Wiscasset Family Medicine

Cortney Linville, DO
Edward B. Kitfield, MD
Sarah L. Hurley, PA-C
Mary S. Rafter, FNP
Sarah H. Robey, PA-C

Dear Patient,

Thank you for choosing Wiscasset Family Medicine for your medical care.

We would like you to review and complete the following new patient forms prior to your visit.

- Authorization to Release Medical Information
- Authorization to Share Medical Information
- Scheduled Appointment Agreement
- Patient Medical History Form

Please complete our Authorization to Release Medical Information and return to us as soon as possible so we can request records from your previous provider.

Bring the rest of the forms in your new patient packet and a list of ALL your current medications with you when you see the doctor.

If your insurance company requires that you pay a co-pay for your visit that co-pay MUST be paid on the day you are seen.

Arrive 15 minutes prior to your appointment.

If you are unable to keep your appointment, please call our office as soon as possible. We look forward to meeting you and hope that Wiscasset Family Medicine will meet all of your health care needs.

In Good Health,
Wiscasset Family Medicine

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Vision

We are a collaborative patient centered medical home providing preventative and acute healthcare services of the highest quality to the families of Midcoast Maine.

Mission

- ✓ We place our patients in the center of our heath care team, providing them with a safe, welcoming environment where they are listened to and heard in a non-judgmental manner. We empower them to make positive choices for their health incorporating body, mind and spirit.
- ✓ We exhibit high standards of confidentiality and ethical behavior.
- ✓ Our motto is respectful, personalized and exceptional heath care services.
- ✓ We strive to be examples to our patients by taking responsibility for our own health through prevention and lifestyle choices.

Services offered

- 24/7 on call coverage for emergency questions
- Same day scheduling and access to “quick care” visits
- Extended office hours
- Newborn, Pediatric, Reproductive health & Geriatric Care
- Dermatologic Office Surgeries
- On site laboratory testing
- Cardiac risk assessment
- Osteopathic Manipulative Treatment
- Addiction Medicine treatment
- On site behavioral health assessment and treatment

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Hours of Operation

Phone Hours of Operation: Wiscasset Family Medicine's staff is available by phone from 7:30 AM to 5:00 PM EST, Monday through Friday. We will be out of the office from 12:15 PM to 1:30 PM each day for daily meetings and lunch.

Extended Hours of Operation: Wiscasset Family Medicine schedules 7:00 am appointments and offers quick care access to provide access for routine and urgent-care appointments outside regular appointments during business hours.

Monday & Wednesday **-** First appointment is scheduled at 7:00 AM; last appointment is scheduled at 4:45 PM.
Tuesday & Thursday - First appointment is scheduled at 7:30 AM; last appointment is scheduled at 4:45 PM.
Friday - First appointment is scheduled at 7:00 AM; last appointment is scheduled at 4:30 PM.

Same Day Access: Wiscasset Family Medicine reserves some appointments for same-day routine care

Quick care: acute care appointments for an urgent issue based on patient's preference and needs.

Phone Access after Regular Hours of Operation: Wiscasset Family Medicine will turn their phones over Monday-Friday at 5:00 PM. During this time, patient's can call our on-call service for EMERGENT concerns at 207-882-1056 which is available from 5:00 PM to 7:30 AM Monday-Friday and 24/7 availability during weekend hours. Wiscasset Family Medicine's on-call service will assist you in contacting the Wiscasset Family Medicine's provider on-call.

24/7 Access to Clinical Advice: By means of Wiscasset Family Medicine's Patient Portal, patients have 24/7 access to their medical health record and upcoming appointments. Once registered for the portal, you have the ability send prescription, referral, or appointment request and e-mail general questions to your healthcare provider. **Under no circumstances should the patient portal be used for means of communication regarding urgent care. Wiscasset Family Medicine asks that patient allow 24-48 hour turnaround for all patient portal electronic messaging requests.**

Wiscasset Family Medicine Policy for Staff/Provider Response Times:

Non-Urgent: All Non-Urgent patient questions/requests/concerns should be addressed within 24-48 hours of initial telephone encounter or secure electronic message.

Urgent Clinical Advice: All urgent patient questions/requests/concerns should be addressed the day of the initial contact. Under no circumstances should urgent care be addressed the next business day.

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Patient's Rights and Responsibilities

PATIENT'S RIGHTS

- Receive care, no matter your age, race, ethnicity, culture, color, national origin, language, sex, gender identity or expression, sexual orientation, appearance, socio-economic status, physical or metal disability, religion, or diagnosis.
- You have the right to designate a support person of your choosing. This support person may be, but is not limited to a spouse, a domestic partner (including a same sex domestic partner), a family member, or a friend.
- Feel safe at Wiscasset Family Medicine.
- To ask questions if you have concerns.
- To say 'No' to any treatment options we suggest.
- To have your religious beliefs respected.
- You have the right to be well informed about your illness, possible treatments, likely outcomes and unexpected outcomes and discuss this with your health care provider.
- You have the right to be free from all forms of abuse or harassment.
- You have the right to have your choices about health care decisions respected.
- You have the right to have your choices about health care decisions respected.
- To be treated politely with consideration.
- To have your privacy respected.
- To receive a copy of, or review your medical records and to have information explained, except when restricted by law.
- To have your questions about any costs or bills answered at any time.
- To high quality of care.
- To information and education.
- You have the right to know the names of your health care providers, medical assistants and health care administrative assistants and all personnel involved in your health care.
- You have the right to expect that treatment records are confidential unless you have given permission to release information or reporting is required or permitted by law. When Wiscasset Family Medicine releases records to others, such as insurers during the billing process, we emphasize that the records are confidential.

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Patient's Rights and Responsibilities continued

CONCERNS, COMPLAINTS OR GRIEVANCES

As a patient of Wiscasset Family Medicine, you also have the right to…

- Receive a reasonably timed response to your request for services.
- Be involved in resolving issues involving your own care, treatment and services.
- To express concerns, complaints and/or a grievance to Wiscasset Family Medicine personnel. You may do this by contacting the Wiscasset Family Medicine Practice Manager:

Shelley Strozier, Practice Manager
P.O. Box 351, 66 Water Street
Wiscasset, ME 04578
(Phone) 207.882.6008 (Fax) 207.882.7803

PATIENT'S RESPONSIBILITIES

- Give correct and complete information about your health status and health history.
- Ask questions if you do not understand information or instructions.
- Inform your caregivers if you do not intend to or cannot follow the treatment plan.
- Accept health consequences that may occur if you decide to refuse treatment or instructions.
- Cooperate with your caregivers.
- Tell your caregivers of any medications you brought from home.
- Tell your caregivers at Wiscasset Family Medicine if you received care in another facility or practice.
- Give other providers or facilities your personal clinician's information when you seek care outside of Wiscasset Family Medicine.
- Report any changes in your health status to your caregivers.
- To follow rules and regulations.
- Respect the rights and be considerate of Wiscasset Family Medicine personnel, property of the practice and other patients.
- To keep your scheduled appointments, or let us know if you are unable to keep them.
- To pay your bills or make arrangements to meet the financial obligations arising from your care.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Each time you visit us, we keep a record of your care and treatment. We take the protection of your personal information seriously. We are required to provide you with this Notice of Privacy Practices to tell you about our legal duties and ways we may use and share your information, and to inform you about your rights regarding your health information. We give a small number of examples to describe what the categories mean, but not every use or disclosure can be listed on this Notice.

You have a right to a paper copy of this Notice of Privacy Practices.

This Notice is effective as of: November 1, 2012. **(*UPDATED: April 20th, 2018)** We will ask you to sign a written acknowledgement of receipt of our Notice. We reserve the right to change the terms of this Notice and post the current Notice in our office. You may obtain an updated Notice from our practice at any time.

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer: Shelley Strozier here in the office or by phone: 882-6008.

How We May Use and Disclose Protected Health Information:

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and related services in our office or with a third party. For example, we may share your protected health information with a pharmacy for filling prescriptions, a laboratory or imaging center if you need diagnostic services, with a specialist to whom we refer you, or with a home health agency that provides care to you. We may share information with persons involved in your care, such as family members.

For Payment: We will use your protected health information to get paid for your healthcare services. We may share information with your insurance company to obtain payment for services or to seek pre-approval for hospital stay or procedures. We may also share (financial) information with a Business Associate to process your refunds.

For Our Healthcare or Business Operations: We may disclose your protected health information to support the business activities of this office, such as reviewing our care and our employees, for education and training, to support our electronic health record system, or for legal or accounting matters. We may use a sign-in sheet at the registration desk so that we may call you by name when we are ready to see you, and we may contact you to remind you of your appointment. If we involve third parties, such as billing services, in our business activities, we will have them sign a “Business Associate Agreement” obligating them to safeguard your protected health information according to the same legal standards we follow.

When Allowed By Law: The law allows us to use or disclose your protected health information in certain situations, including:

- When required by state or federal law;
- To report abuse or neglect;
- To persons authorized by law to act on your behalf, such as a guardian, health care power of attorney or surrogate;
- For disaster relief purposes, such as to notify family about your whereabouts and condition;
- To comply with Food and Drug Administration requirements;
- For health oversight purposes such as reporting to Medicare, Medicaid or licensing audits, investigations or inspections;
- Where required by U.S Department of Health and Human Services to determine our compliance;
- In connection with Workers' Compensation claims for benefits; and
- To assist coroners or funeral directors in carrying out their duties.
- To comply with a valid court order, subpoena or other appropriate administrative or legal request if you are involved in a lawsuit or to assist law enforcement where there was a possible crime on the premises. We may also share your information where necessary to prevent or lessen a serious or imminent threat to you or another.
- If you are an inmate, we may release your information for your health or safety in the correctional facility; We may share your information with appropriate military entities if you are a member or veteran of the armed forces; We may be required to disclose information for national security or intelligence purposes.

With your Authorization: Other uses and disclosures will be made only with your written authorization. For example, we will ask for your written permission before promoting a product or service to you for which we will be paid by a company, and generally before sharing your health information in a way that is considered sale under the law. If you sign an authorization, you may revoke it at any time, except where we have already shared your information based on your permission.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to access, inspect and copy your protected health information.

- This usually includes medical and or billing records. You must submit a written request to us, and you agree to pay the reasonable costs associated with complying with your request BEFORE we provide you with your record
- You may ask us to provide your electronic record in electronic format. If we are unable to provide your record in the format you request, we will provide the record in a form that works for you and our office. You may ask us to transmit your record to a specific person or entity by making a written, signed request. You may request the information be sent via our email system if you sign a statement that you understand that email comes with inherent risks for which our office is not responsible.
- Under certain circumstances, your provider may not allow you to see or access certain parts of your record. You may ask that this decision be reviewed by another licensed professional.

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You have the right to request to receive confidential communications, and request contact from us by **alternative means** or at an alternative location.

You have the right to request a restriction of your protected health information.

- This means you may ask us not to use or disclose all or part of your protected health information for certain purposes. We will consider your request carefully, and may honor reasonable requests where possible. The law does not require us to agree to every request.
- However, if you wish to restrict certain sensitive or other health information from your insurer after you or your personal representative have paid out of pocket in full for your services, please discuss request with us. We will honor your request where we are not required by law to make the disclosure. If your insurance plan "bundles" your services together so that we cannot withhold only one item or service from your claim, we will discuss your options with you.
- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request MUST state the specific restriction requested and to whom you want the restriction to apply.

You have the right to receive an accounting of certain disclosures we have made of your protected information. Please speak with us if you have this request.

You may have the right to request amendment of your protected health information. While we cannot erase your record, we may add your written statement to your protected health information to correct or clarify the record where your provider approves. If the provider disapproves, you may submit a statement of disagreement and we may submit a rebuttal, which will remain with your record.

Fundraising: We do not currently conduct fundraising campaigns. If we do so in the future you have the right to "opt-out" of any fundraising solicitation or communication.

Breach notification: We are required to have safeguards in place that protect your health information. In the event that there is a breach of those protections, we will notify you, the U.S Department of Health and Human Services and others, as the law requires.

You may file a complaint with us by notifying our Privacy Office with your written complaint. We will not retaliate against you for filing a complaint with us or the Office of Civil Rights.

You may complain to the Office of Civil Rights at the Department of Health and Human Services (OCR) if you believe your privacy rights have been violated by us. You should contact the OCT in writing at:
http://www.hhs.gov/ocr/privacy/hippa/complaints/index.html

Date Received: _____

Wiscasset Family Medicine

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____ Apt. # _____
City: _____ State: _____ Zip Code: _____ Ph# (___) _____

I hereby authorize the release of copies of my medical records concerning my illness, treatment or recommendations while I was a patient at the medical facility, during the dates of: _____

These records should be released:

From:
Name: _____ Phone Number: _____
Address: _____ Fax Number: _____
_____

To:
Wiscasset Family Medicine, LLC.
P.O. Box 351 / 66 Water St.
Wiscasset, Maine 04578

Phone Number: (207) 882-6008
Fax Number: (207) 882-7803

I request the following information be released:

_____ Inpatient hospital record ____ ER/ First Care Visit _____ X-Rays or EKG _____ Lab/Path report
_____ Clinical Offices (specify) _____ _____ Other (specify) _____
_____ Abstract (choose for personal use, and continuation of care) _____ Complete Copy (used for legal purposes)

Please initial the following specific authorizations: [Required by law]:

_____ AIDS/HIV and other Communicable Disease
_____ Alcohol and/or Drug Abuse Treatment
_____ Mental Health Services provided by: A clinical nurse specialist; Psychologist; Social Worker; counseling professional; or a physician specializing in psychiatry licensed under the provision of Title 32.

Purpose of disclosure: (Check applicable purpose)

☐ Transfer of Care ☐ Continued Medical Care ☐ Other: _____

I understand I may revoke all or part of this authorization by notifying Wiscasset Family Medicine. This authorization will be retained as part of my medical record. I may refuse to disclose all or some of the information in my medical record. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or claim for health benefits, or other adverse consequences. I may cross out any words on this authorization with which I disagree. I may have a copy of this authorization upon request. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. If I refuse to sign this authorization I understand my records will not be released.

This authorization will expire 90 days from the date I sign this form.

_____ _____ _____
Signature of Patient or Legal Representative | Relationship to Patient | Date

Wiscasset Family Medicine may take up to 30 business days to complete requests. If picking up records, please bring a photo ID.

Charges are as follows for the processing of medical records:
Paper copies - $5 for the first page and $0.45 per page following, up to a maximum of $250 for the entire treatment record or medical report.
Digital or Electronic copies - $50 flat rate fee.

There are no charges for provider to provide care. We accept checks, money orders, Visa or MasterCard.

Date Received: _____

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Authorization to Share Medical Information

Patient Name:_____ **Date of Birth**: _____

☐ **I do not wish to have messages left on my answering machine.**

☐ **I can be contacted via portal message**

I hereby authorize **Wiscasset Family Medicine** to include, person named below, in the management of my health care. This includes access to **ALL my medical information**, the ability to make appointments, receive test results and discuss my medical treatment with medical providers. They are authorized to request copies of my records as needed.

In an EMERGENCY, we would contact your "emergency contact", therefore, this form may be left blank.

Person included in my care:

Name: _____ Phone # _____ Relationship: _____

Name: _____ Phone # _____ Relationship: _____

Name: _____ Phone # _____ Relationship: _____

I authorize the provider to use or disclose information related to (please initial) [Required by State law]:

_____ **AIDS/HIV and other Communicable Disease**

_____ **Alcohol and/or Drug Abuse Treatment**

_____ **Mental Health Services** provided by**:** A clinical nurse specialist; Psychologist; Social Worker; counseling professional; or a physician specializing in psychiatry licensed under the provision of Title 32.

I understand I may revoke all or part of this authorization by notifying Wiscasset Family Medicine. This authorization will be retained as part of my medical record. I may refuse to disclose all or some of the information in my medical record. I may have a copy of this authorization upon request. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date

Date Received: _____

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Patient Medical History Form

Name: _____ Age: _____ Date of Birth_____/_____/_____

PHYSICIAN you were seeing previously: _____

Other **SPECIALISTS** you currently see:

_____

_____

CURRENT Medical Concerns

_____

_____

_____

List all **CURRENT PRESCRIPTION & OVER THE COUNTER MEDICATIONS** (include dosage, reason you take it, who prescribed it, use last page for more room if you need to)

_____	_____	_____	_____
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
_____	_____	_____	_____
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
_____	_____	_____	_____
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
_____	_____	_____	_____
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)

List all ALLERGIES (include food, environmental, & medication allergies)

_____

_____

_____

_____

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List all SURGERIES you have had (include year, surgeon, and hospital)

_____

_____

Describe **HOSPITALIZTIONS/ILLNESSES** do not include above (Include year, hospital)

_____

_____

MEDICAL HISTORY

Have you had (check all that apply):

☐ migraines	☐ hepatitis	☐ mono	☐ ulcer	☐ bleeding problem
☐ blood clots	☐ head injury	☐ drug addiction	☐ gallstones	☐ tuberculosis
☐ STDs	☐ seizures	☐ memory trouble	☐ arthritis	☐ shingles
☐ psoriasis	☐ heart murmur	☐ rheumatic fever	☐ polio	☐ gout
☐ alcoholism	☐ drug abuse	☐ depression	☐ mental illness	☐ hemorrhoids
☐ hearing trouble	☐ vision trouble	☐ other(s): _____		

Do you have a Living Will? ☐ Yes ☐ No **If not, are you interested in having one?** ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

(please list family medical problems, including substance abuse or mental health concerns or cause of death)

Mother: _____
Father: _____
Siblings: _____

Please list pertinent diseases that run in your family and specify your relationship to each family member listed.

_____

_____

_____

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WOMEN'S MEDICAL HISTORY

Birth control method _____

Date of last Pap _____/_____/_____ Result_____ Done where? _____

Date of last mammogram ____/____/_____ Result _____ Done where? _____

Anything else you would like us to know?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ADDITIONAL PRESCRIPTIONS

(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)
(Prescription)	(Dosage)	(Reason)	(Prescribing Provider)

Date Received: _____

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Scheduled Appointment Agreement

Our responsibility to the patient is to provide care and order labs based on your individual medical needs and current prevention guidelines and the standard of medical care. Please take the time to familiarize yourself with your insurance benefits with a phone call to your insurance company, if necessary. There are many plans and their benefits change often, so we have no way of knowing what is current for you.

You may schedule an appointment as WELLNESS EXAM, PHYSICAL EXAM or ROUTINE CARE EXAM, and it will be billed as such to your insurance plan. Due to coding rules, we MUST bill this exam as Preventive Care. If during your visit you have additional concerns or problems that require a diagnosis and/or other treatment it would be considered a Problem-Oriented Exam and you may incur additional office or lab charges. These charges and any for your Preventive Care Exam will be billed to your insurance company. If you would like to keep preventive care charges separate from your Problem-Oriented Exam, we prefer this too and we would be happy to schedule it that way for you. You may be asked to schedule a separate appointment for specific concerns, based on time constraints.

If your insurance company does not cover some or all of theses charges, you will be billed directly for the balance they indicate is “patient responsibility”. Please do not ask us to re-bill your insurance by changing the procedure or diagnosis codes. We are unable to make a change once the insurance has been billed.

Any laboratory services that are not provided by Wiscasset Family Medicine (in house) are provided by NorDx Laboratory and have no direct financial or other affiliation with Wiscasset Family Medicine. This means the blood may be drawn by Wiscasset Family Medicine, but the laboratory work is done and is billed entirely by NorDx. If a billing question about laboratory service occurs, it is the responsibility of the patient to direct those questions to the NorDx billing department, and please note, that we can not change codes after the service is obtained.

I acknowledge that I have read and understand the information above. I understand I will be financially responsible for services that my insurance company indicates are “patient responsibility”.

_____
Printed Name

_____
Signature

_____/_____/_____
Date

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SIGNATURE ON FILE

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)			E-Mail	
Billing Address		City	State	Zip
Physical Address		City	State	Zip
Home Phone	Cell Phone		Work Phone Ex:	
Social Security No. (SS#)	Sex:	Marital Status	Date of Birth	PCP Selection ☐ Cortney Linville, DO ☐ Sarah Hurley, PA-C ☐ Mary Rafter, FNP
Employer Name	Employer Address			
Permitted Contact Method(s) (circle all that apply) home phone cell work phone e-mail mail			Ok to leave message on answering machine/voicemail? Yes_____ No_____	
Pharmacy Name: Address: Pharmacy Phone:				

Race		Ethnicity		Language	
American Indian or Alaska Native	☐	Hispanic/Latino	☐	English	☐
Asian	☐	Non Hispanic/Latino	☐	Spanish	☐
Native Hawaiian	☐	Unreported/Refused to Report	☐	Indian	☐
Black or African American	☐			Russian	☐
White	☐			Other	☐
Hispanic	☐				
Other Race	☐				
Other Pacific Islander	☐				
Unreported/Refused to Report	☐				

INSURANCE INFORMATION

Primary Insurance Co. Name	Group No.	ID/Certificate No.
Policy Holder's Name/Parent's Name	DOB	Policy Holder's SS#
Secondary Insurance Co. Name/Policy Holder's Name	Group No.	ID/Certificate No.

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EMERGENCY INFORMATION

Person to Notify in Case of Emergency		Relationship	Home Phone		Cell Phone
Address	Apt No.	City		State	Zip

INFORMATION FOR THE PATIENT

1. Patients who **do not** carry standard health insurance should remember that professional services rendered will be billed to the patient. All patients without standard health care insurance are expected to make payments in full as services are rendered **at the time of service**.
2. Patients with contract health insurance should present their insurance ID card to the receptionist to be copied into the patients chart. Some health plans require a co-payment; patients with co-pays will be expected to pay their co-payment **at the time of service.**
3. By signing you hereby authorize health care services by your provider and his/her designee(s) as your provider may deem advisable and in your best interested. This may include routine diagnostic, laboratory procedures and medication administration.

_____ Date _____/_____/_____
Patient/Guarantor Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please sign below and return this form to Wiscasset Family Medicine so that we know you have received our Notice of Privacy Practices.

I, _____ acknowledge receipt of the Notice of Privacy Practices prepared by Wiscasset Family Medicine. Also, I acknowledge that I have had and opportunity to ask questions about the practice's Notice of Privacy Practices.

_____ Date _____/_____/_____
Patient/Guarantor Signature

_____
Print Name