Patient Annual Update Packet

Mark Akers M.D., Inc. | 81 Ashwood Drive, Tiffin, OH 44883 | Ph (419) 447-8444 | Fax (419) 447-8446

Personal Information

Patient name | Date of birth | Age

Address

City, State, ZIP | SS#

Home phone | Cell phone | Email

Preferred contact: ☐ Home ☐ Cell | Marital status

Employer | Employer phone

Emergency contact | Phone | Relation

Pharmacy

Race / ethnicity (check all that apply)

☐ White ☐ Black ☐ Asian

☐ American Indian ☐ Native / Pacific Islander ☐ Latino

☐ Other

If other, specify:

Insurance Information

Please have insurance card(s) available to be copied into your medical record. Specify primary and secondary when more than one plan is present.

Primary insurance | ID #

Secondary insurance | ID #

Assignment of Insurance Benefits

I hereby authorize direct payment of Medical Benefits to Mark Akers M.D. for services rendered by him in person or under his supervision. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all necessary information to obtain payment. I request that payment of authorized benefits be made on my behalf to Mark Akers M.D., and authorize submission of a claim to Medicare or my private insurance on my behalf.

☐ I understand that all co-payments are due at the time of service.

☐ I understand that I am financially responsible for all charges not covered under my insurance plan.

☐ I understand that all balances for office services are due in full 30 days following receipt of insurance payment (including office visit fees, lab fees, imaging fees, and procedure fees).

If the patient is under age 18, a parent/guardian signature is required for financial responsibility and consent for treatment. By signing below, I certify that the information provided is accurate to the best of my knowledge.

Patient name (print) | Parent/guardian name (print)

Signature | Date

Type in the shaded boxes, then print or save.

Wellness / Preventive Care Notice

Mark Akers M.D., Inc. | 81 Ashwood Drive, Tiffin, OH 44883 | Ph (419) 447-8444 | Fax (419) 447-8446

The office of Mark Akers MD, Inc. considers your healthcare our top priority. Your participation is critical for us to assure the best possible medical care for you. This office participates with meaningful use regulations in regards to your health as directed by your insurance and Medicare. These regulations require us, as your PCP, to follow through with your wellness requirements. Some examples of these required regulations are mammograms, colonoscopy, immunizations, routine bloodwork, and other tests that are important to your well-being.

Non-compliance with certain wellness examinations and tests could result in higher insurance costs and lower reimbursement for the office. Wellness examinations and tests are designed for your well-being and to help detect and deter many life-threatening illnesses.

Signature

Date

This area intentionally left blank.

Type in the shaded boxes, then print or save.

HIPAA Authorization Form

Mark Akers M.D., Inc. | 81 Ashwood Drive, Tiffin, OH 44883 | Ph (419) 447-8444 | Fax (419) 447-8446

I, _____ , give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s) _____ Relationship & phone _____

Health information to be disclosed (check all that apply)

- ☐ My complete health record (diagnosis, lab tests, prognosis, treatment, and billing for all conditions)
- ☐ My complete health records, as above, with exception of the following:
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other: _____

This health information may be used to enable the persons I authorize to know and understand my condition and treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- ☐ All past, present, and future periods
- ☐ Date or event: _____ unless I revoke it.

NOTE: You may revoke this authorization in writing at any time by notifying your health care providers. Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies.

Printed name _____ Authorized signature _____ Date _____

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Type in the shaded boxes, then print or save.

Authorization to Leave Results by Voicemail

Mark Akers M.D., Inc. | 81 Ashwood Drive, Tiffin, OH 44883 | Ph (419) 447-8444 | Fax (419) 447-8446

Patient name | Date of birth

It is policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, "by phone or other means designated by you to provide results from exams, tests and to provide information that describes or recommends alternatives regarding your care. This practice requires the following authorization for release of protected health information (PHI) via alternative means other than direct contact with the patient themselves."

I authorize the practice to disclose or provide PHI to me by leaving a voicemail on my home or cell phone number that is provided by myself if I am not available to answer the call at the time the call is received. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

Phone number | Cell phone number

Signature | Date

This area intentionally left blank.

Type in the shaded boxes, then print or save.

Appointment Reminder Consent

Mark Akers M.D., Inc. | 81 Ashwood Drive, Tiffin, OH 44883 | Ph (419) 447-8444 | Fax (419) 447-8446

I authorize Mark Akers M.D., Inc. and/or any entity authorized by Mark Akers M.D., Inc., including those using automated dialing systems, to communicate with me for appointment reminders by calling any telephone number I have provided, including live, pre-recorded, or text messages. Cellular provider fees may apply.

☐ I consent. Initials:

☐ I do not consent. Initials:

Patient name

Date

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Type in the shaded boxes, then print or save.

Medications, Allergies & Specialists

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Prescription medications

Drug	Dose	How often

Birth control: ☐ Yes ☐ No Name

Allergies

Drug / product	Reaction

Over-the-counter / herbal

Aspirin: ☐ Yes ☐ No Dose Other OTC / herbal

Specialists and other physicians

Name Specialty Phone

Last seen

Name Specialty Phone

Last seen

Name Specialty Phone

Last seen

Name Specialty Phone

Last seen

Other information your physician should know

Weight Height

Type in the shaded boxes, then print or save.

Past Medical, Surgical, Family & Social History

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Patient name _____ Date of birth _____

Past medical history — check any that apply

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH / enlarged prostate
- ☐ Cancer
- ☐ COPD / emphysema
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD / reflux
- ☐ Gout
- ☐ Heart attack
- ☐ High cholesterol
- ☐ Hypertension
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraine
- ☐ Osteoporosis
- ☐ Seizure disorder
- ☐ Sleep apnea
- ☐ Stroke / TIA
- ☐ Ulcer

Other / cancer type _____

Surgical history (procedure and year)

Family history — check if a blood relative has had:

- ☐ Heart disease
- ☐ Stroke
- ☐ Diabetes
- ☐ Hypertension
- ☐ High cholesterol
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ Prostate cancer
- ☐ Lung cancer
- ☐ Emphysema
- ☐ Other
- ☐ Adopted / unknown

Social history

	Yes	No	Age started	Age quit / notes
Tobacco	☐	☐		
Alcohol	☐	☐		
Illegal drugs	☐	☐		
Sexually active	☐	☐		

Women's history

pregnancies _____ # births _____ Miscarriage / abortion _____

Age at first period _____ Last period _____ Birth control Y/N _____

Last PAP _____ Abnormal? ☐ Yes ☐ No Last mammogram _____

Mammogram abnormal? ☐ Yes ☐ No

Type in the shaded boxes, then print or save.

Request to Send Records to This Office

Mark Akers M.D., Inc. | 81 Ashwood Drive, Tiffin, OH 44883 | Ph (419) 447-8444 | Fax (419) 447-8446

To (office / hospital) _____ Fax _____

Date _____

This is a request to have my medical records faxed or sent to Dr. Mark Akers MD, Inc.

Name (print) _____ Date of birth _____

Signature _____ Witness _____

Send records to

Dr. Mark Akers, MD, Inc.
81 Ashwood Dr.
Tiffin, OH 44883
Fax: 419-447-8446
Phone: 419-447-8444

Disclosure notice

The recipient of this patient information is prohibited from disclosing the information to any other party and is required to destroy the information after the stated need has been fulfilled.

Confidentiality notice

The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, any disclosure, copying, or distribution is strictly prohibited. If you received this in error, notify the sender immediately and arrange for return or destruction of these documents.

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Type in the shaded boxes, then print or save.