Stephen M. Swetech, DO Medical Center, PC
Financial Responsibility, Consent to Treat, and Policies

By signing below, I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that Stephen M. Swetech, DO Medical Center, PC may use my health information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services rendered and for determining insurance benefits or the benefits payable for related services. I understand that collection fees may apply if services are not paid for in a timely fashion. I understand that co-pays, prior balances, and deductibles are collected up front, prior to services rendered.

I understand that I need to take an active role in my own health. I understand that the practice of medicine is not an exact science. I understand that all medical treatments, medications, procedures, and osteopathic manipulations carry risks that can include anything from allergic reaction, infections, damage to tissue and organs, all the way up to death. I give my consent to treatment knowing this reality and take liability for my own care. I understand that my physician is weighing risks vs benefits and trying to make the best recommendations given all the variables of my case. I will make sure to ask any questions I may have and will voice my concerns if I am uncomfortable with the risks and benefits or I don't fully understand my condition and/or treatments. I consent to tissue examination by a pathologist if deemed necessary. I consent to drug screening randomly or if deemed necessary. I understand that follow-up and monitoring is important on all medical conditions and concerns. I understand that many refills will not be given without this monitoring and following. If not instructed otherwise, I will follow-up at 3 month intervals. I will make a preventative visit annually where preventative services will be addressed. I am responsible for making my own appointments for testing and with specialists that I am referred to. I will call the office to follow up on test results if I do not hear anything in a reasonable time frame.

If I have new, continued, or worsening symptoms I will notify Stephen M. Swetech, DO Medical Center, PC and/or go to the nearest emergency room preferably by calling 911. I will call 911 if I have any suicidal or homicidal thoughts. In the event of a needle stick or exposure to body fluids by staff, I consent to testing of communicable diseases. I understand that I may be discharged from the practice for non-compliance or any breakdown of doctor-patient relationship. I understand that I may need to reschedule my appointment if more than 15 minutes late and that I may be charged a fee for inconveniencing the staff.

I understand that prior authorizations for medications are very time consuming and have a low success rate, often delaying treatment. Other appropriate medications will be substituted unless there are no other options. I understand that pharmacies routinely fax refill requests that aren't requested or needed and I will contact Stephen M. Swetech, DO Medical Center, PC instead of my pharmacy if I need a refill. I understand that it can take up to two business days for refills left on the refill line and will plan accordingly. I will not call the refill line for refills on controlled substances. I understand that mixing medications with any other mind-altering or controlled substances can be dangerous. I will not sell or share my medications with others.

I understand that referrals and pre-authorizations for testing take time to arrange, often up to a few days, and will plan accordingly. I understand that any forms that may be completed other than insurance health-risk assessments are not included and may carry a fee for completion, these must be provided to front desk prior to visit. I understand that my physician is interested in maximizing function and forms for disability are not routinely done except in appropriate circumstances. I will stay aware of office hours and understand that calls to the answering service deemed non-urgent are subject to a fee for the physician's time.

Patient's name printed: _____

Patient or Representative Guardian Signature:_____Date:_____

Stephen M. Swetech, DO Medical Center, PC
HIPAA Consent

In April of 2003, new federal requirements regarding privacy of information for patients took effect. HIPAA, the Health Information Portability and Accountability Act requires that all providers, insurance companies, and others put in place controls to ensure that your personal medical information is safe. Stephen M. Swetech, DO Medical Center, PC requests that each patient sign this consent form which allows us to share protected health information with other physician's offices, hospitals, insurance company(ies), and authorized individuals.

Our Notice of Privacy Practices provides information on how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

By signing below, I acknowledge that it is my responsibility to make sure Stephen M. Swetech, DO Medical Center, PC has up to date contact information. I authorize Stephen M. Swetech, DO Medical Center, PC staff to leave messages about concerns or results on my voicemail or with household members. Stephen M. Swetech, DO Medical Center, PC may discuss these concerns or results to anyone answering provided phone numbers within reason, unless I specifically instruct them otherwise in writing. I give my consent for Stephen M. Swetech, DO Medical Center, PC to request and obtain medical records from other providers/hospitals as necessary. Stephen M. Swetech, DO Medical Center, PC may release medical information to emergency contacts, and other medical providers involved in my care. Many of our patients allow family members, friends, or significant others to call and request the results of tests and procedures. Under the requirements of HIPAA we are not allowed to give this information to these individuals without the patient's consent. In addition to the individuals and entities authorized above, I authorize Stephen M. Swetech, DO Medical Center, PC to release my protected health information to the following individuals:

1.) _____ Relation to Patient:_____
2.) _____ Relation to Patient:_____

Patient's name printed: _____
Patient or Representative Guardian Signature:_____Date:_____

Patient Information:

Full name: _____
DOB: _____

Address: _____
_____

Primary Phone: _____
Secondary Phone: _____

Marital status: _____
Social Security #: _____
How did you hear about us? _____
Religious Preference: _____
Race/Ethnicity: _____

Emergency Contact: _____
Phone number: _____
Relationship: _____

Employer: _____
Address: _____
_____
Employer phone: _____

Do you have an advanced directive? _____(please provide a copy for your medical record)

Update to medical history:

Past medical problems: _____
_____

Past surgeries: _____
_____

Medical problems in family: _____
_____

Tobacco use?: _____
Alcohol use?: _____
Illicit drug use?: _____

Last dental visit (you need to see dentist at least twice annually)?: _____
When was your last colonoscopy (if done)?: _____

Patient or Representative Guardian Signature: _____Date:_____

Reviewing Physician Signature: _____Date:_____