

# Jessica Davis MD

The New Mom's Family Doctor

781 Hudson Avenue | PO Box 173 | Stillwater, NY 12170  
phone: 877.664.6116 | email: DrJess@jessicadavismd.com

## NEW PATIENT FORMS v. 2

Welcome to my practice! Congratulations on taking a positive, active step towards better health. I look forward to being a partner in your healthcare and applaud you for taking an interest in Integrative and Holistic Medicine and the Ideal Micropractice Model. I hope that our partnership will be beneficial and lasting.

Here are some highlights about the practice. For more information, please read my website at <http://www.jessicadavismd.com>

1. **Ideal Micropractice Model:** I work solo, with no staff, in order to keep overhead low, maximize continuity, provide longer appointments and high quality holistic care. This also means that your best results happen when you are an active participant in your healthcare. At this time, I refer patients out for hospital coverage and laboratory services.
2. **Integrative Holistic Family Medicine:** The care I provide is a combination of diagnostic skills and treatment options from training in both conventional family medicine and integrative holistic medicine. My goal is to have a practice that serves as a peaceful, safe place with an environment of mutual respect and caring. A core philosophy is that healing goes beyond fixing physical dysfunction, and instead requires both patient and physician to attend to mind, body and spirit.
3. **Sustainability:** I choose not to take insurance because I want to create a practice that is accessible and affordable for everyone, including the uninsured and underinsured. The administrative time and overhead involved in tracking down insurance payments would drive up costs and decrease appointment times. By eliminating the insurance middleman, you can be sure that I am working and advocating for you, not your insurance company. Members of the practice pay a monthly membership fee, in addition to visit fees. The membership fee includes a free annual wellness visit for adults, or all recommended well child checks for babies.
4. **Email communication:** Email is the primary and preferred form of communication.
5. **Fees:** (See website for additional details and most current fees) Annual Membership Fee \$33/mo adults, \$43/mo under 2 yo, \$23 ages 2-21 yo, Office Visits 30 minutes \$50, Phone visits and WebVisits \$25. No-Show Fee \$20 (\$50 for a new patient visit), Insufficient Funds Fee/Bounced Check Fee \$30.

Take comfort in knowing that your family has 24/7 phone and email access to your provider!

I look forward to meeting you on your path to wellness.

To your good health,

Jessica Davis MD

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## CHECKLIST FOR NEW PATIENTS

### What to bring to your first appointment

#### Before the first appointment:

- Complete the medical history form, and **return it to me at least 3 days** before your appointment; (return by mail to PO Box 173 Stillwater NY 12170, drop it off at the office, fax or email). If not received in advance, you may be asked to reschedule your first visit).
- Please release your medical records from your previous physician by supplying them with the Medical Record Release form prior to your appointment.
- Review Practice Policies (on Forms page of website, includes Email Policy & Privacy Policy)
- Review directions to the office! See details on my webpage...GPS is usually NOT accurate.
- Write down any questions you might have

#### Completed Paperwork:

- Driver's License
- Signature Page
- Patient Registration Data Form
- Meliora Plan Enrollment Contract

#### Payment: (cash, check or credit card)

- Registration Fee
- Annual Payment or complete Credit Card Authorization Form for Recurring Monthly Payments

#### If you are on Medicare:

- Medicare Private Contract

#### Other (optional before first visit but should be completed within first year):

- How's Your Health Survey (expected to be completed once yearly)  
<http://www.meliorafamilymedicine.com/pages/howyourhealth.html>
- Advance Directives (Living Will and Health Care Proxy available on website)

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## REGISTRATION DATA FORM

Patient Name \_\_\_\_\_ Sex: M\_\_ F\_\_ DOB \_\_\_/\_\_\_/\_\_\_  
Last First Middle

Address \_\_\_\_\_ SSN: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer/School: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse/Partner's Name: \_\_\_\_\_

### For Minors: Head of Household / Guarantor:

Name \_\_\_\_\_ Sex: M\_\_ F\_\_ DOB \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Insurance Plan (if any): \_\_\_\_\_

Do you have an Advanced Directive, Health Care Proxy or Living Will? Yes / No

How did you hear about Dr. Davis? \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Office Use Only: Membership Plan A B C

Account # \_\_\_\_\_

Acupuncture Only

Account # \_\_\_\_\_

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## SIGNATURE PAGE

**Please print this page after reading the Practice Policies, sign it and bring it to your first appointment.**

1. I have read the information about e-mail procedures and privacy and have received answers to all of my questions about using e-mail to communicate with Dr. Davis.
2. Please choose one of the following options regarding use of email:
  - Secure Option:** Please send all email containing personal health information via the secure Onebox option. This requires logging in to a patient portal to receive the message. I realize that even this more secure method is not 100% guaranteed. Administrative emails will still be sent using standard email.
  - Standard Option:** Please send all emails including those with personal health information via standard email.
  - No Email:** I do not use email at all, or I check it less than once a week. Please provide test results, appointment reminders, and other communication via: (choose one)
    - Phone Preferred number: \_\_\_\_\_
      - OK to leave message with results or information
      - No, this is not a private line, just leave message to call office
    - Regular Mail (\$25 annual fee or self-addressed stamped envelopes)
    - In Person (office visit rate applies)
3. I understand that any e-mail that I send may be seen by people other than my doctor and that the Internet is not an error-free network. I understand that e-mail is never appropriate for urgent or emergency situations, or sensitive subjects.
4. I understand the terms outlined in this notice, and I consent to the use of unsecured e-mail in addition to other methods of communication with Meliora Family Medicine PLLC.
5. It is my responsibility to notify Dr. Davis in writing if my e-mail address changes.
6. I understand that I or my doctor may choose to discontinue the use of email at any time.
7. I have read the Practice Policies, Fees, Email Policy and Privacy Practice for Protected Health Information policy of Meliora Family Medicine and have have had all of my questions answered regarding their contents. I understand that non-payment of the aforementioned fees is grounds for dismissal from the practice.
8. I give consent to treatment by Jessica Davis, MD.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian if applicable \_\_\_\_\_

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## AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_ - \_\_\_ - \_\_\_\_

### Records to be released:

<input type="checkbox"/> from	Name: _____	<input type="checkbox"/> to	<b>Meliora Family Medicine PLLC</b> <b>Jessica Davis, MD</b> <b>PO Box 173, Stillwater NY 12170</b> <b>Fax: 877-664-6116 (Please call first)</b>
<input type="checkbox"/> to	Address: _____	<input type="checkbox"/> from	
	Phone: _____		

### This request and authorization applies to:

- All records
- Health care information relating to the following treatment, condition or dates:

Please DO NOT release records of the following:  mental health,  drugs/alcohol,  HIV

### Please include the following information:

- |                                  |   |
|----------------------------------|---|
| Problem List                     | Most Recent Discharge Summary (if any)                |
| Medication List                  | Laboratory Results <b>from the last 12 months</b>     |
| List Of Allergies                | X-Ray /Imaging Reports <b>from the last 12 months</b> |
| Immunization Record              | Consultation Reports <b>from the last 12 months</b>   |
| Most Recent History And Physical | Progress Notes <b>from the last 12 months</b>         |

**This release expires (choose one) : After 1 time / 1 year after the date signed / Never**

I have the right to refuse to sign this authorization. I have the right to revoke this authorization in writing except to the extent that the practice has already acted in reliance upon this authorization. There is no fee to provide records to another health provider. There will be a fee to provide records to any other party such as an attorney, insurance company, etc.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Guardian Name

\_\_\_\_\_  
Relationship