Katherine J. Atkinson, M.D., P.C.
Jessica Jimison, FNP
Katelyn Dutkiewicz, PA-C
Charles M. Milch, MHP, MBA, PA-C
Miranda Tsoumas, PA-C
Wendy Chabot, M.D.
Nora Schwartz-Martin, M.D.

Atkinson Family Practice

Caring for you and your Whole Family

17 Research Drive
Amherst, MA 01002
Phone (413) 549-8400
Fax (413) 549-8409

www.atkinsonfamilypractice.com

Welcome to our Practice
Adult Packet

We feel that we have something special here at Atkinson Family Practice and we look forward to caring for you and your family. Let us tell you more about ourselves and our philosophy regarding patient care.

Expectations: In being accepted in to our practice, **patients are expected to be seen once every calendar year for a physical exam, more frequently if they have chronic diseases, and/or issues for which we prescribe medications.** It is our policy that you **schedule next year's physical exam upon checking out of your current exam.** If you do not wish to schedule your Physical Exam Appointment at that time, **we will schedule it for you and send a letter notifying you of the appointment**.

Of course, if it is not convenient for you, **please call us or email to reschedule**. Please note, if you do not schedule your Physical Exam on your way out from your visit, we cannot guarantee that your next yearly physical exam will be with your preferred provider. We will do everything we can to keep you with your Primary Care Provider, but if there is not a time available with your Primary Care Provider we will schedule your exam with an available provider.

Appointments: If you **do not show** for your appointment or **cancel with less than 2 hours notice**, you will be charged a **$25 no show fee and be asked to reschedule your appointment.** If you **do not show** for your **Annual Physical** appointment or **cancel with less than 2 hours notice,** you will be charged a **$50.00 no show fee and be asked to reschedule your appointment.** If you know you are going to be late, please call to let us know. We will do everything we can to try to accommodate you.

Refills: Please request your medication refills at least 24-48 hrs. in advance. **REMEMBER PLEASE:** this means if you call on a Friday afternoon the refill may not be done until Monday. In most instances we do try to do them same day; but we cannot guarantee it. Most medication refills are NOT an emergency. Please do NOT call on weekends/after hours for refills unless it is to leave a voice message for us to retrieve on Monday. Our providers are busy with their own families; so if you could please remember that weekend/night calls are for urgent matters only.

We DO NOT practice "phone-medicine." If you or your family members are sick we prefer to see you in the office. Prescribing drugs over the phone simply is not safe medicine. Reasons for treating over the phone do NOT INCLUDE how far away you live or not wanting to pay a co-pay. If you live so far away that you're coming in is too challenging we would suggest that you select a closer provider for your family's care. Your co-pays are determined by your insurances not by us. *Besides we are worth it!* Our staff works very hard to take care of you.

Our office has a strict policy about prescribing narcotic medications. *We do not prescribe narcotics for chronic, non-cancer pain*. Feel free to talk to your provider about any of our policies.

Insurance: There are many, many insurances each with many different programs—we CANNOT know what your insurance covers. You are responsible to know what your policy states. If you tell us before your visit that your insurance doesn't cover something we can often note it accordingly but we can NOT change the note after your visit is done. Try to select the insurance plan which fits your family's needs—we do not set your co-pay or deductible—your policy does. After your insurance has paid we will expect you to pay the balance in a reasonable amount of time. Just as you have to pay your own rent and utility bills so do we.

Payments: We count on your payments to keep our office operating. You are responsible for paying for your own medical care. We sign contracts with your insurers agreeing to collect co-pays; so we are not able to waive them. We would appreciate you not asking us to do so. **Co-pays not paid at the time of the visit will be assessed an additional fee of $10.00 as it costs us money to mail invoices**. **If a check is returned for non-payment, there will be a $30.00 bounced check fee applied to your account and check writing will be prohibited with the office for one year.**

PHONE : 413-549-8400 Our phones are on **weekdays 730am to 7:00pm Mon, Tues, Wed. Thursdays and Fridays till 5:00pm off for lunch from 12:30- 1:30pm.** After hours you have two options—push #1 and you can leave a non-urgent message to be heard on the next business day. Push #2 and you will be directed to the answering service who will page the doctor on call. Please allow an hour for the provider to get back to you.

If it is a life-threatening emergency do not call us, call 911 or go to the ER. We will always approve an ER visit so you do NOT need to get permission from a doctor first. We share call with the South Deerfield Family Practice so you may talk with one of their providers on nights or weekends. If you are waiting for a return call please **UNBLOCK YOUR PHONE** so we can reach you!

*If for any reason you cannot reach us after hours (if phones or electricity are down for instance) you may also call the Cooley Dickinson hospital operator at 413-582-2000

2. EMAIL: www.doctorkate.net Each provider and the front desk have their own email addresses which they respond to personally. You can find them through our website. **Please do not send emergency messages on email as we do not necessarily check them every day.** Also, sometimes email messages get lost or stuck in the spam filter—if you haven't heard back in 2 business days it is not impolite to follow up with a call or a repeat email. **Email does not replace required follow up appointments as recommended by your provider.**

Rules about email

1. Always include your **full name and date of birth**.
2. Please only **discuss one patient** on each individual email and **no more than 2 problems** on each note. If your problem is too complex we may ask you to schedule an appointment.
3. It is ok to send multiple emails at the same time and actually easier for us to respond and file them if you **keep different problems** separate.
4. Always put a **reason in the subject line**.
5. **Your email will be entered into your computerized chart.**

3. FAX: 413-549-8409 You can fax requests or short notes to us. Examples are lists of blood pressure results or blood sugar readings. This is NOT a good way to have an interaction with your provider—please book an appointment for that.

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NOTICE OF PRIVACY PRACTICES

Effective Date: August 13, 2013

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices. We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted within the walls of the practice, as well as, on our website www.doctorkate.net.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure of accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required. If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided on the following page under Privacy Complaints.

How We May Use or Disclose Protected Health Information - Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

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Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Social Media–We enjoy sharing news from our practice to you and the world at large. With your permission, we may use your photo, or your family member's, photo on our website, Facebook page, Electronic Bulletin Board, or other media outlets. If you send us a photo then we will assume that you have implied consent. Our office also offers scholarships and that information may be posted on any or all of the above listed media venues.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints
You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. **You may file a complaint with us by notifying the Privacy Manager at: Atkinson Family Practice, 17 Research Drive, Amherst, MA 01102.**

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Practice Policies and Guidelines

I have read, understand, and agree to the Policies of Atkinson Family Practice.

_____
Initial

I have received a copy of the Atkinson Family Practice Policies and Guidelines.

_____
Initial

I have received a copy of The Notice of Privacy Practices.

_____
Initial

_____
Patient Name (print)

_____
Signature

_____
Parent/Guardian Signature (If patient is a minor)

_____/_____/_____
Date

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Authorization for Release of Medical Information

ALL SECTIONS BELOW MUST BE COMPLETED FOR PROCESSING

Patient Name:_____ Relationship to Patient : _____
Last First MI

Maiden or Former Name : _____ Date of Birth: ____ / ____ / _____

Patient Address:_____ Phone: ( ) _____ - _____
Street Apt. # City State Zip

☐ **OBTAIN MEDICAL RECORDS -** I hereby authorize the below named Physician/Facility to release my health information to:

Atkinson Family Practice, 17 Research Drive, Amherst, MA 01002

Previous Physician/Practice:_____ Phone: ( ) _____-_____ Fax: ( ) _____-_____

Address :_____
Street Suite. # City State Zip

☐ **DISCLOSE MEDICAL RECORDS -** I hereby authorize **Atkinson Family Practice** to release my health information to:

New Physician/Practice :_____ Phone: ( ) _____-_____ Fax :( ) _____-_____

Address :_____
Street Suite. # City State Zip

Purpose of this Release:

[ ] Transfer** [ ] Continuity of Care (not leaving practice) [ ] Legal [ ] Insurance [ ] Consult Appointment [ ] Personal

[ ] Other: _____ ** IF YOU ARE TRANSFERRING OUT OF AFP, PLEASE TELL US WHY ON THE BACK OF THIS FORM? THANK YOU!

Medical Information to be Disclosed:

[ ] All Records [ ] Consultations [ ] Diagnostic Tests (labs, x-rays, EKG, colonoscopy, etc.) [ ] Hospital Notes

[ ] Progress Notes [ ] Immunizations [ ] Other: _____

Authorization Covers:

[ ] Past Three Years [ ] Entire Period of Care, which began in : ____ _____ [ ] Specific Dates: _____
Mo Yr

Release of sensitive, protected information related to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases, drug/alcohol use/treatment and/or mental health/psychiatry is authorized only through express consent.

INDICATE THE AREAS YOU AUTHORIZE BY INITIALING EACH ONE BELOW:

_____ **HIV/AIDS** _____ **Sexually Transmitted Disease** _____ **Mental Health/Psychiatry** _____ **Drug/Alcohol**

This authorization **EXPIRES ON**: _____ _____, or if unspecified, one year from date of signature.
Mo Yr

I understand that I may revoke this authorization at any time by making a written request to Atkinson Family Practice. I understand that actions taken in reliance on this authorization prior to revocations may not be reversible. I understand that Atkinson Family practice may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. State law prohibits redisclosure without written authorization.

I acknowledge that I have signed this Authorization voluntarily:

_____ _____ _____
Signature of Patient or Authorized Representative | Print Name of Patient or Authorized Representative | Date

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STATEMENT OF UNDERSTANDING

ASSUMPTION OF FINANCIAL RESPONSIBILITY FOR MEDICAL SERVICES

I am enrolled in the following insurance plan(s):

Primary :_____

Insurance ID #:_____

Secondary :_____

Insurance ID #:_____

Tertiary :_____

Insurance ID #: _____

I acknowledge that I have voluntarily sought the services of Katherine Atkinson's M.D. P.C, a participating provider. I accept full responsibility for paying for services provided by Katherine Atkinson's M.D. P.C. I understand that my insurer will not pay the provider nor reimburse me for the cost of services rendered here, or for any subsequent or ancillary services which the provider may order on my behalf, if this insurance is not truly in effect or if the provider is not considered my primary care physician. I further acknowledge that it is my responsibility and not the provider's to know what services are covered by my insurer. I accept full responsibility for paying for services provided if they are not covered by my insurance. If the above information changes at any point, it is my responsibility to notify Atkinson Family Practice.

_____ _____

Patient Name **Date of Birth**

_____ _____

Responsible Party's Signature **Date**

ASSIGNMENT AND RELEASE

I certify that I and/or my dependents assign our insurance benefits directly to Katherine J Atkinson MD, PC. I understand that I am financially responsible for all charges whether or not they are paid by the insurance company. I authorize the use of my signature on all insurance submissions. I certify that Katherine J. Atkinson MD, PC and its employees have the right to disclose my (or my dependents') health care information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits and payments for related services. This consent will remain active unless I cancel it in writing.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

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ADULT REGISTRATION FORM

PATIENT INFORMATION

Name _____
Last Name *First Name* *Middle Name*

Address_____ **Email** _____

City_____ **State**_____ **Zip**_____

Sex _____ **Age**_____ **Date of Birth** _____ / _____/ _____ SSN _____ _____ _____

School/Employer_____

Please list other family members living in your household.

_____ _____

_____ _____

_____ _____

Preferred Pharmacy: _____

Please put an X in the box to designate which phone number is the primary number to call

☐ **HOME PHONE#** _____ **Can we leave a message at this number? YES NO**

☐ **CELL PHONE#** _____ **Can we leave a message at this number? YES NO**

☐ **WORK #** _____ **Can we leave a message at this number? YES NO**

In case of an Emergency, who can we notify?

Name _____

Address _____

Phone Number _____ **Relationship to Patient** _____

HEALTH INSURANCE INFORMATION:

Person Responsible for Account _____

Name of Insurance Company _____

Insurance ID # _____

Who holds the insurance? _____

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Patient Demographics
Name:
Address:
Phone No.:

Language preference			
English ☐		Other ☐	(specify):

Race	
American Indian or Alaskan Native	☐
Asian	☐
Native Hawaiian or Other Pacific Islander	☐
Black or African American	☐
White	☐
Hispanic	☐
Other Race	☐
Other Pacific Islander	☐
Decline to Answer	☐

Ethnicity	
Hispanic or Latino	☐
Not Hispanic or Latino	☐
Decline to Answer	☐

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HIPAA

Contact/Sharing Information Consent

Patient Name: _____ **DOB:**_____

Address: _____ **City** _____ **State** ____ **Zip** _____

	May we leave a message and/or medical info?	Which number is primary for messages?
Phone (Home) _____	**Y / N**	☐
(Work) _____	**Y / N**	☐
(Cell) _____	**Y / N**	☐

Do you have an email address? **Y / N**
If so, may our providers contact you at that address with possible medically sensitive details? **Y / N**
Please provide your email address by **printing clearly on the line below:**

_____

Email Address

Would you like to receive a monthly E-Mail newsletter from our office letting you know of upcoming events at the Atkinson Building, along with informative healthcare topics of interest? Y / N

Due to HIPAA regulations, we may only discuss health information with people that you have listed (*that includes parents and/or spouses*). Please list **all people** that we may speak to about you and your medical status below.

NAME	PHONE NUMBER	RELATION TO PATIENT
Dragonfly Integrated Care Group—for medical/behavioral collaboration as appropriate		

Please note that this consent will be valid for one year (from date signed)*****. If your contact information changes before the end date, please complete a new form. This may be revoked at any time, in writing. The information is for your protection and we appreciate your cooperation in protecting you and your rights.

_____ *****Date:_____

Patient/Legal Representative Signature ***Valid for one year from this date***