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

UPMC - CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO) IN PENNSYLVANIA

Imprint Patient Identification Here

I. CONSENT TO TREATMENT

This consent cannot be modified. Any hand written changes to the form shall not be legally binding or enforceable.

1. I, _____ (print or type name) on behalf of _____ (patient name and relationship) give my permission to be treated. This may include examinations, tests and procedures, medical treatment, mental health, and drug/alcohol abuse treatment. This may include admission to UPMC hospitals, and other health care facilities under the care of a doctor and/or care provider (all "affiliates"), which they or their authorized agent (someone who has the power to act on their behalf), may think is necessary or the best course of action. I understand specific consent forms may need to be signed for specific procedures. If I have a religious objection to specific care to be provided, I may ask UPMC not to provide that care.
2. I understand and agree that my care may include taking photographs/video and making sound recordings that may be used for my care and/or by UPMC for education, as well as, health care operations purposes.
3. I understand and agree that others, under the direction of a doctor and/or care provider, may help with or take part in giving hospital and/or medical care to me at UPMC teaching facilities. These may include but are not limited to doctors and/or care providers in training (residents and fellows), and medical/nursing students.
4. If it applies to me, I give UPMC permission to properly dispose of any specimens/tissue (such as blood samples, PAP smears, skin tags, etc.) taken from my body. Once disposed of, these specimens/tissue cannot be recovered. I understand and agree that UPMC and those it chooses can use these specimens/tissue for educational purposes. I understand that state and federal laws let UPMC use my specimens/tissue for research without my permission as long as my identity cannot be linked to the specimens/tissue. If my identity is/can be linked to the specimens/tissue, I will be asked to give permission first.
5. I understand that no guarantees have been made about the outcome or results of any examination or treatment.
6. I understand and agree that UPMC may provide care or services to me through video, called "telehealth". Telehealth may include sending videos, sound recordings, images, pictures, and other types of information in real time, or it may be stored and forwarded through an application, or "web or mobile app". The telehealth provider will decide whether the condition being diagnosed or treated can be properly managed through telehealth. I understand that a separate consent may be required to provide mental health and drug and alcohol abuse treatment "telehealth" services.
7. When a doctor and/or care provider orders home health, hospice, or additional services they will be directed to a UPMC provider unless you ask us not to or if it is required by your insurance. UPMC honors patient choice for your providers of health care.

II. MEDICARE CERTIFICATION (IF APPLICABLE)

I confirm that the information gave when applying for payment under Title XIX of the Social Security Act is correct. I give permission to those who have medical or other necessary information about me to share it with the Centers for Medicare and Medicaid Services or its agents or carriers, as needed for this or any related Medicare claims. I ask that approved benefit payments to be made for me. I give permission to transfer the payments for doctors and/or care providers to them or their organization providing the services or give them permission to submit a claim to Medicare for payment for me. I confirm that I received an important message from MEDICARE/MEDICARE HMO/TRICARE (formerly known as CHAMPUS/CHAMPVA) and does not give up any of my rights to ask for a review.

III. MEDICAID CERTIFICATION (IF APPLICABLE)

I confirm that the information given in this consent is true, complete, and correct. I understand that federal and state funds will be used to pay for and settle this claim and that federal and state laws can be used to punish any false claims, statements, documents, or hiding of important facts.

IV. RECEIPT OF NOTICE OF PRIVACY PRACTICE/RELEASE OF INFORMATION

1. I have received the UPMC Notice of Privacy Practices, either now or in the past.
2. I understand and agree that UPMC and the people it identifies can use my information as described in the UPMC Notice of Privacy Practices.
3. UPMC can store information about me and my care in different ways, including on computer systems, electronic media, paper, etc. This information may include sensitive information such as HIV information, mental health information and drug and alcohol abuse treatment information.
4. To the extent allowed under state and federal law, UPMC hospitals, staff, doctors and/or care providers, and other facilities and programs may access and share my medical and other information as is necessary for UPMC to provide treatment to me, seek payment for services it provides, or for UPMC's own health care-related operations.
5. I understand and agree that UPMC may release my information, including but not limited to, automated notifications of encounters, to my primary care/family doctor(s) and other providers as is necessary for treatment, consultation referral and/or other treatment related health care services to me. However, to follow certain federal and state laws, I may be required to sign a separate consent in order for UPMC to release certain types of sensitive information – including HIV information, mental health information and drug and alcohol abuse treatment information. I also give permission for UPMC to release patient and educational information to my home caregiver.
6. I understand and agree that UPMC may contact me using the contact information I have provided, including by phone (including cell phone), text message, and email to communicate with me about my care, scheduled services, and financial accounts. This may include pre-recorded messages.

7. I understand that UPMC is a research institution and may contact me with opportunities to participate in research studies in accordance with applicable laws. If I do not wish to be contacted about research opportunities, I can opt out by calling 412-624-1030 .
8. I understand and agree that my information may be released if required by local, state, or federal law.

V. FINANCIAL ARRANGEMENTS

I agree to the following terms related to payment for services provided by UPMC and affiliates:

1. I give UPMC permission to bill my insurance company, and I ask for those payments to be made to UPMC. I verify that the information I have given about my insurance or other payment sources is correct.
2. I give UPMC the right to insurance payments or benefits that I may be owed for services that UPMC has provided. I give UPMC permission to represent me and ask my managed care plan for an internal and/or external review process or an appeal of my coverage.
3. I give UPMC permission to release any medical or other information required by third parties, my insurer, other payers, and their agents for payment related purposes. I also give UPMC permission to release medical or other information required by third parties, my insurer, other payers and their agents, government agencies or their chosen representatives for review of the care provided to me.
4. I give UPMC the rights to benefits, insurance proceeds or other payments or judgments that I may be entitled to for hospital-based doctor and/or care provider services (pathology, radiology, neurology, cardiology, anesthesiology, etc.) and/or emergency room services, and/or rehabilitation services to the doctor and/or care provider or organization providing the service. I also give permission to submit a claim for payment on my behalf to my insurance carrier.
5. I understand and agree that any hospital and doctor and/or care provider charges not paid by my insurance are my responsibility. I understand and agree that final billing will be made once all charges have been included, minus any payments actually received, and/or allowed adjustments from insurers contracted with UPMC. I understand that it is my responsibility to pay UPMC all charges so incurred in line with UPMC's standard charges as set forth in UPMC's Charge Description Master (CDM). For more information about UPMC's Charge Description Master, please go to https://www.upmc.com/patients-visitors/paying-bill/services.
6. If I choose to pay for certain services out of pocket and exercise my right to limit sharing of the information to my payer about those services, I understand that a separate financial agreement will be put into place about the self-pay services and this section will not apply to those services.
7. If I apply for Medical Assistance/Financial Assistance (or one is made on my behalf), UPMC is allowed to provide information as is necessary to determine if I am eligible.

VI. PATIENT VALUABLES

I release UPMC from any responsibility for any loss, damage, or theft of my personal property, including clothing, cash, jewelry, dentures, glasses, or other valuables that I choose to keep with me while I am a patient. I agree UPMC will not be responsible for replacing any lost, damaged, or stolen, items that I choose to keep with me, or anything that is brought to me while I am a patient.

VII. AGREEMENT THAT ANY LEGAL ACTION WILL BE FILED IN A COUNTY IN WHICH CARE IS PROVIDED

I understand and agree that any lawsuit or legal action which is in any way related to the medical care I receive must be filed in the County where the care at issue is provided.

VIII. MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s) _____,
I am allowed under Pennsylvania Law to consent to medical, dental or other health services for myself, and if applicable, for my minor children without the consent of any other person. _____ **Patient Initials (required if completing this section)**

I have read this Authorization/Consent for Treatment, Payment and Health Care Operations (TPO) form or have had it read to me, and it has been explained to my satisfaction. I understand pursuant to this TPO form, the component of my consent relating specifically to treatment may be valid for up to one (1) year from the date that I sign it and applies to all UPMC facilities (such as physician practices, hospitals, clinics, etc.) All other promises set forth in this agreement remain enforceable upon the expiration of the consent for treatment.

Patient Signature (Witness is required for verbal consent)	Date	Time	Signature of UPMC Representative/Witness
Signature/Identify on behalf of patient/relationship Name	Date	Time	