WELCOME

JOSEPH T. HAYES, M.D., M.P.H.
MERCY SUBURBAN HOSPITAL -MAP
2705 DeKalb Pike, Ste. 307
East Norriton, PA 19401
Telephone: (610) 633-6814

1 PATIENT INFORMATION

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

City ______

State ______ Zip ______

E-mail ______

Sex ☐ M ☐ F Age ______ Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ______

Patient Employer/School ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

2 INSURANCE

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

______
Name of Insurance Company(ies)

and assign directly to Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

______
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

______
Signature of Beneficiary, Guardian or Personal Representative

______
Please print name of Beneficiary, Guardian or Personal Representative

______ ______
Date Relationship to Beneficiary

3 PHONE NUMBERS

Home (____) ______ Cell (____) ______

Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT

Name ______ Relationship ______

Home Phone (____) ______

Work Phone (____) ______

4 FAMILY HISTORY

Date of last physical examination ______

What is your reason for visit? ______

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**
☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other ______

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5 HEALTH HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ____________

Date of last Pap Smear ____________

Have you had a mammogram? ____________

Are you pregnant? ____________

Number of children ____________

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations ____

6 MEDICATIONS/ALLERGIES

List medications you are currently taking ____________________

____

Pharmacy Name ____________________

Phone (____)____________________

List allergies to medications or substances ____________________

____

7 HEALTH HABITS

Check (✓) which you use and how much:
- ☐ Caffeine ____________
- ☐ Street Drugs ____________
- ☐ Tobacco ____________
- ☐ Other ____________

Check (✓) if your work exposes you to:
- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other ____________

____

8 SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

______________________________ Signature of Patient, Parent, Guardian or Personal Representative

______________ Date

______________________________ Please print name of Patient, Parent, Guardian or Personal Representative

______________ Relationship to Patient

______________________________ Reviewed By

______________ Date

Joseph T. Hayes, M.D., M.P.H.

1970 North Broad Street
Lansdale, PA 19446

Mercy Suburban Hospital
Medical Arts Pavilion
2705 DeKalb Pike, Suite 307
East Norriton, PA 19401

Phone: 610-633-6814 • Fax: 732-840-5374

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THE INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS TO PHYSICIAN

The office of Joseph T. Hayes M.D., P.C. has agreed to accept your insurance/health plan for payment of all services rendered unless specified otherwise. By signing below, you authorize this office to accept payments from your insurance company or health care plan. We further agree not to bill you for any balance that exceeds payment made by your insurance company or health care plan with the exception of all applicable co-pays, deductibles, and non-covered services. All applicable co-pays are due at the time services are rendered. **You may be charged for professional services rendered not covered under your plan at the time of service.**

NO SHOW FEES

Our practice is very unique because our average patient visit is 45 minutes long. Furthermore, for our patient's convenience, we attempt to keep your waiting time in our waiting room to a minimum; we have about a 90% record of getting our patients in on time. It is rare that a patient has to wait more than 10 or 15 minutes. To that end, we are very strict about our schedules. Thus, we ask for the patient's cooperation by being on time so they can get the maximum benefit of their visit. Also, no shows can be very disruptive, and they may deprive other patients of the opportunity for an appointment. In addition, no shows may cause an unnecessary wait for a new patient's first appointment. Therefore, we have set up the following No Show Fee Policy. We ask for a 3 day notice for cancellation of an appointment with no charge (calls must be received by 10 a.m.). Two day cancellations will result in a no show fee of $50.00. A one day notice or a total no show will result in a $100 no show fee. Thank you for your cooperation. All cancellations must be made to 610-633-6814.

RETURN CHECK FEE

Return checks will be charged at $25.00 plus the outstanding balance.

I hereby agree to the terms above and authorize release of medical information necessary to file a claim with my health care plan or insurance company and assign benefits otherwise payable to Joseph T. Hayes, M.D.

Patient Signature ______________________________

Patient/Print name ______________________________

Date ______________________________

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HAYES PAIN MANAGEMENT

CONSENT AUTHORIZATION FOR TREATMENT

I, ____, signed this form and requesting and consenting to the service offered by Joseph T. Hayes, M.D., which may include, but is not limited to medication administration, trigger point injections, nerve blocks, diagnostic tests, physical medicine, Trans Cutaneous Nerve Stimulation, acupuncture, Percutaneous Electric Nerve Stimulation, and psychological counseling to be performed by Joseph T. Hayes, M.D. and/or staff.

I hereby warrant that I have not been legally judged as incompetent. I understand that it is my right to determine the extent of my medical care, and that I may at the time refuse treatment and withdrawal my consent to the performance of any procedure and treatment.

I understand and have been informed that in the therapies described above, there are some risks to treatment. These risks include but are not limited to contusions, bruises, bleeding, and infections. I do not expect the clinician to be able to participate and explain all risks and complications, and I wish to rely on the clinician to exercise judgment during the course of treatment, to determine the best course of treatment which the clinician feels at the time based upon the facts then known is in my best interest. I recognize that no guarantees have been or can be made regarding the likelihood of success or of the outcome of any evaluation, treatment, procedure, or therapy performed by Joseph T. Hayes, M.D., and/or staff.

I hereby warrant that I have read and understand to my satisfaction all of the above.

____
Print Name   Date

____
Patient's Signature   Date

HAYES CENTER FOR PAIN AND ADDICTION
CONSENT AUTHORIZATION AND OFFICE POLICY FOR PREAUTHORIZATIONS AND REFERRALS

Many patients have health care plans, insurance plans, and/or pharmacy medication insurance plans that require preauthorizations. All pharmacy plans are different, and they are specific for many medications. In most cases, you will not know that your medication requires a preauthorization until you attempt to fill your prescription at the pharmacy. It is YOUR responsibility to ensure that the proper paperwork is sent from your insurance company to this office if your health plan requires us to verify your medication. It is a common misconception that it is the doctor office's or the pharmacy's responsibility to arrange for this documentation. Once our office receives the proper documentation that YOU ensure is transmitted from your pharmacy plan to this office, we will cooperate within a reasonable period of time to complete same.

This office REQUIRES a 72 hours (3 business days) notice from you for any preauthorizations for medication required. Therefore, by signing this document, you agree to be updated with your health care pharmacy plan and to give this office 72 hours so your documentation can be processed. This ensures your coverage will not run out and decreases the chances of any out-of-pocket expense you may incur.

If your medication is denied by your health plan and we are notified, we will notify you. In order to facilitate an appeal, it is YOUR responsibility to have the medical director of your pharmacy plan contact this office for a peer to peer review. This office will gladly speak to the pharmacy representative, maximizing our efforts in order to get your medication covered.

PREAUTHORIZATION FOR PROCEDURES AND
DIAGNOSTIC STUDIES (CAT Scans, MRIs)

It is YOUR responsibility to contact your insurance plan to have the appropriate paperwork and information sent to this office so that the paperwork can be properly processes to facilitate your procedure and/or diagnostic study. This office requires a 72 hour (3 business days) notice for completion of same. If your procedure is denied, it is YOUR responsibility to contact YOUR health plan/member services and have the medical director or other representative contact this office for a peer to peer review to ensure you will receive coverage.

By signing below, I agree to the terms of this agreement.

NAME PRINTED--

NAME WRITTEN--

DATE--