WELCOME TO AVEON HEALTH!

I am honored that you chose Aveon Health as your Healthcare Home and I am committed to providing you with the best care I can. My hope is that we form a partnership to keep you as healthy as possible, no matter what your current state of health. I will share my medical expertise with you, and I hope you'll take responsibility for working toward the healthy lifestyle that is so important to your well-being. Few of us, myself included, have a completely healthy lifestyle, but each day we can take a step closer to a healthier life.

Here are some important steps you can take toward better health:

- Don't smoke cigarettes or use other tobacco products.
- Drink alcohol in moderation, if at all, and never drive when you've been drinking.
- Eat a healthy, balanced diet.
- Exercise at least three times a week.
- Properly care for chronic conditions.
- Learn ways to deal with stress and tension
- Get vaccinated against COVID19

For the safety of all our vulnerable patients and to protect our staff, we are requiring all new patients to be vaccinated or willing to get vaccinated against COVID19. Failure to comply could result in discharge from our office.

It will give us great pleasure to work with you on these goals, either through our own expertise or through patient education materials we will provide.

We want everyone to be involved in maintaining a healthy lifestyle. Everyone who joins our practice should start by having a complete physical exam followed by periodic check-ups to test for a few specific diseases.

I look forward to working with you as your family doctor. Please contact me whenever you'd like to talk about anything you think may be affecting your health. It's my hope that we can have a relationship where the lines of communication are open and communication goes both ways. Let's work together to help you live the healthy and happy life that you deserve.

Sincerely,

Dr. Sam S. Fereidouni
Medical Director

Patient Responsibilities

- During my visits with the clinician I understand that I may be given recommendations. Alternative treatment(s) for my condition may exist. I may be presented with information about these options, including the option to do nothing.
- I understand that during the course of treatment material may be discussed that may be upsetting to me.
- I accept results are not guaranteed to meet my full expectation but are a best effort to improve my health, condition, and/or symptoms.
- It is my responsibility to follow treatment as directed by the clinician and to report any worsening symptoms during treatment.
- I recognize I have voluntarily chosen to seek service and I understand that I may terminate treatment at any time.
- I agree not to post negative, inflammatory, or objectionable reviews, materials or comments about individual clinicians of Aveon Health without written consent from Aveon Health office manager
- I understand that there is no guarantee that I will feel or become better.
- I understand that state laws require that my clinician must report all cases of physical or sexual abuse or neglect of minors or the elderly and all cases in which the patient presents as a danger to themselves or others to law enforcement.

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Signature of Patient / Responsible Party

Policy of Patient Financial Responsibility

Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

We accept certain insurance plans; therefore please provide us with your insurance card. We will let you know if your plan is one for which we are a designated clinician. If you wish to be seen at Aveon Health, you are responsible for payment of all co-pays and/or deductible charges at the time of service. If your insurance is a plan for which we are not a designated clinician, we are more than willing to provide care and you will be responsible for payment at the time of service.

Your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your claim and ensure your carrier remits payment. If a problem occurs with your claim, you will be required to establish written financial arrangements with Aveon Health until your insurance problem is resolved.

Please remember that insurance policies may not cover all conditions and fees. To be fully aware of your schedule of benefits, please read your policy or talk with an insurance representative.
Any laboratory analysis that we require, but do not perform in-house will be sent to an external laboratory as required by your insurance. You may receive a separate bill for laboratory services.

We accept payment in the form of cash, check, credit or debit card (VISA, MasterCard, Discover, AMEX, & Digital Crypto Currency). Any checks returned to us due to insufficient funds will result in a fee of $75.00 each.

All patient accounts are due and payable within thirty (30) days of services rendered. Each month you will receive a monthly statement for services, which is due and payable within ten (10) days. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice indicating there is a problem with your account. If three consecutive reminders are mailed to you and you do not respond then your account will be sent to collections and you will not be allowed to schedule an appointment until your entire account balance is paid in full. Please notify us immediately if a mistake appears on the statement.

Aveon Health offers appointment reminder calls as courtesy to our patients. If you arrive more than 10 minutes late for your scheduled appointment, we may ask you to reschedule your appointment. If you No Show an appointment or cancel and do not notify us at least 24 hours prior to your scheduled appointment, you may be charged a $45 No Show Fee. Any early weekend or extended appointments missed may be charged $75.00. After 3 No Shows the office has may discharge you from our care, as your absence impedes your clinician from providing quality medical care.

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Signature of Patient / Responsible Party

Patient Information Form

Patient Full Name _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____

Race _____ Ethnicity _____

If patient is a minor, parent or guardian name _____

Marital status _____ Email _____

Emergency contact name _____ Phone # _____

Relation to patient _____

How did you hear about us? _____

What do you do for work? _____

Release of Test Information

I give consent for the following individual to be able to access my health information and speak with Aveon Health doctors and staff members about my care, condition, and treatments:

Name: _____ Relationship to Patient: _____

Phone #: _____

I give consent for Aveon Health to leave a detailed messages to be left on my voice mail? **Yes** ◯ **No** ◯

I give consent for Aveon Health to contact myself at my place of employment **Yes** ◯ **No** ◯

If yes Employment Phone Number: _____

Signature _____ Date _____

Health Questionnaire

Patient Full Name:

Medication Allergies:

Current Alcohol Use: Y N Drinks per week:

Current Tobacco Use: Y N

Past Tobacco Use: Y N Date Quit:

Current Recreational Drug Use: Y N Type of Narcotic:

Past Recreational Drug Use: Y N Date Quit:

Marital status: Spouse Name:

Do You Exercise: Days per week Exercise type:

Sexually active? Y N

Sexual Partners: Male Female Both

Form of protection

Last physical exam date:

Previous Dr. Name: Phone Number:

Do you see any specialists? if so what type of specialists?

Health Questionnaire Continued

Past Medical History: Do you or have you had any of these problems?

☐ Irregular heart beat	☐ Stroke	☐ Blood clot	☐ High Cholesterol	☐ Pneumonia
☐ High blood pressure	☐ Heart attack	☐ Heart murmur	☐ Asthma	☐ Gallstones
☐ Emphysema	☐ Pulmonary embolism	☐ Tuberculosis	☐ Sleep apnea	☐ Anxiety
☐ Chronic bronchitis	☐ Liver Disease	☐ Hemorrhoids	☐ Stomach ulcer	☐ Gout
☐ Diverticulitis	☐ Prostate disease	☐ Fracture	☐ Arthritis	☐ Dementia
☐ HIV	☐ Blood transfusion	☐ Anemia	☐ Depression	☐ Diabetes
☐ Bleeding disorder	☐ Seasonal Allergies	☐ Alcohol abuse	☐ Substance abuse	☐ Back Pain
☐ Congestive heart failure		☐ Thyroid Disease	☐ Kidney disease or infections	

☐ Have you ever had falling episodes ☐ Use of aspirin or any Antithrombotic ☐ Kidney disease or infections

☐ Ulcerative colitis/Crohn's ☐ Skin Disease, List Type:_____ ☐ Cancer, List Type:_____

Date of last influenza vaccine:_____ Date of last pneumococcal vaccine:_____

Date of last colorectal screening:_____ Date of last mammogram screening:_____

Date of last DM eye exam:_____

Surgical history: Have you had any surgeries?

Surgery	Date

Family History: Do any close relatives have the following?

KEY: **M** = Mother **F** = Father **PGF** = Paternal Grandfather **MGF** = Maternal Grandfather **PGM** = Paternal Grandmother **MGM** = Maternal Grandmother **B** = Brother **S** = Sister

Condition	Who	Condition	Who
Alcohol Abuse		Glaucoma	
Anemia		Heart Attack	
Anxiety		High Blood Pressure	
Asthma		Kidney Disease	
Cancer		Liver Disease	
Cancer Type		Prostate Disease	
Cholesterol		Stroke	
Depression		Thyroid Disorder	
Diabetes		Tuberculosis	
Epilepsy		Other	
		Other	

HIPAA Privacy Practices

Our Notice of Privacy provides information about how we use and disclose protected health information about you. The Notice contains a section concerning Patient Rights under the law. The Notice is available to you at the front desk at your request. You may review the Notice before signing the consent. The patient has the right to restrict the uses of their information.

By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your Health Insurance Company and overall health care operations. You have the right to revoke this consent in writing with your signature.

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Signature of Patient / Responsible Party

Authorization to Release Medical Information from Other Entities

I, the undersigned, do hereby grant permission for Aveon Health to receive health information from pharmacies and third party databases, including State & DEA databases

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Signature of Patient / Responsible Party

Minor Consent Form

I am the parent and or legal guardian of the patient and hereby grant Aveon Health the authority to treat him/her by the clinician(s)

The clinician(s) are authorized to:

- Provide medical care and procedures as may be appropriate in emergency circumstances by our physicians.
- Provide routine medical treatment for such as an illness.
- Give immunizations
- Discuss & treat reproductive health matters
- Run diagnostic tests such as but not limited to, X-Rays, blood work, etc.

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Signature of Patient / Responsible Party