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Philadelphia, PA 19004

2981 Grant Avenue
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274 Susquehanna Avenue
Wyoming, PA 18644

(P) 610-419-3388 (F) 610-419-3266

# PERSONAL

## Patient Intake and Medical History

*(All information requested is required. Please do not leave anything blank)*

Name: _____ DOB: _____

SSN: _____-_____-_____ Phone: _____

Address: _____ Apt: _____
City: _____ State: _____ Zip: _____

Consent to call/text: (circle one) **YES | NO** Marital Status: _____

Email address: _____

Pharmacy Name and location: _____

Emergency contact: _____ Relation: _____
Emergency contact phone number: _____

**Primary Insurance Information**

Name: _____ ID#: _____
Insurance Address: _____
Insurance Phone: _____ Group#: _____
Primary Subscriber Info (only fill out if you are ***NOT*** the primary holder)
Name: _____ DOB: _____
Address: _____

**Secondary Insurance Information**

Name: _____ ID#: _____
Insurance Address: _____
Insurance Phone: _____ Group#: _____
Primary Subscriber Info (only fill out if you are ***NOT*** the primary holder)
Name: _____ DOB: _____
Address: _____

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Please list any and all allergies to medications below. If none, please circle **NKDA**

_____

_____

Reason for today's visit: _____ Pain level: (0-10) _____

Family Medical History (i.e., diabetes, hypertension, asthma, cancer, anxiety, etc.)

Maternal (moms' side) _____

Paternal (dads' side) _____

Able to care for yourself: (please circle yes or no) **YES | NO**

Are you currently employed: (please circle yes or no) **YES | NO**

What is your general stress level: (please circle one) **LOW | MEDIUM | HIGH**

Number of Children? _____

What is your alcohol intake: (circle one) **NONE | SOCIAL | MODERATE | HEAVY**

Are you hard of hearing in one or both ears: (circle one) **YES | NO ONE | BOTH**
Are you legally blind in one or both eyes: (circle one) **YES | NO ONE | BOTH**

Are you sexually active: (please circle one) **YES | NO**
if yes, protected: (please circle one) **ALWAYS | USUALLY | NEVER**

Are you a current everyday smoker: (please circle one) **YES | NO**
if yes, how many years: _____ how many a day: _____

Please list all surgeries and dates (or year) below:

_____

_____

_____

Are you currently taking any **prescribed** medications: (circle one) **YES | NO**
if yes, please provide a list of names, dosage, and the reason its prescribed:

_____

_____

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Medical History: **PLEASE CIRLCE ALL THAT APPLY TO YOU**

ADD/ADHD AIDS/HIV Abuse/Domestic Violence Allergies/Hayfever Anemia

Anesthesia Complications Anxiety Arthritis Asthma Autism Bedwetting

Bladder/Kidney Problems Blood Disease Blood Transfusion Breast Cancer

Breast Problems COPD Cancer Chicken Pox Chronic Ear Infections

Congestive Heart Failure Constipation Coronary Artery Disease Depression

Developmental/Behavioral Disorder Diabetes Difficulty Swallowing Diverticulitis

Ear/Hearing Problems Easting Disorder Eczema Endometriosis Fibromyalgia

GI Problems Gout Headaches Heart Disease Heart Problems Hepatitis

High Cholesterol High Blood Pressure Infertility Kidney Disease Kidney Stones

Liver Disease Lung Disease MRSA Exposure Maniere's Disease

Mental Disorder Mental Illness Muscle problems Obesity Osteoporosis

Ovarian Cancer Polyps Pre-Eclampsia Pulmonary Embolism Reflux/GERD

Seizures/Epilespy Skin Problems Stroke Thrombophilia's Tuberculosis

Varicosities Vision Problems

**The following only applies to women:**

Date of last PAP: _____ Was it normal: **YES | NO**
If postmenopausal, age at menopause: _____
HPV Vaccine: **YES | NO** Sexual Problems: **YES | NO** STDs: **YES | NO**
Age at first child: _____
Current birth control method: (indicate NONE if none) _____
Most recent mammogram: (indicate NONE if you never had one) _____
How many pregnancies have you had: (indicate 0 if none) _____
Full term pregnancies: _____Premature pregnancies: _____
Abortions induced: _____Abortions spontaneous: _____
How many children do you have living: _____

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# Medication Contract

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following:

_____1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication **will not be replaced** regardless of the circumstances.

_____ 2.) Refills of controlled substance medications;

_____a) Will be made only during regular office hours *Monday through Friday, in person, once a month, and during a scheduled office visit.* Refills will not be made at night, weekends, or during holidays and through answering service.

_____b) Will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

_____c) I understand that I must call ahead within 72 hours to schedule an appointment.

_____ 3.) It may be deemed necessary by my doctor that I see a medication-use specialist (pain management) at the time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications will no longer be filled.

_____4.) I agree to comply with urine testing and pill counts at every appointment, thereby, documenting the proper use of any medications.

_____ 5.) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

_____ 6.) I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

_____ 7.) I understand that the long term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and

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agree that there may be unknown risks associated with the long term use of controlled substances that my physician will advise me of advances in the field and will make necessary treatment changes.

_____ 8.) I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

_____ 9.) I understand that I will only use one pharmacy (or pharmacy brand ex. CVS, Rite aid, etc.)

_____10. I give permission to my physician and staff to monitor my prescription history and current status through PDMP (Prescription Drug and Monitoring Program)

_____ 11. I understand that the office of Dr. Hernandez will not tolerate any abusive, aberrant and negative behavior. This will also give the office permission to dismiss me as a patient if not adhered.

_____ 12. I understand that the pain medication prescribed to me by Dr. Hernandez is for my personal use ONLY. I will take every precaution to safe guard it. I also know and understand that selling my medication is against the law, and will be terminated from the practice immediately and without notice.

**Pharmacy name**: _____ **Phone Number**: _____

I have been fully informed by **Dr. Hernandez** regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms.

**The office of Dr. Hernandez will be instituting the following policies effective immediately.**

1. All schedule 2, 3, and 4 medications* will be written for only one month at a time. Every month, I will be seen in the office and will review my pain management contract with Dr. Hernandez

*This includes the following:

- All forms of hydrocodone – (vicodin, Lorcet, Lortab)
- All forms of oxycodone- (Percocet/percodan, oxycontin, Tylox)
- Most muscle relaxers- (valium, soma, Etc.)
- Duragesic, Fentanlyl patches
- Most sleeping agents- Ambien (Zolpidem), Lunesta,
- All Benzodiazepines- Klonopin (clonazepam), Restoril (temazepam), Serax (oxazepam), Xanax (Alprazolam)

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- Codeine Preparations (Tylenol # 3, Tussionex)
- Testosterone replacements (Testim, Androgel, Fortesta, Axiron, Cypionate, Enanthate)

2.) I understand that **THERE WILL BE NO REPLACEMENT PRESCRIPTIONS GIVEN. NO EXCEPTION>** a police report will be required to continue as a patient of the practice.

3.) I understand that I must bring all medication bottles and/or pills to every appointment for pill count verification.

We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice the art and science of medicine in the safest and most efficacious manner possible.

Patient Signature _____ Date ____/_____/_____

Dr. Danny Hernandez _____ Date ____/_____/_____

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# Consent to Communicate

I, the undersigned, give the office of Dr. Hernandez permission to communicate with myself and with the following persons and/or phone numbers.

| Name | Phone number/email | Relationship | Leave message Yes/NO | Able to discuss medical info Yes/NO |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

THIS CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING.

Patient signature:_____ Date:_____

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# Consent to Treat

*Please read and sign*

1. I, the undersigned, herby consent to the following:
    a. Administration and performance of all treatment
    b. Use of prescribed medications
    c. Performance of diagnostic procedures/tests
    d. Performance of medically necessary laboratory tests
2. I understand that this is given in advance of any specific diagnosis or treatment.
3. I intend this consent to be continuing in nature even after s specific diagnosis has been made and treatment recommended. THIS CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING.

Treatment outcome: include, but limited to, performance and administration of all treatments, the use of prescribed medications, diagnostic procedures and tests, laboratory testing.

Procedure outcome: risks and benefits including complications were discussed to my full understanding. These include, infection, wound healing problems, vascular events.

Payment: include, but not limited to, authorization of payment directly to DWH Medical Center, PC, office of Dr. Danny Hernandez. I also authorize the disclosure of my personal information to third party billing, collection agency, auto accident, Workers compensation, and attorneys. I understand that I Am financially responsible for charges not covered. I understand that my medical record is stored electronically.

**PHOTOCOPY /SCANNED COPY OF MY CONSENT SHALL BE CONSIDERED AS VALID AS THE ORGINAL.**

Patient name: _____ Signature: _____

Date: _____

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# AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

**Name of Patient:** _____

**Date of Birth:** ____/____/_____ **Social Security Number:** _____-_____-_____

I requested and authorized, the release of healthcare information or access to the information specified below from the medical record(s) of the above-named patient.

**RECORDS TO BE RELEASED FROM:**

_____

(Doctor, Hospital, Clinic, etc.)

(____) _____-_____ (____) _____-_____

Fax Phone

**INFORMATION SHOULD BE RELEASED TO:**

**DWH Medical Center, PC**
**1707-1709 W Hamilton Street**
**Allentown, Pa 18104**

**THIS REQUEST AND AUTHORIZATION APPLIES TO:**

- ☐ History & Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Discharge Summary
- ☐ X-Ray Report
- ☐ Emergency Room Record
- ☐ Laboratory Reports
- ☐ Entire Medical Record
- ☐ Other: _____

*I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to his authorization may be subject to re-disclosure by the recipient and is no longer protected. I understand that the specific information to be released may include, but is not limited to: history, diagnosis, and or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency System (AIDS). I authorize the release of specific data. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of the information has been made prior to receipt of the revocation. This authorization expires one year from the date of signature unless I specifically request or otherwise revoke it. I understand I may be charged a fee for retrieval/processing and copying of my medical records.*

**I HAVE READ AND UNDERSTAND THIS CONSENT AND I HAVE SIGNED IT VOLUNTARILY AND OF MY OWN FREE WILL.**

_____

(Signature of Patient) (Signature of Parent/Legal Representative)

_____/_____/_____

(Date)

*THIS AUTHORIZATION EXPIRES IN NINETY (90) DAYS AFTER IT IS SIGNED*

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# Prior Authorization Protocol Signature sheet

Patient Name: _____ DOB: _____

I, the undersigned, have been aware, read and fully understand the following protocols associated DWH Medical Center, PC, the office of Dr. Danny Hernandez.

Initial:

_____ Prior Authorization protocol

Signature: _____ Date: _____

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Our office policy in regards to prior authorizations is as follows:

1. ***We require minimum of 72 hours to initiate the prior authorization process.***
2. Insurance companies have a 24 hour turnaround time for the first response. This is not always an approval. If additional paperwork is necessary, we will try our best to get it to them on a timely basis, but usually will require an additional 24-72 from our office, and again another 24 hour turnaround time from the insurance, and so on.
3. As you are aware, most prior authorizations take on average 1 week to approve (some even more), therefore, please make sure we have the following on hand at all times to make the process more streamlined.
    a. Up to date insurance and demographic information
    b. Any failures and documented with Dr. Hernandez office visit note.
4. Please keep track of how long your prior authorization is good for. If it is due to expire, please make sure the staff is aware, and you attend a visit minimum one week prior to running out of your current medication.
5. If you are requesting a change of medication, please do so at least one week prior to running out of your current medication, to ensure we have adequate time to get the prior authorization.
6. Remember, WE ARE UNABLE TO START THE PRIOR AUTHORIZATION UNTIL YOU PLACE A SCRIPT AT THE PHARMACY. PLEASE BE AWARE OF TIMING AND CONSTRAINTS WE HAVE WITH YOUR INSURANCE TURN AROUND TIME.
7. Please have your counseling sheets faxed to 610-419-3266.

Office Manger: _____ Mais Khamiss, MBA

**PLEASE KEEP for your records.**