Sheridan Medical Group, LLP.
Get Well • Be Well • Stay Well

Welcome Letter & Guide For Our Patients

Welcome to Sheridan Medical Group and thank you for choosing us as your provider for primary medical care. Our primary goal is to provide quality medical care which is easily accessible and responsive to you in your time of need. Our staff includes a comprehensive interdisciplinary team of professionals who will consistently strive to exceed your expectations to ensure that your experience with us is as comfortable as stress-free as possible.

We Are A Patient Centered Medical Home

As a *Patient Centered Medical Home*, our approach is to provide our patients with comprehensive health care, which is focused on all aspects of your health and overall well-being, including emotional, family and social concerns. Along with your physician and other health care providers, you are the most important person in managing your health.

A "Medical Home" makes it easier and more comfortable for you to access care on a day to day basis by strengthening your relationship with your primary care provider and the team responsible for your care. With a medical home, your quality of care will be significantly improved, and it will take less time for you to get the care when you need it.

Benefits of A Medical Home Team

- ✓ Your medical home team will have an ongoing relationship with you and your family to manage your healthcare needs.
- ✓ You will see the same team each visit and they will assist you in coordinating care with other providers, specialists, and community resources if needed.
- ✓ Your team will have access to all of your health information through electronic records in order to effectively manage your care.
- ✓ You will have easy access to care through open scheduling, expanded hours and other methods of communication with your team.

How You Can Help

- ✓ Talk with your primary care provider and team about any questions you have.
- ✓ Keep in touch with your team if further questions arise about your health.
- ✓ Take care of your health by following the plan recommended by your team.
- ✓ Schedule a complete physical exam at least once a year.
- ✓ Always let us know how we're doing and how we can improve.

Sincerely,

Dr. Richard A. Carlson Jr.
Dr. Rajiv K. Jain

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OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

OFFICE HOURS

Our office is available Monday-Friday 8:00am to 5:00pm, and may be reached at **332-4476.** Our Physicians are available "after hours" 24 hours per day/365 days per year by calling our phone number and following the prompts. **If you need an appointment, prescription refill or test results, please call during regular business hours.**

URGENT CARE

WALK IN urgent care is available for all of our registered patients. This service is available Monday-Friday 8:30am-10:30 am. Our goal is to provide urgent medical care for acute illness within one hour of your arrival.

APPOINTMENTS

Sheridan Medical Group is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates. When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any *updated contact or insurance information*.

While we strive to schedule appointments appropriately, emergencies *can and do* occur in Primary Care. We strive to give all of our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.

To ensure quality care, *Sheridan Medical Group*, does not treat patients we have not seen (i.e., we will not call in prescriptions or offer medical advice for patients *prior* to their initial visit). Follow up may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate plan for your healthcare can be determined.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients please be courteous and call Sheridan Medical Group promptly if you are unable to attend an appointment. This time will be reallocated to another patient who is in need of treatment. This is how we can best serve the needs of all of our patients.

If it is necessary to cancel your scheduled appointment we require that you call one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another patient the ability to have access to timely medical care.

NO SHOW POLICY

A "no show" is the term we use when a patient misses an appointment without cancelling it within one (1) business day in advance. Unfortunately, "No-Shows" inconvenience those patients who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no show". An administrative fee of $35.00 will be billed to your account. You will be sent a letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment within one (1) business day in advance along with the bill for the administrative fee. A copy of the letter will be placed in your medical record. Three (3) "no-shows" within one (1) calendar year will result in a temporary suspension of services. In order to reinstate services, you will be required to meet with your Primary Care Physician within 30 days of the third no show letter to evaluate your situation. In the event you do not respond and/or schedule an appointment within 30 days, we will consider your patient status as terminated.

Please Note

No-Show charges are patient responsibility and will not be billed to your insurance company.

OFFICE CLOSINGS DUE TO WEATHER OR OTHER CIRCUMSTANCES

If our office is closed due to weather conditions or other circumstances beyond our control, the following procedures are used to inform our patients:

- If you are scheduled for an appointment, you will receive an automated message by telephone.
- Closings will be displayed on the three major television stations (2, 4, and 7).
- Closings will be displayed on our website and on Facebook.

INSURANCE

- *Sheridan Medical Group* accepts most insurance plans. If you have specific questions regarding your insurance, please contact our billing department at 332-4476 extension 318.
- It is patient responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment.
- All patients will be asked to present their current insurance card at each appointment. Failure to have your card could delay your appointment, and it will be the responsibility of the patient to provide proof of coverage.

PAYMENTS

- Patients are responsible for co-pays at *time of service.* There will be an additional fee of $10 for all co-pays not paid on the day of appointment.
- If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.
- *Sheridan Medical Group accepts cash, personal checks, MasterCard, Discover, Visa and American Express.* Checks can be made out to *Sheridan Medical Group*.
- It is the policy of Sheridan Medical Group to make all reasonable attempts to collect outstanding balances' should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

- Please inform Sheridan Medical Group of which Pharmacy you use and update us if this should change. Please allow two to three business days for refill requests. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed.
- **Please note that we do not fill Narcotic Medications or order Antibiotics over the phone.**
- **Our Practice does not routinely order Narcotic Pain Medicine, therefore you may be required to obtain these medications through a Pain Management specialist.**

CONFIDENTIALITY & MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records one time, free of charge. Additional copies may be requested at a cost of $0.75 per page. The law allows Medical Offices 30 days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner.

COMPLETION OF FORMS/LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Sheridan Medical Group will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, please allow 7-10 days for completion of requested forms/letters.
The charges for completion of these forms is as follows.

- If the form can be printed directly from the appointment summary checkout – no charge.
- Forms are 1 to 3 pages long - $10.
- Forms are more than 3 pages - $20.
- The payment is due at the time the forms are received / dropped off.

OUR PATIENT PORTAL

As a means of ensuring timely communication with our patients, we strongly encourage you to sign up for the **Patient Portal**, which can provide a quick and easy method for scheduling appointments, entering and updating medications, etc. As a new patient, you will receive instructions on how to sign up for the Patient Portal. If you have questions or need assistance, please feel free to speak with a member of our reception team.

ADDITIONAL INFORMATION

If you have further questions or need additional information about our services, please feel free to call our office at 332-4476 and/or visit our website at www.SheridanMedGroup.com.

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Behavioral Health Services

In collaboration with the wide range of medical services provided by Sheridan Medical Group, our **Behavioral Health Services** department is available to provide patients with the following services for mental health, alcohol/substance abuse, and other psycho-social concerns impacting your overall health:

- ✓ Consultation and information for patients and families regarding services in the community
  - Mental health
  - Family issues
  - Bereavement
  - Eldercare concerns
  - Alcohol/substance abuse
  - Domestic violence

- ✓ Assessment/referral assistance and advocacy for patients

- ✓ Brief crisis and supportive counseling and referral assistance, as needed

- ✓ Case management/care coordination for patients in need of behavioral health services

- ✓ Educational groups for patients and families
  - Behavioral health topics (e.g. mental health, trauma, grief, substance abuse)
  - Understanding the critical relationship between physical and behavioral health
  - Coping with chronic health conditions
  - The important role of your primary care provider in coordinating your care
  - Information about community resources

- ✓ Online information and resources for patients and families

If you need assistance for behavioral health concerns, **please talk with your primary care provider and/or your medical home team**.

You may also contact Rob Schwartz, Manager of Behavioral Health Services at 332-4476, ext. 353.

SHERIDAN MEDICAL GROUP

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

RECEIPT ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the *Sheridan Medical Group* OFFICE POLICIES & PROCEDURES FOR PATIENTS form.

_____

Printed Name

_____ _____

Signed Name Date

THANK YOU!
Sheridan Medical Group, LLP

NEW PATIENT MEDICAL HISTORY FORM

Date: _____

Name: _____ Date of birth: _____

Address: _____

Primary Physician: _____How were you referred to our office: _____

Insurance: _____ ID#: _____Group#: _____ Effective: Date_____

What is the name, address, phone number, and fax number of your pharmacy? _____
_____

Where do you go for bloodwork? ☐Quest ☐ Labcorp ☐ Hospital ☐Home Draw ☐Other: _____

Recent hospitalization: ☐ NO ☐YES, Location/Dates: _____
Details: _____

DEMOGRAPHIC AND CULTURAL HISTORY

Primary Language: _____ Translator Services Requested? ☐YES ☐NO

Do you have any cultural or religious customs that we should be aware of? ☐YES ☐NO
If yes, explain _____

RACE: (please circle): White, Black/African American, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, Other_____, Decline/Unknown

PAST MEDICAL HISTORY

Please describe any <u>medical conditions</u> you have related to the following:	**Circle Yes or No**	**Date of onset**	**Treating Doctor** *(if different from Primary Physician)*	**Details**
Eyes, Ears, Nose or Throat	**YES NO**			
Mood, Behavior or Mental Health	**YES NO**			
Heart, Blood Pressure, Circulation or Blood	**YES NO**			
Lungs or Breathing	**YES NO**			
Stomach or Digestion	**YES NO**			
Brain, Spine or Neurological	**YES NO**			

Endocrine: *Examples include Diabetes, Thyroid, & Hormones*	**YES NO**			
Reproduction	**YES NO**			
Bones & Muscles	**YES NO**			
Urinary & Kidneys	**YES NO**			
Skin	**YES NO**			
Sleep	**YES NO**			
Cancer	**YES NO**			

OTHER PAST MEDICAL HISTORY: _____
_____

PLEASE BRING ALL OF YOUR CURRENT MEDICATION BOTTLES WITH YOUR TO YOUR FIRST APPOINTMENT

MEDICATION LIST

(use separate page if needed)

Medication *(if different from Primary Physician)*	**Dose**	**Times per day**	**Name of the DR. that orders**	**Refill needed?**
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO
				YES NO

ALLERGIES & SENSITIVITIES

Medication	**Reaction/Side effect**

PAST SURGICAL HISTORY

Operation	**Date**	**Details**

TOBACCO USE

TOBACCO	Never	Current	Former	Age of Onset	Packs Per Day	# Years	Year Quit
CIGARETTES							
PIPE							
CIGAR							

FAMILY HISTORY

Medical History	Circle Yes or No	Family Members (circle all that apply)	Age of Onset
Eyes, Ears, Nose or Throat	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Mood, Behavior or Mental Health	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Heart, Blood Pressure, Circulation or Blood	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Lungs or Breathing	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Stomach or Digestion	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Brain, Spine or Neurological	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Endocrine: *Examples include Diabetes, Thyroid, & Hormones*	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Reproduction	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Bones & Muscles	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Urinary & Kidneys	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Skin	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Sleep	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Cancer	**YES NO**	**Parent – Grandparent - Sibling - Other**	
Other:	**YES NO**	**Parent – Grandparent - Sibling - Other**	

Signature of Patient _____ Date: _____

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Today's Date: _____ Patient Account _____

As a patient centered medical home, our primary goal is to provide comprehensive health care focused on ALL aspects of your health, including emotional, family, and social concerns. In an effort to get to know more about you, we would appreciate it if you could respond to the questions below. ***Please feel free to discuss any of these concerns with your primary care provider****.*

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, hopeless.	0	1	2	3
Total each column				

a. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

b. **In the past 2 years**, have you felt **depressed or sad** most days, even if you felt OK sometimes? ❑ YES ❑ NO

c. Are you currently taking medication for depression? ❑ YES ❑ NO

d. Are you currently receiving counseling for depression? ❑ YES ❑ NO

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not able to stop or control worrying.	0	1	2	3
Total each column				

a. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

b. **In the past 2 years**, have you felt **anxious or worried** most days, even if you felt OK sometimes? ❑ YES ❑ NO

c. Are you currently taking medication for anxiety? ❑ YES ❑ NO

d. Are you currently receiving counseling for anxiety? ❑ YES ❑ NO

Use of Alcohol, Medications/Drugs & Coping With Stress

1. How many days per week do you drink alcohol? _____
2. On a typical day when you drink, how many drinks do you have? _____
3. What is the maximum number of drinks you had on any given day in the past month? _____
4. Do you sometimes adjust the dosages or frequency of medications without consulting with your physician? ❒ YES ❒ NO
5. Are you currently using any medications/drugs which have not been prescribed **for you** by a physician? ❒ YES ❒ NO
6. Are you a primary caregiver for someone with a serious health or mental health condition? ❒ YES ❒ NO
7. Have you had any major surgery for a serious health condition during the past 6 months? ❒ YES ❒ NO
8. Are you ever hurt or feel threatened (either physically or emotionally) by a partner or family member? ❒ YES ❒ NO
9. Do you feel *unsafe* at home? ❒ YES ❒ NO
10. While you were growing up:
    a. Did you ever feel neglected or abused by any members of your family? ❒ YES ❒ NO
    b. Did any members of your family have mental health, alcohol, and/or drug abuse problems? ❒ YES ❒ NO
    c. Did any members of your family attempt or commit suicide? ❒ YES ❒ NO
11. Are you currently experiencing any other stressful situations at home, work, or school? ❒ YES ❒ NO

Feel free to use other side for additional comments