WELCOME NEW PATIENTS!

Thank you for choosing

Family Medicine – North Main

Please arrive 20 minutes prior to your appointment time.

Please wear a mask if you are experiencing cold or flu-like symptoms.

Free parking is available behind the building.

Please bring the following items to your appointment:

- ✓ Completed new patient paperwork
- ✓ Insurance card(s) including Medicare card if applicable

  If your insurance card lists a PCP or specific practice name, this must be changed to Family Medicine North Main or the name of your new Family Medicine North Main PCP* ***before your appointment *. Otherwise, your insurance company may not pay for your visit, and you may receive a bill.*
- ✓ Photo ID or driver's license
- ✓ Current medication list
- ✓ Previous medical records, if available

- If you No-Show for your new patient appointment, you will not be rescheduled.
- If you arrive late, your appointment will be rescheduled.
- Please call 24 hours in advance if you need to reschedule your visit.

NEW PATIENT INFORMATION

Name_____ DOB ___/___/___
Address_____ City _____State ____ Zip_____

If patient is a minor:
Mother's full name _____Father's full name_____
Legal guardian's full name (if not mother or father)_____
Primary insurance holder for patient_____

Briefly describe your top 3 concerns today:
1)_____
2)_____
3)_____

Please list all prescriptions, over the counter medications and vitamins.

NAME OF DRUG	DOSE

Drug allergies:_____
Preferred pharmacy:_____

TURN PAGE OVER

Please list previous surgeries. Name_____ DOB___/___/___

TYPE OF SURGERY	YEAR	REASON

Past medical history – please check all that apply.

	Aids / HIV		Drug Abuse		Pacemaker
	Alcohol Abuse		Eczema		Palpitations
	Allergies		Enlarged Prostate		Pneumonia
	Asthma		Fibromyalgia		Psoriasis
	Anemia		Gallbladder Disease		Sciatica
	Anxiety		GERD (Reflux)		Seizures
	Arthritis		Glaucoma		Sexual Dysfunction
	Atrial Fibrillation		Gout		Sleep Apnea
	Back Pain		Headaches		STD
	Blood Clots		Heart Attack		Stomach Ulcer
	Cancer		Heart Disease		Stroke
	Chest Pain		Heart Murmur		Swollen Ankles
	Congestive Heart Failure		Hemorrhoids		Thyroid Disease
	Constipation		Hepatitis C		Tuberculosis
	COPD		High Blood Pressure		Ulcerative Colitis
	Crohn’s Disease		High Cholesterol		UTI (Recurrent)
	Depression		Kidney Stones		Other:
	Diabetes Mellitus-Type I		Kidney Disease (Renal Insufficiency)		Other:
	Diabetes Mellitus – Type II		Liver Disease		Other:
	Diverticulitis		Osteoporosis		Other:

Name_____ DOB___/___/___

Do any family members have a history of the following:

ILLNESS	FAMILY MEMBER	AGE OF ONSET	ALIVE	DECEASED
Diabetes				
High Blood Pressure				
Heart Disease/Bypass Surgery/Heart Attack				
Stroke				
Mental Disease/Anxiety/Depression				
Cancer (type_____)				
Drug/Alcohol Addiction				
Glaucoma				
Bleeding Disorder				
Blood Clots				
Other_____				
Other_____				

Please answer the following questions related to safety.

	YES	NO
Do you wear a seat belt?		
Are you exposed to secondhand smoke?		
Do you drink caffeinated beverages?		
Have you had 2 or more falls in the past year?		
If there is a gun in your home, is it stored unloaded in a secure location away from children?		
Are you in a verbally or physically abusive relationship?		
Do you feel safe in your home?		

TURN PAGE OVER

Name_____ DOB___/___/___

Please answer the following questions regarding your personal history.

What is your highest education level? Grade_____ Please check: Some College_____ College Graduate_____ Advanced Degree_____
Do you have children? No_____ Yes _____ If yes, how many? _____
How often do you exercise each week? No exercise _____ 1-2 x per week_____ 2-3 x per week_____ 3-4 x per week_____
What kind of exercise?
With whom do you currently live?
Marital status: Partner/Significant other _____ Never married _____ Married _____ Divorced _____ Separated _____ Widowed _____
Are you currently working? No _____ Yes_____
What is your current or past occupation?

Please answer the following questions about your social history.

Are you a smoker? No _____ Yes _____
CURRENT SMOKER: How many cigarettes/ cigars per day? Please check: 5 or less _____ 6-10_____ 11-20 _____ 21-30_____ 31+ _____
FORMER SMOKER: How long ago did you quit smoking?
Please list any other tobacco use:
Are you sexually active? Yes _____ No _____ My partner preference is: Male _____ Female_____ Both _____
Did you have a drink containing alcohol this year? No _____ Yes _____
If yes, how often do you drink alcohol? Please check: Monthly or less _____ 2-4 per month _____ 2-3 per week 4 + per week _____
How many drinks on a typical day? Please check: 1-2 _____ 3-4_____ 5-6_____ 7-9_____ 10+ _____
How often have you had 6 or more drinks on one occasion? Please check: Never _____ Less than monthly _____ Monthly _____ Weekly _____ Daily _____
Do you use drugs that are not medical? No_____ Yes _____
If yes, please list any non-medical drugs:

Name_____ DOB___/___/___

Please answer the following questions regarding your mood.

In the past 2 weeks, do you report:
Little interest or pleasure in doing things? Yes _____ No_____
Feeling down, depressed or hopeless? Yes _____ No_____

Please answer the following questions if you are age 65+

Have you had 2 or more falls in the past year? Yes _____ No_____
FEMALES ONLY:
Do you have urinary leakage when you laugh, cough or sneeze?
Yes _____ No_____
Do you ever have loss of bladder control? Yes _____ No _____

Please answer the following questions about your health maintenance.

MALES ONLY: When was your last:	Date
Prostate Exam	
Colonoscopy	
PSA Test	
Flexible Sigmoidoscopy	
Hemoccult Cards	

FEMALES ONLY: When was your last:	Date
Pap smear	
Mammogram	
Breast Exam	
Bone Density Exam	
Colonoscopy	
Flexible Sigmoidoscopy	
Hemoccult Cards	
Age menstrual cycle began:	Frequency of menstrual cycle:
Length of periods:	Date of last menstrual period:

UPMC
LIFE CHANGING MEDICINE

UPMC Washington Physician Offices
HIPAA Communication

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

I give permission to the staff of UPMC Washington Physician Offices to communicate with the following individual(s) regarding my medical care, including my medical condition, test results, appointment dates/times.

Name	**Relationship**	**Telephone Number**

I give permission for WHS Physician Offices to contact me in the following methods:

❑ **Phone:** Phone messages may include reminder phone calls for important health services and appointment reminders. Please check the preferred number for staff to contact.

❑ **Home #:** _____

❑ **Cell #:** _____

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❑ **Text Messaging**: Text messages may include reminders for important health services and appointment reminders.

❑ **Patient Portal**: Secure online communication where you can send and receive messages to your providers and office staff. You will receive an email reminder for upcoming appointments and notification when UPMC Washington Physician Offices test results and other information is available. You can retrieve messages by logging on to the secure portal or by using the HEALOW app.

eMail address: _____

I understand that it is my responsibility to notify the UPMC Washington Physician Office where I am receiving care if any of the above information changes.

Signature: _____ Date/Time: _____
(Patient or Authorized Signature/Relationship)

Patient unable to sign due to:
❑ Mental Incompetency ❑ Physical Inability ❑ Minor Under 18 ❑ Other:_____

UPMC

WASHINGTON PHYSICIANS GROUP

Cancellation and No-Show Appointment Policy

Our physician practices firmly believe that the foundation of a good relationship between our patients and providers is good communication. We understand that situations arise in which you must cancel your appointment. It is requested that if you need to cancel your appointment please provide us at least 24-48 hours' notice when possible. This will enable other patients who are waiting for an appointment to be scheduled in that appointment slot, which is not always feasible if less than 24 hours' notice is given.

When you do not cancel and do not arrive (**or no show**) for your appointment it jeopardizes your health.
In order to be respectful of the medical needs of other patients, please be courteous and call promptly if you are unable to keep an appointment. This time will be reallocated to someone who is in need of treatment. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

You will receive a confirmation phone call and/or text message/email reminding you of your appointment 2 days in advance of your scheduled appointment. If you cannot keep this appointment please call and cancel and you can reschedule at that time.

Consequence of cancellations and no shows

If you miss more than 4 appointments from any Washington Physician Practice within a year you may be dismissed from the practice.

Patient dismissal is at the discretion of your medical provider

If you are dismissed from any Washington Physician Practice office ** your remaining scheduled appointments will be cancelled and emergency care will be provided to you for 60 days.

You may reapply after 6 months after your dismissal to be considered to be cared for by your provider again. Repeated offenses will not be eligible for consideration.

I have read and understand the Washington Health System, Washington Physicians Group Cancellation/No Show Policy.

Patient Name	Patient Date of Birth	Date/ Time

Guarantor Signature	Date/ Time

** Family Medicine - North Main / Family Medicine – Waynesburg / Family Medicine – California / Lakeside Primary Care / Internal Medicine / Infectious Disease Washington Pediatrics / Behavioral Health /Cardiovascular Care / Orthopedics and Sports Medicine / Pulmonology / Thoracic Surgery / Cardiothoracic Surgery / General Surgery / Urology

REVISED 12/20/18; 10/14/2025

Physician Practice
Records Management
10 Leet Street
Washington, PA 15301

UPMC | WASHINGTON

Phone: (724) 229-2657
Fax: (724) 579-1596

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization must be signed by the patient. If the patient is under 18 years of age, legally incompetent, or physically unable to sign, the parent or legal guardian must provide authorization.

Patient Name:_____ Date of Birth:_____
Address:_____ Soc. Sec. Number:_____
City:_____ Phone Number:_____
State:_____ Zip:_____ Email:_____

I HERE BY AUTHORIZE WASHINGTON HEALTH SYSTEM TO:

Obtain Records From:		**Release Records To:**	
Name:		**Name:**	**WHS Family Medicine North Main**
Address:		**Address:**	**190 North Main Street Floor 2, Suite 204 Washington, PA 15301**
Phone:		**Phone:**	**724-225-9970 Fax: 724-223-4253**

INFORMATION TO BE RELEASED/OBTAINED:

ONLY NEED to include last 1 yr. (from the date of this request) of medical records listed below.

☐ Problem List ☐ Consultation Reports ☐ Lab Data ☐ Hospital Discharge – excludes WHS facilities
☐ Medication List ☐ Immunization Record ☐ Cardiology Data ☐ **Last Mammogram, Pap, Colonoscopy Result**
☐ Allergy List ☐ Radiology Data ☐ Progress Notes ☐ Other:_____

This information will be used for the following purpose:

☐ Continuing Care/Medical Facility ☐ Legal ☐ Personal Use ☐ Insurance ☐ Other_____

HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

DO NOT RELEASE: _____ ☐ Drug/Alcohol ☐ HIV/AIDS ☐ Mental Health

This authorization automatically expires 6 months from the date of the patient's or personal representative's signature.

- I understand that there may be information in my health record information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I may revoke this authorization at any time by submitting a *written* notice of revocation to the records department to the WHS Physician Practices Records Management office. I understand that notice cannot be revoked if records have already been released.
- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I may refuse to sign this authorization. My refusal will not affect my treatment or payment for my care. The WHS Physician Practices Records Management department may receive compensation for the use or disclosure of this information.
- In the case of a minor child: I certify that no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.
- In the case of a deceased patient: I, the undersigned next of kin, certify that I assumed responsibility for the disposition of the body of the deceased. There has been no probate of the decedent's Estate and there is no intent to enter the Estates into probate.

_____ _____
Patient or Personal Representative Signature Date / Time

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient (if applicable)

UPMC | WASHINGTON

WASHINGTON HEALTH SYSTEM (WHS) AUTHORIZATION AND CONSENT TO TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

I, _____
(Patient Name)

(or _____acting on behalf of _____),
(Name of Authorized Representative/Relationship) (Patient Name)
consent to the following:

CONSENT TO TREATMENT

- **I consent** to the rendering of medical care, which may include routine diagnostic procedures and such medical treatment as the named attending physician(s), or others of the Washington Health System's Medical Staff consider to be necessary.
- **I understand** that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as a result of the examination or treatment at Washington Health System (WHS).
- **I understand** that absent emergency or extraordinary circumstances, no substantial procedures will be performed unless I have had an opportunity to discuss them with the physician or health care professional to my satisfaction. Special consent forms may need to be signed for specific procedures. I have the right to consent, or refuse to consent, to any proposed procedures or therapeutic course. I will not be involved in any research or experimental procedure without my knowledge or consent.
- **I understand** that many of the physicians on the staff of the WHS are not employees or agents of the WHS, but rather are independent contractors who have been granted the privilege of using its facilities for the care and treatment of their patients. Further, I realize that among those who attend patients at WHS are medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care as a necessary part of their education.
- **I consent and willingly authorize** the taking of photographs and/or audio-visual recordings for the express purposes of medical treatment, planning and assessment unless I request otherwise. I understand that except for purposes of treatment, planning and assessment or unless otherwise required by law, such photographs and/or audio-visual recordings will not be released without specific authorization by me or my personal representative.
- **I authorize** WHS, and its designees, which include its Physician Groups or The Washington Physician Hospital Organization, permission to use my information as described in Washington Health System Notice of Privacy Practices. This includes information that might be related to drug or alcohol or psychiatric conditions and/or sexually transmitted diseases including HIV testing and other AIDS related testing information.

PERSONAL PROPERTY

- **I understand** WHS is not responsible for and does not insure for the loss of my personal property, including money, dentures, glasses, hearing aids, electronic devices, or any other items I wish to keep with me while I am a patient. I understand that I take full responsibility for the safeguarding of any such articles in my possession.

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY INSURANCE BENEFITS

- **I authorize** WHS to bill my insurance carrier and request such payments to be made directly to WHS. I certify that the information I have given about my insurance coverage or other payment sources is correct.
- **I assign** to WHS all rights to insurance payments or benefits to which I may be entitled for services provided to me by WHS. I authorize WHS to act on my behalf as my representative to request reconsideration (internal and/or external review process) by my managed care plan or utilization review entity for coverage or grievance review.
- **I authorize** WHS to release any medical or other information about WHS services, or services provided by third parties, if required to obtain payment from my insurer or other payor and their agents to process payments. I also authorize WHS to release any medical or other information required by my insurer, other payors and their agents. I also authorize WHS to release medical or other information required by my insurer, other payors and their agents, government agencies or their designees for review of the care provided to me.

Name: _____

Date of Birth: _____

- **I assign** all rights to benefits, insurance proceeds or other payments or judgments to which I may be entitled for hospital-based physician services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services to the physician or organization providing the service. I also authorize submission of a claim for payment on my behalf to my insurance carrier.
- **I understand** that any amounts not paid by my insurance are my responsibility. I am responsible for being knowledgeable of my benefit plan and the co-pays and deductibles that I will be required to pay.
- **I understand** if I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payor (insurance carrier) regarding those services, I understand that a separate financial agreement will be put into place regarding the self-pay services and this section will not apply to such services.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENT

- **I certify** that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

MEDICAL ASSISTANCE CERTIFICATION STATEMENT

- **I certify** that the information shown on this invoice is true, correct, and accurate. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of material facts, may be prosecuted under applicable federal and state laws.

CONSENT TO PROPER VENUE

- **I agree** that any controversy, dispute, claim or lawsuit for damages arising out of or relating to my care and treatment by any provider or entity of Washington Health System shall be litigated in the county where my care and treatment occurred.

ACKNOWLEDGEMENT OF INFORMATION ON PATIENT RIGHTS

- **I have had the opportunity to review/receive a** copy of "Patient Rights at Washington Health System."

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

- **I have had the opportunity to review/receive a** copy of the "Notice of Privacy Practices at Washington Health System."
- **I consent** to Washington Health System providing medical or other information related to my treatment and/or services to my primary care/family physician(s) and other healthcare providers as necessary for referral, consultation, treatment and /or the provision of other treatment-related healthcare services to me.
- **I understand** this information may be maintained on electronic information systems or stored in various other forms, including regional, state and national Health Information Exchange (HIE), and that I can elect to opt out of HIE upon request.
- **I understand** I may be contacted by Washington Health System (WHS) by cellular phone, which may include the use of pre-recorded/artificial voice messages, and /or automated dialing device or by text messages or email in connection with any communication made to me or related to my accounts.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reasons I am entitled under Pennsylvania law to consent to treatment for myself, and if applicable, for my minor children without the consent of any other person.

☐ Marriage ☐ High School Graduate ☐ Pregnancy condition to be treated
☐ Mental health illness (14 yrs-18 yrs of age) ☐ Substance abuse ☐ Sexually transmitted diseases

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I have read this Authorization/Consent for TPO form or have had it read to me, and it has been explained to me. I am satisfied that I fully understand its content and significance.

Signature: _____ Date: _____ Time: _____

This patient is unable to consent due to:
☐ Mental Incompetency ☐ Physical Inability ☐ A minor under 18 years of age ☐ Other:_____

Authorized Signature/Relationship: _____ Date: _____ Time: _____