999 must be paid within 8 months
- Balances $1,000 or higher must be paid within 12 months

I HAVE READ ALL OF THE ABOVE STATEMENTS AND I AGREE TO THE TERMS OF THIS AGREEMENT. I HAVE READ THE DISCLOSURE AND AGREE THAT THE LENDOR/CREDITOR MAY CONTACT ME AS DESCRIBED IN SECTION 4. I UNDERSTAND THAT REFUSAL TO WORK WITH FAIRFIELD MEDICAL ASSOCIATES REGARDING PAYMENT OF BALANCES WILL RESULT IN DISMISSAL FROM THE PRACTICE. I UNDERSTAND THAT REFUSAL TO SIGN THIS DOCUMENT WILL RESULT IN DISMISSAL.

SIGNATURE: ____ Date: _____________________

Fairfield Medical Associates

Board Certified Physicians

Sarah J. Alley M.D. Michelle L. Graham M.D.

Agnes M. Laus M.D., F.A.A.P. Jill Schellhase, M.D.

Patient Information

Name: ____

Address: ____

Home Phone: ____________________ Cell Phone: ____________________

E-Mail Address: ____________________ Date of Birth: ____________________

Race: ____________________ Martial Status: ____________________

Ethnicity ____________________ Social Security #: ____________________

Employers Name & Address: ____

Work Phone: ____________________ Primary Care Physician: ____________________

Who referred you to our office? ____

Responsible Party

Relationship to the patient: ____

Name (If other than SELF) ____

Address (If different from patient) ____

Home Phone: ____________________ Cell Phone: ____________________

Insurance Information

Primary Insurance: ____

Policy Holder: ____________________ Relation to Patient: ____________________

Policy Holders Date of Birth: ___/___/_____ Policy Holder's Social Security #: ____________________

Address (If different from patient's) ____

Secondary Insurance: ____

Policy Holder: ____________________ Relation to patient: ____________________

Policy Holders Date of Birth ___/___/_____ Policy Holder's Social Security #: ____________________

Emergency Contact Information

Name: ____________________ Relation to Patient: ____________________

Phone: ____________________

Signature of Patient or Responsible Party: ______________________________ Date: ____________________

FAIRFIELD MEDICAL ASSOCIATES
1781 COUNTRYSIDE DRIVE
LANCASTER, OHIO 43130

DATA BASE SHEET

Name:____ Gender: ___Male ___Female
Last First M.I.
D.O.B.______________ SSN: ____________________ ___ Single ___Married ___Divorced ___Widowed

Spouse/Partner's Name: ____

Number of Children/ Ages: ____

PAST MEDICAL HISTORY – Please check yes or no if you have had any of the following:

	YES	NO		YES	NO
Anemia	___	___	High Blood Pressure	___	___
Artificial Joints	___	___	High Cholesterol	___	___
(Antibiotics before procedures)	___	___	HIV/AIDS	___	___
Artificial Heart Valves	___	___	Keloid	___	___
(Antibiotics before procedures)	___	___	Kidney Disease	___	___
Arthritis	___	___	Lupus	___	___
Asthma	___	___	Lung Disease	___	___
Cancer	___	___	Pacemaker	___	___
Type ________________			Psoriasis	___	___
Treatment: Radiation / Chemotherapy			Psychiatric Problems	___	___
Cataracts	___	___	Skin Cancer	___	___
Depression	___	___	Type	________________	
Defibrillator	___	___	Location	________________	
Diabetes	___	___	Sexually Transmitted		
Eczema	___	___	Disease	___	___
Epilepsy/Seizures	___	___	Sleep Apnea	___	___
Glaucoma	___	___	Snoring	___	___
Hay fever/Seasonal Allergies	___	___	Stomach Ulcers	___	___
Heart Disease	___	___	Thyroid Disease	___	___
Hepatitis/Liver Disease	___	___	Tuberculosis/+PPD	___	___
Herpes	___	___	Varicose Veins	___	___

Other____

FAMILY HISTORY – Please check the corresponding box if any blood relative has ever had the following. ***Please indicate which relative.***

___TB (Tuberculosis) ________________
___High Blood Pressure ________________
___Heart Trouble ________________
___Kidney Disease ________________
___Sugar Diabetes ________________
___Cancer or Tumor ________________
___Anemia or Low Blood ________________
___Gall Bladder Problems ________________
___Asthma or Hay Fever ________________
___Thyroid Problems ________________
___Glaucoma ________________
___Others ________________

Please list any surgeries/operations that you have ever had:

____

____

____

Please list any current medications, including aspirin, over the counter, herbal, vitamins and topical therapies:

____

____

____

Please list any allergies to medications:

____

REVIEW OF SYSTEMS – Please check if you currently have any of the following symptoms.

General	___weight loss/gain	Musculoskeletal	___joint aches/pains
	___fever/chill		___muscle aches/pains
Eye	___vision problems	Psychiatric	___depression
	___glasses/glaucoma/cataracts		___psychiatric problems
ENT	___hearing loss	Allergies	___seasonal allergies
Cardiac/	___chest pain		___food allergies
Vascular	___palpitations	Skin	___hair loss
	___leg swelling		___rash/itching
Gynecological	___pregnant/nursing		___skin sensitivity
	___irregular menses	Neuro	___easy fainting
	___post menopausal		___seizures
Respiratory	___shortness of breath		___headaches
	___cough		___migraines
Gastro	___stomach problems	Endo	___thyroid problems
	___abdominal pain		___diabetes
Urinary	___urinary problems	Blood	___abnormal bleeding
	___kidney problems		___anemia

HABITS – Please check any of the following past or present habits.

___Cigarettes		___Sunscreen use
Per day	_____	___Regular Exercise
# of years	_____	___Recreational Drugs
___Alcohol		___Marijuana
# of drinks per week	_____	___Illicit Drugs

I have reviewed the information on the questionnaire and verify that the above information to the best of my knowledge.

______________________________________ ______________________________

Signature of Patient or Legal Guardian if Patient is a minor or unable to sign Date

Internal Use: I have reviewed this intake questionnaire with the patient at the time of this visit.

______________________________________ ______________________________

Physician's signature Date

Family Medical Tree

Instructions: List any known hereditary illnesses or cause of death of each deceased family member. Enter names of children in appropriate spaces.

Grand Father Illnesses ______

Illnesses Grand Mother ______

Grand Father Illnesses ______

Illnesses Grand Mother ______

Brothers
Illnesses ______

Father
Illnesses ______

Sisters
Illnesses ______

Brothers
Illnesses ______

Mother
Illnesses ______

Sisters
Illnesses ______

Children

Name:

1. Illnesses ______
2. Illnesses ______
3. Illnesses ______
4. Illnesses ______
5. Illnesses ______

Signature: ______

Important Notice Regarding the Privacy of your Health Information

Your privacy is important to us. We create information about you so that we may provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regard to your health information, as well as how we may use your health information, and how we must protect the confidentiality of your health information. This is a summary of the more detailed information contained in our Notice of Privacy Practices.

Your rights include:

- A right to inspect and copy your medical information.
- A right to amend your health information.
- A right to request restrictions on what information we use or how we disclose your health information.
- A right to receive an accounting of certain disclosures we have made of your health information.
- A right to receive a paper copy of our Notices of Privacy Practices.

These rights do have special restrictions, so it is important that you read the full Notice.

We may use your health information and/or records to:

- Plan for your care.
- Help your health care providers communicate and work together to care for you.
- Submit bills to pay for your care.
- Help health care payers make sure services were actually provided.
- Help improve the quality of health care. For example, after your visit we may contact you to see how you are doing and to find out how you felt about our service.
- Disclose information to certain officials or organizations where we may, or are, required to do so by law.

We encourage you to carefully read the Notice.

I have received the Notice of Privacy Practices for Fairfield Medical Associates, LLC

Printed Patient Name: ________________________________ Date of Birth: _____________

Signature: ____ Date: ___________________

Documentation of Attempt: _____________________________Date: ___________________

Consent for Release of Information

Patient Name: ____ DOB: ____________________

Home Phone: _______________________ Cell: _________________________ Work Phone: ______________

*Are we allowed to leave a detailed message with appointment information, lab, diagnostic and/or any other test results? Test results of a sensitive nature will continue to only be given directly to the patient.

YES NO

*Are we permitted to give appointment information or to give lab, diagnostic and/or any other test results to family members?

YES NO

If yes, please list any family members information may be given to.

Name: ____________________________ Phone#: _____________________ DOB: _________________

Name: _____________________________ Phone#: _____________________ DOB: _________________

*Are family members and/or other persons permitted to pick up written prescriptions?

YES NO

If yes, please list their name, phone number and date of birth.

Name: _____________________________ Phone #: ___________________ DOB: _________________

Name: _____________________________ Phone #: ___________________ DOB: _________________

Patient name (printed) ___________________________________ **Date of Birth:** ____________________

Patient signature ____ **Date:** ______________________

Consent in effect until revoked by patient or physician.

No Show Policy

If you are unable to keep a scheduled appointment, please let us know 24 hours in advance. A **NO SHOW** is when a patient fails to keep a scheduled appointment. A no show will generate a $25.00 fee that will not be billed to the patient's insurance company and could result in being discharged from the practice at the physician's discretion. Missing three appointments in a twelve month period will result in being discharged from the practice.

We thank you for your assistance in this very important matter.

Patient Portal User Agreement

Fairfield Medical Associates, LLC provides this site in partnership with e-MD's® for the exclusive use of their established patients. The Patient Portal is designed to enhance patient-physician communications. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal can provide the following services:

- Medication refill requests.
- Communication of laboratory results from staff to patient.
- Review a patient's medical summary, medication list, treatment history and visitation dates.
- Limited communication regarding on-going treatment

The Patient Portal is not intended to provide internet based diagnostic medical services. Also, the following limitations apply:

- No internet based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and **SEES** the Doctor.
- No Emergent communications or services.
- No requests for narcotic pain medication will be accepted.

The Patient Portal is provided as a courtesy to our patients. While some office charge for this convenience on an annual basis, we are focused on providing the highest level of service and health care. However, if abuse or negligent usage of Patient Portal persists, we reserve the right at our own discretion to terminate Patient Portal offering, suspend user or modify services offered through the Patient Portal.

The Patient Portal is provided in partnership with e-MD's, our EHR software vendor, who electronically houses the software. The data is on HIPAA compliant VPN with high level encryption that exceeds HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee that unforeseen, adverse events cannot occur.

All new and established patients have signed a HIPAA Agreement form and have been given a copy of our HIPAA policy. If you do not recall having signed the

HIPAA Agreement form or need to reacquaint with our HIPAA policy, a print will be provided for your review.

Once you have signed the Patient Portal Consent Agreement and have provided us with a legitimate e-mail address that is secure, you will be e-mailed our system generated unique user id and password. You will then be able to use this information to access portions of your medical records and to communicate securely with our office. Keep your id and password secure.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I have been given the risks and benefits of Patient Portal and agree that I understand the risks associated with online communications between my physician and patient, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal in entirely voluntary and will not impact the quality of care I receive from Fairfield Medical Associates should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been proactive about asking questions related to this consent agreement. All my questions have been answered with clarity.

Patient Name:____

Patient DOB:_________________Patient E-Mail Address:___________________________

Patient Signature: _______________________________________ Date:_________________

Parent or Legal Guardian Signature: _______________________________Date:___________

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for Fairfield Medical Associates to access my pharmacy benefits data electronically through RxHub. This consent will enable Fairfield Medical Associates to:

- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Patient Signature: ______________________________ Date:___________

Emergency Contact Information:

Patient Name: ____ DOB: ____________________

EMERGENCY CONTACTS:

Name: ____ Relationship: ______________________

Home or cell Number: ___________________________Work Number: ______________________

Address: ____

Name: ____ Relationship: ______________________

Home or cell Number: ________________________Work Number: _________________________

Address: ____

PARENT OR LEGAL GUARDIAN (If not emergency contact):

Name: ____ Relationship: ___________________

Home or cell Number: ___________________________ Work Number: _____________________

Address: ____

Name: ____ Relationship: ___________________

Home or cell Number: ___________________________ Work Number: _____________________

Address: ____