Montgomery County Medical Associates, Ltd.

Internal Medicine

1650 Huntingdon Pike, Ste.159
Meadowbrook, PA 19046
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JOHN M.BUTLER,M.D.
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DOMINICK A.GALLUZZO,M.D.
MELISSA A.JOHN,M.D.
DAVID L.LITT,M.D.

TIN #23-2076126 NPI #1871530618

Dear _____,

Welcome to our practice. Thank you for choosing us for your health care needs. Please complete the entire enclosed packet and **bring it to your appointment. Please do not mail it back to us.**

Your first visit will take approximately 1/2 to 1 hour. During that time an EKG and lab studies may also be ordered. If you have specific questions for your Dr., you may want to list them in the "Ask the Doctor" section.

Payment for your visit will depend on your insurance plan. Be sure to bring all insurance cards. You will be expected to pay your insurance copay at the time of your visit, or full payment if your insurance does not cover office visits or testing.

If you have coverage under an HMO plan or your insurance requires you to pick a primary care physician (PCP), you must make sure Montgomery County Medical Associates is listed on your card. Our NPI # is listed above. This must be done *PRIOR* to your visit to assure that you have coverage with our practice or you will be responsible for the cost of your visit and testing if seen. If you have not chosen Montgomery County Medical Associates prior to your visit, you will be asked to reschedule.

Our new patients are allotted an extended amount of time so that our Doctors and Nurse Practitioners can address all your questions and concerns during your physical. Therefore, cancellations must be made **24 hours** prior to your visit or you will be charged accordingly. Cancellation notice allows us ample time to schedule other patients needing an appointment.

We look forward to meeting you. If you have any questions, please do not hesitate to call our staff.

Thank you.

Dr._____/N.P._____ will see you at:

Location _____

Date _____ Time _____

MONTGOMERY COUNTY MEDICAL ASSOCIATES, LTD

PATIENT PROFILE UPDATE

PLEASE PRINT CLEARLY

LAST NAME ______________________ FIRST NAME ____________________ MIDDLE INITIAL ______

DATE OF BIRTH ______________ SOCIAL SECURITY #____________________

ADDRESS______________________________

______________________________ EMAIL ADDRESS:____________________

____

TELEPHOHE HOME:____________________ WORK:________________

CELL: ____________________

EMERGENCY CONTACT NAME______________________ PHONE#______________ RELATIONSHIP__________

RACE __ American Indian/Alaska Native __Asian __ Pacific Islander __Black/African American __White __Hispanic __Other

ETHNICITY __Hispanic or Latino __Not Hispanic or Latino __Refuse to report

LANGUAGE __ English __ Indian (includes Hindi & Tamil) __ Other __Russian __Spanish

- -

1. PHARMACY NAME __________________ PHARMACY LOCATION ____________________________

PHARMACY PHONE #______________ FAX # (IF KNOWN) ______________ ☐ MAIL ORDER

2. PHARMACY NAME __________________ PHARMACY LOCATION ____________________________

PHARMACY PHONE #______________ FAX # (IF KNOWN) ______________ ☐ MAIL ORDER

- -

INSURANCE NAME:____________________ NAME OF CARDHOLDER____________________D.O.B________
PRIMARY RELATIONSHIP______________

INSURANCE NAME:____________________ NAME OF CARDHOLDER____________________D.O.B________
SECONDARY RELATIONSHIP______________

FINANCIALLY RESPONSIBLE PERSON NAME:______________________ D.O.B.__________ RELATIONSHIP________

☐ CHECK BOX IF SAME AS ABOVE ADDRESS:________________________ PHONE #________________

____

- -

PATIENT OR AUTHORIZED PERSON SIGNATURE________________________ DATE:______________

Montgomery County Medical Associates

Adult Medical History Form

Today's Date: _____

Name (Last, First, MI):	**Date of Birth :**

Personal Medical History: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

- □ Eye/Vision Problems
- □ High Blood Pressure
- □ Depression or Anxiety
- □ Diabetes
- □ High Cholesterol
- □ Anemia
- □ Cancer Type_____ Date_____
- □ Hearing Loss
- □ Migraine Headaches
- □ Heart Problems
    - □ Valvular (mitral/aortic)
    - □ Rhythm (a-fib)
    - □ Blockage (heart attack)
- □ Lung Problems (asthma, COPD):_____
- □ Stroke
- □ Thyroid Problems
- □ Gastrointestinal problems(ex. Acid Reflux, Constipation, IBS)
- □ Urinary incontinence
- □ Other: _____

Surgical History: (please list all prior operations and dates)

Hospitalization History: (please list all prior hospitalizations and dates)

Health Maintenance: (please list dates of prior health screenings if you have completed and where you completed if applicable)

Mammogram Date _____ Where _____
Pap Smear Date_____ Where _____
Colonoscopy Date _____ Where _____
Prostate Exam Date_____ Where _____

Other Providers : (Please list all prior providers or specialists you have seen and continue to follow with. **Include their phone numbers and fax numbers if possible**)

_____ _____
_____ _____
_____ _____
_____ _____

Family History

Relative	Year of Birth or Age	Please Circle if Alive or Deceased	Age of Death	Medical Problems
Father		Living / Deceased		
Mother		Living / Deceased		
Brother/Sister		Living / Deceased		
Brother/Sister		Living / Deceased		
Brother/Sister		Living / Deceased		
Brother/Sister		Living / Deceased		
Child		Living / Deceased		
Child		Living / Deceased		

Women's Gynecologic History:

# of Pregnancies: ____# of Deliveries:___# of abortions:____# of miscarriages:____
Age at 1st period: _____ Date of Last Menstrual Period_____
Frequency of periods:_____ Length of Menstrual Period : _____

Social History

Occupation:	
Marital Status (please circle) Married / Single/ Divorced / Widow	Number of Children:
Alcohol: □ Never □ Occasional □ Daily □ Prior Use □ Quit Date _____ □ Amount per week: _____	History of drug abuse: □ Yes □ No Name of Drug if applicable _____ Recreational drug use □ Never □ Occasional □ Daily □Prior Use Name of Drug if applicable _____
Tobacco: □ Current - Type: _____ Freq: _____ □ 2nd Hand □ Never □ Prior Use □ Quit Date _____	Caffeine Intake □ Never □ Occasional □ Daily Exercise □ Never □ Occasional □ Daily

Immunizations: Please list your most recent immunizations and date received (your best estimate of the month/year it was given)

- □ Pneumonia Vaccines
  - □ Prevnar 20
  - □ Pneumovax 23
  - □ Prevnar 13
- □ Hepatitis B
- □ Hepatitis A
- □ Tetanus/Diphtheria/Pertussis (Tdap) or Td
- □ Varicella (Chicken Pox)
- □ Shingles
  - □ Zostavax (1 shot)
  - □ Shingrix (2 shots)
- □ COVID 19
- □ Measles/Mumps/Rubella (MMR)
- □ Gardasil (HPV)
- □ Meningitis

Allergies or Reactions to Medicines/Foods/Other Agents: □ Check if no allergies

Medications : Please include Prescription, non-prescription medicines, vitamins, home remedies, birth control pills, herbs. Attach additional sheet if necessary

Name	Dose	How Many Times per day

Additional Medications :		
Name	Dose	How Many Times per day

Any Questions or Concerns for Provider:

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CONSENT FOR PURPOSE OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS
HIPPA COMPLIANCE

I consent for the use or disclosure of my protected health information by Montgomery County Medical Associates, Inc.(further known as MCMA) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of MCMA. I understand that diagnosis or treatment by Drs. Dominick Galluzzo, David Litt, John Butler, Melissa John and Nurse Practitioners Barbara Holdren, Heidi Gibbons and Julianne Rutz (further known as providers) may be condition upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. MCMA. is not required to agree to the restrictions that I may request. However, if Montgomery County Medical Associates, Ltd. agrees to a restriction that I request, the restriction is binding on MCMA and its providers.

I have the right to revoke this consent, in writing, at any time, except to the extent that said provider and MCMA has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my provider, another health care provider, a health plan or future physical or my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review MCMA's Notice of Privacy Practices prior to signing this document. MCMA's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of MCMA. The Notice of Privacy Practices for MCMA is also on the wall in the reception area. The Notice of Privacy Practices also describes my rights and MCMA's duties with respect to my protected health information.

MCMA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next visit.

Name of Patient _____
(Please Print)

Signature of Patient _____

OR

Signature of Responsible Authority _____ **Relationship** _____

Date _____

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PATIENT FINANCIAL RESPONSIBILITY

I FULLY UNDERSTAND THAT I AM RESPONSIBLE TO PROVIDE ACCURATE AND COMPLETE INSURANCE INFORMATION TO THIS OFFICE AS APPLIES. I ALSO UNDERSTAND THAT IF MY INSURANCE REQUIRES ME TO PAY A COPAY UNDER MY CONTRACT, IT IS TO BE PAID AT THE TIME SERVICES ARE PROVIDED.

I ALSO UNDERSTAND THAT ANY AND ALL SERVICES PROVIDED THAT ARE NOT COVERED BY AN INSURANCE PLAN, IS MY RESPONSIBILITY, AND PROMPT PAYMENT IS TO BE MADE TO THIS OFFICE. IF PAYMENT IS NOT MADE WITHIN 30 DAYS, MY ACCOUNT WILL BE HANDED OVER TO A COLLECTION AGENCY.

Name of Patient _____
(Please Print)

Signature of Patient _____

OR

Signature of Responsible Authority _____ **Relationship** _____

Date _____

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CONSENT TO RELEASE MEDICAL INFORMATION

I _____ HEREBY GRANT MONTGOMERY COUNTY

MEDICAL ASSOCIATES TO DISCUSS ANY / ALL MEDICAL INFORMATION TO

_____RELATIONSHIP_____

VIA TELEPHONE, MAIL OR OFFICE VISIT, ON MY BEHALF.

OR

☐ CHECK BOX IF MEDICAL INFORMATION IS NOT TO BE RELEASED.

Name of Patient _____
(Please Print)

Signature of Patient _____DATE_____

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PRESCRIPTION CONSENT FORM

ePrescribing

By signing this consent form you are agreeing that Montgomery County Medical Associates, Ltd. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent Montgomery County Medical Associates, Ltd. to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Name of Patient _____
(Please Print)

Signature of Patient _____ **DATE** _____

OR

Signature of Responsible Party _____

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MEDICAL RECORDS RELEASE AUTHORIZATION

(PLEASE PRINT)

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip Code:_____

I authorize the release of my medical records from _____to:

DR / NP _____at
Montgomery County Medical Assoc., Ltd.
1650 Huntingdon Pike, Suite 156
Meadowbrook, PA 19046
215-947-7924 (f) 215-947-0187

for the purpose of medical care: Dates of service _____.

Description of records requested: _____.

☐ Exception: I do not give permission to release (please specify any exception of records):

_____

ATTENTION PATIENT

I understand and authorize the release of this information unless noted above as an exception. I also understand that my records may contain: AIDS / HIV related information if ordered by my physician
Mental health information
Drug or alcohol information and test results

I also understand that the provider may not hinder treatment, payment, reenrollment or eligibility for benefits on whether I sign this authorization.

- I acknowledge that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient in accordance with laws and regulations.
- I understand that this consent may be revoked by me at any time by submitting a written revocation notice.
- I understand that my authorization will remain effective for a period of 90 days from date of my request.

Signature of Authorized Person: _____ Date:_____

Relationship to patient if other: _____