Davenshire Medical Center

ADULT

3740 Carlisle Road
Dover, PA 17315
Phone: 717-292-3168 Fax: 717-292-3479
www.DavenshireMC.com
Like us on Facebook!

Welcome to Davenshire Medical Center! Thank you for choosing us as your primary care physicians. We are dedicated to providing the best possible care to our patients. Please take a few moments to look over our practice information and policies to help prepare you for your first appointment.

About Our Providers: Dr. Czulada graduated from the Philadelphia College of Osteopathic Medicine in 1987 and has been with our practice since 1989. He has three sons & a daughter. Dr. Baylor graduated from the Philadelphia College of Osteopathic Medicine in 1996 and has been with our practice since 1998. She has two sons and a daughter. Each doctor has completed a family practice residency, are board certified, and are affiliated with York & Memorial Hospital. Amy Potter, CRNP attended school at College of Notre Dame and earned a degree in Nursing. She relocated to Pennsylvania six years ago and attended York College to become a Certified Nurse Practitioner. She has ten years of nursing experience in critical care. She is board certified by the American Academy of Nurse Practitioners. As an Adult-Gerontological Nurse Practitioner, Amy is licensed to provide primary care to patients ages **twelve and up**.

Office hours*:* Our regular office hours are listed below. Please be aware that these hours are subject to change with physician vacations and inclement weather. A physician is available after hours and can be reached by following the recorded instructions you will receive when calling our office. For a true emergency, please do not hesitate to go to the ER.

Monday	8:00am - 7:30pm
Tuesday	7:00am – 7:30pm
Wednesday	8:00am - 7:30pm
Thursday	9:00am - 5:00pm
Friday	8:00am - 4:00pm

PHONE HOURS ARE 8:00am TO APPROX 30 MINS PRIOR TO CLOSING

Scheduling Appointments: When calling to schedule a non-urgent appointment, (ex: check-up, physical, ear wash, or office surgery), please call several weeks in advance so that we may schedule a time that is convenient for you. Please check with your insurance company to verify your possible out of pocket expense PRIOR to scheduling surgeries, physicals, or procedures. For your protection, please be prepared to present your insurance card and a form of photo I.D. (ex. Drivers license, student I.D., etc.) at each office visit. If you have HMO insurance, you will need to contact your insurance company PRIOR to your appointment to make sure we are listed as your primary care physician or "PCP."

Walk-ins: There may be an additional fee charged to your account for walk-in appointments.

No-Show Policy: We understand that there may be times when an emergency or circumstances may arise making it impossible for you to keep your appointment. If you know that you are unable to keep an appointment, please call AS SOON AS POSSIBLE so that we may offer this time to another patient in need. **NEW PATIENTS who miss their first appointment will NOT be allowed to reschedule.** Patients who chronically miss appointments may be charged a fee and/or asked to find another physician.

Cancellation Policy: As of August 1, 2016, it is now our office policy to charge a fee to patients who cancel scheduled appointments with a less than 2 hour notice. If you are scheduled for an upcoming appointment and you cancel this appointment in less than 2 hours prior to the scheduled time, your account will be charged a $25 fee.

Copays: Please be prepared to pay your copay at every office visit. We accept cash, checks, Visa, MasterCard, and Discover. Copays are a contractual obligation between you and your insurance company, and we are required by your insurance company to collect copays at the time of service. Disregarding this obligation may jeopardize your relationship with our office and your insurance company. As of August 1, 2016, if you do not pay your copay on the same date that you are seen, you will be charged an extra $5 fee.

Motor Vehicle Accident/ Workman's Comp: If you are being seen as a result of a Motor Vehicle Accident or Workman's Comp Claim, please notify our front office staff upon arrival of your appointment so that we may obtain the necessary & correct billing information. If you fail to provide this information to us at your first MVA/WC appointment, there will be a $50.00 fee charged to your account to cover the costly retraction and resubmission fees.

Insurance Referrals/ Authorizations: Please check with your insurance company if a referral or prior authorization is required and notify our office as soon as possible. Some insurance companies require up to a week's notice prior to issuing approval. For your convenience, we have a dedicated referral voicemail that you may leave detailed information pertaining to your request.

Prescription Refills: All prescription *renewals* may be done through your pharmacy. For your convenience, we have a dedicated voicemail for prescription requests. All requests will be addressed as quickly as possible, but we kindly ask for 48 hours notice Monday – Thursdays. Requests received on a Friday will be addressed as quickly as possible, but may take until the following Monday to be filled. If you have any questions, please leave a message on the dedicated prescription line.

Request of Medical Records/Form Completion: Please let us know in advance if you require these services. A small fee may apply.

Please feel free to contact our dedicated staff with any additional questions. Thank you for allowing us the opportunity to partner in your care.

We enjoy providing medical care and getting to know our patients!

☆ **Please ask us how to obtain your activation code for our online "Patient Portal".**
Here you can schedule appointments, send messages, and request prescription refills!***

R09202016

Adult Patient Medical History

First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____

Allergies to Medications, X-ray Dyes, or other Substances: ____ No ____ Yes
(If yes, please list name of medication **and type of reaction**)

_____ _____ _____

_____ _____ _____

Past Medical History and Review of Systems:
Please check off if you have any problems with or are presently experiencing any of the following:

____ Abdominal Discomfort
____ ADD
____ ADHD
____ Alcohol Dependency
____ Anemia
____ Anxiety
____ Arthritis
____ Asthma
____ Back Pain
____ Blood Disorders
____ Blood in Stool
____ Bronchitis
____ Cancer
____ Change in bowels
____ Chest pain/tightness
____ Chicken Pox
____ Colitis
____ Constipation
____ Convulsions
____ Depression
____ Diabetes
____ Diarrhea
____ Difficulty Walking
____ Drug Abuse
____ Frequent/ Difficult Urination
____ Gallbladder Disease
____ Gout
____ Growth Problems
____ Hay Fever
____ Headache
____ Heart Disease
____ Hemorrhoids
____ Hepatitis or Jaundice
____ High Blood Pressure
____ Impotence or E.D.
____ Indigestion
____ Kidney Disease
____ Kidney Stones
____ Lightheadedness
____ Nausea
____ Palpitations
____ Persistent Cough
____ Pneumonia
____ Rheumatic Fever
____ Skin Disease
____ Shortness of Breath
____ Swollen Ankles
____ T.B.
____ Thyroid Disease
____ Ulcers
____ Unexplained weight loss/gain
____ Venereal Diseases
____ Vomiting

Others: _____

_____

_____

Pharmacy Choices (in order of preference):

Name of Pharmacy	Location of Pharmacy
_____	_____
_____	_____

Mail Order Pharmacy (if applicable):_____

This information is for use by your physician as part of your confidential medical records.
R010714

Gynecologic & Obstetric History:

Age at onset of periods: _____ Frequency: _____ Length of periods: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or abnormal bleeding ___ No ___ Yes (please describe) _____

Leakage of Urine ___ No ___ Yes (please describe) _____

Pelvic Pain ___ No ___ Yes (please describe) _____

Abnormal Discharge ___ No ___ Yes (please describe) _____

History of abnormal Pap Smear ___ No ___ Yes (please describe) _____

Please list and Supply the dates of the following:

Operations: _____

Hospitalizations other than for surgery: _____

Immunization History- have you had…?

Hepatitis B ___ No ___ Yes Date_____

Pneumovax ___ No ___ Yes Date_____

Flu ___ No ___ Yes Date_____

Tetanus ___ No ___ Yes Date_____

When was your last…?:

Pap Smear _____ Breast Exam _____ Stool check for blood _____

Mammogram _____ Cholesterol Check _____ Prostate Exam _____

Colonoscopy _____

Medications:

(prescription[s], over-the-counter, vitamins, herbs, etc.)

Drug Name & Daily Dose (***ex: Lisinopril 1 tab a day***)	**Drug Name & Daily Dose**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:
(Have any of your family members including parents, grandparents, or siblings ever had the following?)

	Which family members?	Age when diagnosed
Cancer (specify type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Drug/ Alcohol Addiction (specify)	_____	_____
Glaucoma	_____	_____
Bleeding Disease	_____	_____
Mental Disease (specify anxiety, depression, etc.)	_____	_____
Miscarriages	_____	_____
Tuberculosis	_____	_____
Allergy	_____	_____
Seizures	_____	_____
T.B. Contacts	_____	_____
Other	_____	_____

Prevention:

Do you wear a seat belt?	___ No	___ Yes	If no, why? _____
Do you wear a bike helmet?	___ No	___ Yes	___ N/A
Do you exercise regularly?	___ No	___ Yes	If yes, type, duration, & frequency per week? _____
Do you smoke?	___ No	___ Yes	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	___ No	___ Yes	If yes, how many per week? _____
Do you drink coffee?	___ No	___ Yes	If yes, how many cups per day? _____
Do you drink tea?	___ No	___ Yes	If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded & out of children's reach?	___ No	___ Yes	___ N/A
Do you use drugs? (marijuana, cocaine, etc.)	___ No	___ Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	___ No	___ Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	___ No	___ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	___ No	___ Yes	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, etc.)?	___ No	___ Yes	
Do you ever feel afraid of your partner?	___ No	___ Yes	___ N/A
Do you have a Living Will?	___ No	___ Yes	
Do you have an organ donor card?	___ No	___ Yes	
Do you use a method of birth control?	___ No	___ Yes	If yes, explain: _____

Occupation: _____

Adult Registration Form

First Name: _____ **MI:** ____ **Last Name:** _____

Social Security #: _____-_____-_____ **DOB:** ____/____/____ **Age:** ____ **Sex:** ___ M ___ F

Street Address: _____ **City, State, Zip:** _____

Home Phone: (_____) _____-_____ Cell#: (_____) _____-_____

Email: _____

Employer: _____ Work Phone #: (_____) _____-_____

Spouse's Name: _____ DOB: _____/_____/_____ Age: _____

Cell #: (_____) _____-_____ Social Security #: _____-_____-_____

Employer: _____ Work Phone #: (____) _____-_____

Children/Dependents Living at Home:

Name	DOB	Name	DOB
_____	_____	_____	_____
_____	_____	_____	_____

PROVIDER PREFERENCE

____ No Preference ____ Dr. Gary Czulada, DO ____ Dr. Melissa Baylor, DO ____ Amy Potter, CRNP

The following information is required for our electronic medical records system:
Race: _____ Ethnicity: _____ Language: _____

INSURANCE POLICY

(PLEASE BE SURE TO BRING YOUR INSURANCE CARD TO ALL APPOINTMENTS)

Primary Current Insurance Carrier: _____

ID # _____ Group # _____

Secondary Current Insurance Carrier: _____

ID # _____ Group # _____

This information is for use by your physician as part of your confidential medical records.
R09042015

INSURANCE SUBMISSION & PAYMENT AUTHORIZATION

Patient Name: ________________________________ DOB: _____/_____/_____

<u>Who is responsible for Medical Expenses?</u> **Self [ ]** **Parent [ ]** **Other [ ]**

Responsible Party's Name: ____________________________________ DOB: ___________

Social Security #:_______-________-________ Phone #: (_____) ________-___________

Address: ____

<u>Who is the holder of your health insurance?</u> **Self [ ]** **Parent [ ]** **Other [ ]**

Name: ____________________________________ DOB: ___________

Social Security #:_______-________-________ Phone #: (_____) ________-___________

Address: ____

>>>

MEDICARE LIFETIME ASSIGNMENT
(Including Medicare plans under commercial insurances):

I request payment of authorized Medicare benefits be made either to me or on my behalf to Davenshire Medical Center for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration ("HCFA") and its agents any information needed to determine these benefits or the benefits payable for related services.

____ ______/______/______
Patient/Guardian Signature Date

>>

ALL COMMERICAL INSURANCES (Not Medicare) AUTHORIZATION TO PAY BENEFITS TO PRACTICE

I hereby authorize my insurance company to pay benefits directly to Davenshire Medical Center Partnership. I understand that I am financially responsible for changes not covered by this authorization. I authorize my physician to release any medical information to my insurance company or its agents which may be necessary to determine benefits payable for related services.

____ ______/______/______
Patient/Guardian Signature Date

R010714

FINANCIAL POLICY

In an effort to control costs and to make your visit to our office as pleasant as possible, we would like to have just a few moments of your time to look over our financial policy. Please understand that as your health care provider, our relationship is with you, not the insurance company. While our practice is dedicated to providing the best care possible, it is your responsibility to know your insurance policy and to be aware of any non-covered charges.

If you are experiencing financial difficulties, our Billing Staff is here to assist you.

HELPFUL TIPS: ☺

- Present your current insurance card at every office visit.
- Copays must be paid at time of service. A small fee may apply if not paid in 48 hours.
- PCP assignment: contact your insurance company PRIOR to your appointment to assign us as your primary care physician (PCP) to avoid charges becoming your financial responsibility.
- Verify if services are covered by your insurance company PRIOR to scheduling.
- While physicals, well exams, & pap smears are usually a covered service, discussion of any other problems during these preventative visits is a separate charge and may be considered your financial responsibility by your insurance company.
- Patients who chronically miss appointments may be charged a fee and eventually dismissed.
- NEW PATIENTS who miss their first appointment will NOT be allowed to reschedule.
- There may be a small fee charged to your account for walk-in appointments.
- Please provide the correct billing information at your initial appointment for all MVA or Workers Comp cases to avoid a Retraction/Resubmission fee to your account.
- A small fee may be charged for copies of health records and completion of forms.
- Payment for outstanding balances may be requested at time of check-in.
- There is a service fee for returned checks.
- Please contact our Billing Staff for assistance if you are experiencing financial difficulties.

Thank you. ☺

I have read and understand the Financial Policy for Davenshire Medical Center:

PATIENT'S NAME *(please print)*: _____

_____ _____

Signature of Patient or Responsible Party Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. At Davenshire Medical Center, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment, and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received a copy of Davenshire Medical Center Partnership's "Notice of Privacy Practices" which explains these practices in more detail. I understand that I may request an additional copy at any time either by picking up an extra copy located in the reception area/waiting room or by asking an employee of Davenshire Medical Center Partnership.

I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that you are not required to agree to my request, but if you do agree, then you are bound to abide by such restrictions.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: SELF [ ] PARENT/GUARDIAN [ ] SPOUSE [ ]

SIGNATURE: _____

DATE: _____/_____/_____

BELOW IS FOR OFFICE USE ONLY…….

As an authorized representative of Davenshire Medical Center, I have made a reasonable attempt to obtain the patient's signature but was unable to do so as documented below:

_____

Initials & Date & Reason

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

____ Patient Reviewed HIPAA Privacy Statement (Previous Page)

PLEASE CIRCLE YOUR SELECTIONS

Can detailed APPOINTMENT messages be left…

On a Home Phone?	Yes	No
On a Mobile Phone?	Yes	No
Via Mobile Text?	Yes	No
On a Work Phone?	Yes	No
With Another Person?	Yes	No
Via E-Mail/Portal?	Yes	No

Can detailed MEDICAL messages be left…

On a Home Phone?	Yes	No
On a Mobile Phone?	Yes	No
Via Mobile Text?	Yes	No
On a Work Phone?	Yes	No
With Another Person?	Yes	No
Via E-Mail/Portal?	Yes	No

Special HIPAA Contact Instructions (if applicable): _____

_____

Emergency Contact: Name_____ Phone# (____) _____-_____

Relationship: _____ Address: _____

Can appointment/medical information be released to this person? Yes No

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Under the privacy act known as "HIPAA", I authorize Davenshire Medical Center to release information regarding my health care, health records and/or test results to the person(s) listed below.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

PATIENT'S NAME *(please print)*: _____

DOB: _____

_____ _____

Signature of Patient or Responsible Party Date

This information is for use by your physician as part of your confidential medical records.
R06272017

The following pages are releases of information. These forms are for our office to obtain records from your previous doctor(s).

If your previous doctor(s) IS NOT Wellspan affiliated, please complete the first release with the Davenshire Medical Center letterhead.

If your previous doctor(s) IS part of the Wellspan Health System, please complete the form with the Wellspan letterhead.

DAVENSHIRE MEDICAL CENTER
3740 Carlisle Road
Dover, PA 17315
Phone # 717-292-3168
Fax # 717-292-3479
www.DavenshireMC.com

Record Release Authorization

Patient's **Full** Name: _____

DOB: _____/_____/_____ Social Security #:_____/_____/_____

1) Purpose of this request:
___ Personal ___ Changing Physicians ___ Continuing Care ___ Insurance/Billing

___ Other: _____

2) I hereby authorize Davenshire Medical Center to: [ ] release to [ ] receive from
(Please write the Physician/Facility Name, Address, Phone, &/or Fax #):

_____

_____

_____

_____

3) Please release the following records. (This release will expire one year from the signed date)
Please **X** all that apply:

_____**All Medical Health Records**
_____MVA or Workers Comp notes & reports
_____Other, as specified: _____

4) The following information **will be released**. Please write your initials next to any items you **do not** want to be released.

_____HIV related information
_____Mental health information (ex. Anxiety, depression, etc.)
_____Drug & Alcohol abuse or dependency information

5) You have the right to revoke this authorization in writing by sending a dated and signed letter to our Privacy Officer at the address above. Revoking this authorization will not affect your care by our physicians or the staff employed by Davenshire Medical Center.

By signing below, I understand the nature of this authorization:

_____ _____
Signature of Patient/Responsible Party Relationship to Patient

_____ _____
Employee Signature Date

This information has been disclosed to you from records whose confidentiality is protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosures of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

WELLSPAN HEALTH

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

*** PLEASE READ AND COMPLETE ALL ITEMS ***

Patient Name: _____ **Alias/Maiden Name:** _____

Date of Birth: _____ **Last 4 of Social Security Number:** _____ **Phone Number:** _____

Address: _____

I authorize the use/disclosure of health information about me as described below:

☐ Obtain from:

To obtain from: _____ ☐ Disclose to: _____
(What Hospital/Practice/Service) *(Release to What Organization/Practice/To Whom)*

Address: _____ Address: _____

_____ _____

Fax No.: _____ Fax No.: _____

Share the following information from my medical record: From: _____ To: _____
(Please Specify the Dates of Service)

☐ **Abstract of Hospital Medical Records:**
History & Physical, Emergency Department Physician Notes, Discharge Summary, Consultation Reports, Operative & Procedure Reports, Laboratory Reports, Imaging Reports, All Other Diagnostic Studies, etc.

☐ **Abstract of Medical Group Records:**
Physician Office Notes, Consultation Reports, Procedure Reports, Pathology Reports, Laboratory Reports, Imaging Reports, All Other Diagnostic Studies, Psychiatric and Psychological Evaluations, Therapy Notes, Mental Health Progress Notes, etc.

☐ **Diagnostic Test Results** (please specify): _____

☐ **Imaging** (please select **one** format): ☐ **CD and Reports** ☐ **Film and Reports** ☐ **Reports Only**

☐ **Billing Statements**

☐ **Grant the following authorized user, _____, access to my entire Electronic Medical Record.**
This **DOES NOT** authorize the user to disclose, modify, or provide any official medical advice on my behalf.

☐ **Other** (please specify): _____

For the **purpose** of:

☐ **Further Medical Care** ☐ **Personal** ☐ **Insurance Benefits**

☐ **Legal Investigation** ☐ **Billing Inquiries** ☐ **Establish Payment Plan**

☐ **Other** (please specify): _____

I would like to receive this information via (please select **one**): ☐ **Paper** ☐ **CD** ☐ **Secure Email Notification**

Email Address: _____

- I must provide a valid email address, either my own or that of my designated recipient.
- An email notification will be provided with instructions to retrieve the requested records from a secure portal. These records will only be available as PDF documents on the secure portal for 30 days following the date of the email Notification of Availability.

This Authorization includes the release of any records identified below unless I check **NOT** to disclose such records. Checking or not checking the box is no indicator that such information exists. Records **NOT** to disclose: ☐ AIDS/HIV Related Information and/or Testing; ☐ Behavioral/Mental Health Services; ☐ Drug and/or Alcohol Treatment.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I understand the following:

- There may be charges for the copies of my health record due to procedural and regulated steps involved with the release of information process. All fees are regulated by state and federal law, and are updated annually by the Pennsylvania State Legislature.
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
- The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected under the terms of this authorization. However, certain protected records may not be redisclosed per Pennsylvania state laws and regulations, and/or Federal confidentiality rules.
- I may revoke this authorization at any time. If I decide to revoke this authorization, I must present my written revocation to the Health Information Management – Release of Information Office. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This document authorizes release of information entered into my medical records prior to or within 12 months after the date of my signature. This authorization will expire in 12 months from the date of signature.
- This authorization will not be accepted unless it is completed in its entirety. A copy of this form will be accepted in lieu of an original.

My signature acknowledges that my representative or I received a copy of this document, that I have read and understand the content of this authorization, and voluntarily consent to the release of the information.

Signature of Patient/Representative * _____ Date _____

Print Name of Representative and Relationship to Patient * _____

Signature of Witness _____ Date _____

* A personal representative is the person, under applicable law, with authority to act on behalf of the patient or decedent. **Legal documentation may be required.**

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE:

We, the undersigned, do verify that the above Authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for the release of the above information.

Verbal consent requires the signatures of two witnesses:

Signature of Witness _____ Date _____

Signature of Witness _____ Date _____

PLEASE MAIL OR FAX THIS FORM TO:

WellSpan Health
Health Information Management – Release of Information
912 South George Street
York, PA 17403

Phone Number: (717) 851-6396
Fax Number: (717) 812-8119

*** * * IMPORTANT: Please send copies of medical records directly to the requesting practice or physician. * * ***

Requests for health information and invoices are processed by:

MRO