Green and Seidner
Family Practice Associates, P.C.

Welcome Letter & Guide for Our Patients

Welcome to Green and Seidner Family Practice Associates and thank you for choosing us for your primary medical care. Our mission is to provide high-quality, accessible healthcare to every individual—regardless of race, religion, sex, gender identity, or sexual orientation. Our dedicated team of professionals strives to exceed your expectations and ensure that every visit is comfortable, welcoming, and stress-free.

We believe in partnering with our patients to deliver comprehensive care that focuses not only on prevention, but also on the management of all aspects of your health and well-being. This includes attention to emotional, family, and social concerns. Alongside your physician and healthcare team, *you* play the most important role in managing your health.

How You Can Help

- **Communicate openly** with your primary care provider and care team about any questions or concerns.
- **Stay in touch** if new questions arise after your visit.
- **Follow your care plan** as discussed with your provider and team.
- **Schedule recommended appointments** for lab work, testing, and specialist visits.
- **Plan for preventive care** by scheduling a complete physical exam or periodic health assessment at least once a year.
- **Share your feedback** so we can continue to improve your experience.

Our providers and staff look forward to partnering with you in your healthcare journey. Thank you again for trusting **Green and Seidner Family Practice Associates** as your primary care provider.

Sincerely,
Green and Seidner Family Practice Associates

Green and Seidner
Family Practice Associates, P.C.

New Patient Packet

Welcome to our practice! Before your upcoming appointment, please take a few moments to carefully review and complete all **New Patient Forms** included in this packet. Bringing the completed documents with you will help ensure a smooth and efficient visit.

Please Bring the Following Completed Items to Your Appointment:

- **Receipt Acknowledgment Form** for Office Policies & Procedures
- **Medical History Form**
- **Patient Registration Form**
- **Communication & Disclosure of Protected Information Form**
- **Consent to Obtain External Prescription History**
- **Acknowledgment of Our Notice of Privacy Practices**
- **Current Insurance Card**
  - *If your HMO/PPO plan requires you to select a Primary Care Provider (PCP), please confirm that our practice is listed as your PCP on your insurance card.*
- **Valid Driver's License or Other Photo Identification**
- **Co-payment**
  - *If your co-payment amount is not listed on your insurance card, please contact your insurance provider prior to your appointment.*
- **Medical Records** and/or **Authorization to Release Medical Records**

Appointment Details

Your appointment is scheduled for:_____ at **: AM / PM**

Please plan to arrive **at least 15 minutes prior** to your scheduled appointment time to allow for check-in and processing of your paperwork.

Green and Seidner
Family Practice Associates, P.C.

I certify that the information on this form is correct and current:
Date: __/___/____Signature: _____
Date: __/___/____Signature: _____
Date: __/___/____Signature: _____

PATIENT REGISTRATION FORM

(Please Print)

Name _____ **DOB:** ___/___/_____ **Sex:** M / F / Other
(Last) (First) (MI)

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone_____ **Cell** _____ **Work**_____

Email _____ **Social Security Number** ____/___/____ **Religion** _____

Race: __White __ Black or African American __ American Indian or Alaska Native __Asian
__Native Hawaiian or Other Pacific Islander __ Other __Unknown/Undetermined

Ethnicity: __ Hispanic __ Non-Hispanic **Language Spoken at Home:** _____

Employer: _____ **Occupation:** _____

Marital Status: ___ Single ___ Married ___Partner ___ Divorced ___ Widowed ___ Legally Separated

Spouse/Partner Name _____ Phone Number (_____) _____-_____

If under 18: Father's Name _____ Employer _____
Mother's Name_____ Employer _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

Do you have a living will or Advanced Directives? ___ Yes ___ No

****PHARMACY NAME:** _____ **PHONE: (_____) _____-_____**

*****MAIL IN* PHARMACY NAME:** _____ **PHONE: (_____) _____-_____**

INSURANCE INFORMATION (PLEASE PROVIDE INSURANCE CARD & PHOTO ID)

***Primary* Medical Insurance**

Ins. Name _____ Employer _____

Policy Holder Name_____ Policy Holder DOB_____/_____/_____

***Secondary* Medical Insurance**

Ins. Name _____ Employer _____

Policy Holder Name_____ Policy Holder DOB_____/_____/_____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO GREEN & SEIDNER FAMILY PRACTICE (GSFP). I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES & TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. I AUTHORIZE GSFP TO RELEASE ANY INFORMATION REQUIRED FOR PROCESSING AN INSURANCE CLAIM.

Signature _____ Date _____/_____/_____
(Patient, Parent or Guardian)

FOR MEDICARE PATIENTS ONLY : I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH FINANCING ADMINISTRATION, ITS INTERMEDIARIES OR CARRIER, ANY INFORMATION NEEDED FOR THIS OR RELATED MEDICAL CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

Signature _____ Date _____/_____/_____

Reviewed 12/9/2025 (TT)

Green and Seidner
Family Practice Associates, P.C.

I certify that the information on this form is correct and current:
Date: __/___/____Signature: _____
Date: __/___/____Signature: _____
Date: __/___/____Signature: _____

Patient Contact Information

In General, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided with the right to request confidential communications or that communication of PHI is made by alternative means, such as correspondence to the individual's office instead of the individual's home.

Please indicate how we may contact you regarding your medical care:

Home Phone Number: (____) -_____
May we leave voicemail messages at this number? ☐ Yes ☐ No

Cell Phone Number: (____) -_____
May we leave voicemail messages at this number? ☐ Yes ☐ No

Text Messaging (SMS): ☐ Yes, I consent to text messaging at the cell phone number above.
☐ No, *do not text me.*
I understand that standard SMS is not secure or confidential and may be intercepted.

Email: ☐ Yes ☐ No Address: _____

Authorization to Leave Messages

I authorize the providers and staff at Green & Seidner Family Practice Associates to:

- Leave detailed messages regarding my medical care, including test results, on the phone numbers listed above.
- Speak with person(s) other than myself regarding information specific to my medical care.

I understand:

- Voicemail/and or email messages may not be secure.
- This authorization can be revoked at any time with a written request.
- Messages will not be left with unauthorized person(s).
- Voicemails will only be left if the recorded message states a name and/or telephone number.

Authorization to Contact Others

Regarding my care, the following individuals may be contacted to discuss my medical care if necessary:
I authorize Green & Seidner Family Practice Associates to share my health information with the following family members, relatives, or close friends to help with my care. I can revoke this authorization at any time in writing. Any information shared before I revoke this authorization cannot be undone.

Name	Relationship	Home Phone	Cell Phone	Detailed Msg Yes/No

Signature:

Patient Name (Print): _____ Date: _____

Patient Signature: _____ DOB: _____

If you are not the patient, please specify your relationship: _____

Signature of Parent/Guardian/Representative: _____

If signed by a person other than the patient, indicate: (Required if the patient is a minor or an adult who is unable to sign this form. ☐ Minor ☐ Legally Incompetent / Incapacitated ☐ Deceased

Legal Authority: ☐ Parent* ☐ Legal Guardian ☐ Next of Kin / Executor of Deceased ☐ Power of Attorney for Healthcare

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Name _____ DOB _____
(Print)

Medical History Form

Past and Current Medical History

Do you have or have you ever had any of the following conditions? Check all that apply.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Hypertension (*high blood pressure)*			Male genital/prostate problems			GYN/Female problems		
Asthma			Diabetes			Bleeding Disorder		
Gout			Thyroid Disease			Seizures/Epilepsy		
High Cholesterol			Heart Disease			Migraine/Headaches		
Other Mental Health Issues			Heart Attack			Arthritis		
Hepatitis			Heart Arrhythmia			Back/Spine problems		
Anemia			Stroke			Panic Attack/Anxiety		
HIV/AIDS			Blood Clots			Depression		
Drug Dependency/ Substance Abuse			Congestive Heart Failure (CHF)			Palpitation/ Atrial Fibrillation		
Alcoholism			Kidney Disease			Osteoporosis		
Ulcers			Lung Disease					
Reflux Disease (GERD)			Lyme Disease			Other :		
Cancer (Type/year)			Gallbladder Disease					

List any and all Allergies, and the reactions:

Med/ Environmental/Substance	Reaction	Type (side effect, allergy, etc...)
EXAMPLE: Latex	Itching	Side effect

List of Prescription Medications and Supplements you are taking. (*Over the counter ones as well*)

Name of Medication	Strength	Instructions	Prescriber
EXAMPLE: Diovan	320mg	½ tablet daily	Dr. Smith

Name _____ DOB _____
(Print)

LIST ANY SPECIALIST YOU HAVE SEEN AND WHY.

Physician Name / Office	Reason

LIST ANY SURGERIES/ HOSPITALIZATIONS

Surgery / Hospitalization	Date
EXAMPLE: Tonsillectomy	1/2000

FAMILY HISTORY:

Do you have a family history of any of the following conditions? Check all that apply;

	Mother	Father	Siblings	Children	Paternal Grand Parent	Maternal Grand Parent
Cancer(list type)						
Hypertension						
Diabetes						
Heart Disease						
Thyroid Disease						
Mental Health Issues						
Substance Abuse						
Deceased (age)						
Other						

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Name _____ DOB _____
(Print)

PREVENTION: PLEASE CIRCLE ALL THAT APPLY

Do you wear seat belts?	Yes	No	If no, why not? _____
Do you wear a bike helmet?	Yes	No	N/A
Do you exercise regularly?	Yes	No	How often? _____
Do you smoke?	Yes	No	How many packs per day? _____
Do you drink alcoholic beverages?	Yes	No	How much per week? _____
Do you drink coffee or tea?	Yes	No	How many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	Yes	No	N/A
Do you use drugs (marijuana, cocaine, meth, etc.)?	Yes	No	Explain: _____
Have you ever engaged in any activity which has put you at risk of getting HIV?	Yes	No	Explain: _____
Do you wish to be tested for HIV?	Yes	No	
Have you ever worked with chemicals, paints, asbestos or other hazardous materials?	Yes	No	Explain: _____
Are you in a relationship in which you have been physically hurt by your partner?	Yes	No	
Do you have a "living will"?	Yes	No	
Do you have a donor card?	Yes	No	

Method of birth control _____

Comments: Anything else you would like the provider to know, that is not listed above

_____

_____

_____

_____

_____

_____

_____

Patient Signature _____ **Date:** _____

****IT IS IMPORTANT THAT YOU COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT. If possible you can also fax to 215-855-3786 or email to admin@greenandseidner.com. Please bring the original with you as well.**

Green and Seidner
Family Practice Associates, P.C.

Print Name: _____ Date of Birth: _____

Financial

In the last 12 months did you skip medications to save money?

◯ **Yes** ◯ **No** ◯ **Unable/Decline to Answer**

In the last 12 months, was there a time when you needed to see a doctor but could not because of cost?

◯ **Yes** ◯ **No** ◯ **Unable/Decline to Answer**

Food

In the last 12 months did you ever eat less than you felt you should because there wasn't enough money for food?

◯ **Yes** ◯ **No** ◯ **Unable/Decline to Answer**

Housing

Are you worried that in the next 2 months you may not have stable housing?

◯ **Yes** ◯ **No** ◯ **Unable/Decline to Answer**

Utilities

In the last 12 months has the electric, gas, oil or water company threatened to shut off services in your home?

◯ **Yes** ◯ **No** ◯ **Unable/Decline to Answer**

Transportation

In the last 12 months, have you ever had to go without healthcare because you didn't have a way to get there?

◯ **Yes** ◯ **No** ◯ **Unable/Decline to Answer**

Violence/Safety

Do you feel physically or emotionally unsafe in your home or where you stay?

◯ **Yes** ◯ **No** ◯ **Unable/Decline to Answer**

Social Connection

Do you often feel lonely?

◯ **Yes** ◯ **No** ◯ **Unable/Decline to Answer**

One or more YES responses

Do you want help with any of your needs? ◯ **Yes** ◯ **No**

Are any of your needs urgent? ◯ **Yes** ◯ **No**

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Version Date 5/2023

Green and Seidner
Family Practice Associates, P.C.

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSE OF PROTECTED HEALTH INFORMATION

Please Provide Your Demographic Information (Please Print)

Patient Name: _____ DOB: ____/____/____ SSN: _____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

INFORMATION TO BE RELEASED TO:

Name: _____ Date ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

INFORMATION FROM:

Name: _____ Date ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please stipulate what protected information shall be disclosed:

- ☐ Demographic
- ☐ Pharmacy/Prescription Records
- ☐ History/Physical Summary
- ☐ Emergency Department/Discharge Summary
  - o *Date (s) of Admission/Discharge*

  _____
- ☐ X-Ray/Radiology Records
- ☐ Laboratory/Pathology Records
- ☐ Surgery/Operative Report
- ☐ Other Diagnostic Test/EKG, EEG, Scans ect...

  _____

- ☐ All Records, excluding HIV status, substance abuse, mental illness/counseling
- ☐ All Records, including HIV status, substance abuse, mental illness/counseling
- ☐ All Records, except _____

Information being disclosed from records whose confidentiality is protected by Federal Law{42CFR Part II(Confidential Alcohol and Drug Abuse Patient Information, 42C.F.R. Part II} **and Pa State Statues** {Title 55 P.W. **5100.32 and 5100.34** (a)&(b) **and DACCA, 71 P.S. 1690.108** (b)&(c) (PA Mental Health Procedure Act) (Confidential of HIV-Related Information Act, PA Law Act 148)

AUTHORIZATION AND SIGNATURE

I understand that I do not have to sign this form in order to receive treatment at Green Seidner Family Practice Associates, Even though the consent for release of information is valid for one year. I understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has taken in reliance thereon and that this consent will remain in force in order to effectuate the purposes for which it is given.

I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected healthcare information and there are no claim or orders pending or in affect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Date: ____/____/____

- ☐ Wish for this authorization to expire in 1-year from date of signature
- ☐ Wish for this authorization to expiree before one year: Expiry: ____/____/____

PATIENT SIGNATURE: _____

SIGNATURE OF PARENT/ LEGAL GUARDIAN

AUTHORIZED REPRESENTATIVE: _____ Witness: _____

Describe relationship of signee, if not patient: _____

- ☐ Unable to sign because: _____ Witness: _____

For Office Use Only:

Received: _____ _____ ID Confirmed: _____ _____ Completed: _____ _____

Initial Date Initial Date Initial Date

Green and Seidner
Family Practice Associates, P.C.

Consent to Obtain External Prescription History

I, _____, authorize Green and Seidner Family Practice Associates' providers and staff to view my external prescription history in the PDMP (Prescription Drug Monitoring Program).

I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers will be viewable by Green and Seidner Family Practice Associates' providers and staff, and that this information may include prescriptions I have had filled over the past several years.

_____
Patient Name (PRINT)

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT I AUTHORIZE ACCESS TO MY PRESCRIPTION HISTORY.

_____ _____ _____
Signature of Patient or Guardian Date If Guardian, Relationship to Patient

_____ _____
Witness to Patient/Guardian Signature Date

Green and Seidner
Family Practice Associates, P.C.

Office Policies & Procedures for Our Patients

Office Hours

Monday–Thursday: 8:00 AM – 8:30 PM
Friday: 8:00 AM – 3:30 PM
Saturday: 8:30 AM – 12:30 PM (sick appointments only)

We may be reached at 215-855-1054 during the above hours. Our providers are available 24/7 for urgent medical issues. Call our main number and follow the prompts. Please call during regular office hours for appointments, test results, prescription refills, and non-urgent concerns.

Call Us First!

If you are considering going to an Urgent Care facility, **please call us first** whenever possible.

Emergency Room examples (for life-threatening emergencies):

- Severe chest pain
- Unconsciousness
- Severe shortness of breath
- Major injury or trauma

Non-emergency examples:

- Cough or congestion
- Sore throat
- Rash
- Ear pain
- Diarrhea or vomiting

Revised: 12/2025- RB

Appointments

Scheduling Appointments

Green and Seidner Family Practice is committed to providing timely, high-quality care. To ensure continued care, we encourage patients to schedule follow-up appointments in advance (including during checkout).

When calling for an appointment, please be ready to provide:

- Your name
- Date of birth
- Telephone number
- Reason for your visit
- Updated contact and insurance information

While we schedule responsibly, emergencies can occur in Primary Care. We kindly request your patience should delays or rescheduling become necessary.

To ensure quality care, we cannot treat patients we have not yet seen (e.g., no prescription call-ins or medical advice prior to an initial visit). Follow-up visits may be required to review testing results and develop an appropriate care plan.

We are usually able to accommodate same-day sick appointments, though these may not always be with your primary care provider.

Arriving for Appointments

Please arrive 15 minutes prior to your scheduled appointment. Late arrivals (15 minutes or more) may need to be rescheduled. Bring your photo ID, insurance card, updated medication list, test results, and co-pay.

Thank you for entrusting your medical care to Green & Seidner Family Practice. When you schedule an appointment, we reserve dedicated time to provide you with the highest quality care. Keeping your appointments or notifying us in advance if you cannot attend allows us to serve all our patients effectively.

Cancellations and Rescheduling

If you need to cancel or reschedule an appointment, please contact us as soon as possible, ideally at least 24 hours before your scheduled appointment. This allows us to offer the appointment to another patient who may be waiting.

No-Show or Late Cancellation

- A no-show occurs when you fail to attend a scheduled appointment without providing at least 24 hours' notice.
- A late cancellation occurs when you notify us less than 24 hours before your appointment.
- Fee: A $40 administrative fee may be charged for no-shows or late cancellations to help cover the cost of the missed appointment and the lost opportunity to accommodate other patients.
- Consequences: Multiple no-shows or late cancellations may result in dismissal from the practice at the discretion of your provider.

Late Arrival

- Patients arriving more than 15 minutes past their scheduled appointment time may need to be rescheduled.
- Late arrivals disrupt the schedule and may prevent providers from giving you and other patients the time and attention required for high-quality care.

Exceptions

We understand that emergencies and unforeseen circumstances can occur. Exceptions may be made on a case-by-case basis at the discretion of the practice. Please contact us as soon as possible if such a situation arises.

Fees

- These fees are not reimbursable by insurance.
- You will be billed directly, and payment is expected at or before your next scheduled appointment.

This policy helps us optimize access to care for all patients. We appreciate your understanding and cooperation in helping us provide timely, high-quality care to everyone in our practice.

Office Closings Due to Weather or Other Circumstances

If the office is closed due to weather or other unforeseen circumstances:

- If the office is open and aware of an upcoming closure, we will attempt to contact scheduled patients by phone.
- During inclement weather, please call before leaving home to confirm we are open.
- When possible, closure updates will be posted through Patient Portal and on our Facebook page.

Insurance & Billing Questions

Green and Seidner Family Practice accept most major insurance plans. For specific coverage questions, please contact your insurance company directly.

Claims

Your insurance policy is a contract between you and your insurer. Knowing your benefits is your responsibility.
If your plan requires selecting a primary care provider, you must do this **before your visit** to ensure coverage.

Insurance Cards

All patients must provide up-to-date, valid insurance information at each visit. If insurance is expired or invalid, you will be financially responsible for all charges. Failure to bring your insurance card may delay your appointment.

PLEASE NOTE:

Although your routine visit may be covered by your insurance plan, any additional medical problems discussed and addressed during your appointment may require an additional fee which is determined by your insurance company, such as co-pays and deductibles, and therefore a scheduled Preventative Care Visit, such as your Annual Wellness Visit, may not be covered in full by your insurance.

Payments

- Co-pays are due at the time of service. A $15 fee may be added if not paid that day.
- Deductibles: You are responsible for charges until your deductible is met.
- Non-covered services: Because coverage varies widely, it is your responsibility to know which services your plan covers. Non-covered charges are the patient's financial responsibility.
- Self-pay patients must pay at the time of service unless arrangements have been made with our billing department in advance.
- We accept cash, personal checks, Visa, MasterCard, Discover, Debit, and HSA cards.
- Returned checks incur a $35 fee, payable by cash or credit card.
- Statements are due upon receipt. Accounts in poor standing may be referred to a third-party collection agency.
- Patients currently in collections may be asked to find another provider, at the practice's discretion.
- If you have extenuating circumstances, please contact our billing department.

Laboratory

For established patients, laboratory orders may be created for completion prior to your appointment when appropriate. Completing your labs before your visit allows for a meaningful discussion of results with your provider, enabling you to review findings and plan your care together.

It is your responsibility to:

- Inform the staff which laboratory your insurance requires,
- Notify us of any changes in insurance coverage before labs are completed, and
- Ensure the laboratory is in-network and covered by your insurance.

Laboratory Billing Responsibility

You understand that Green & Seidner Family Practice is not responsible for any charges or outstanding bills from external laboratories. You acknowledge that it is your responsibility to:

- Know which laboratory services your insurance plan covers and any frequency limitations,
- Use laboratories that are acceptable and in-network for your insurance, and
- Complete labs prior to your visit to allow a meaningful discussion of results with your provider.

You understand that the practice may assist with communication or corrections only when supported by accurate documentation. You acknowledge that the practice cannot change, alter, or create information to obtain insurance coverage or payment.

For questions regarding lab billing, you should contact the Clinical Supervisor.

Test Results

Most lab and imaging results are available within 3–5 business days. Some tests (e.g., Lyme, stool studies, cultures, MRIs, CT scans) require more time.

Some results may require an office visit for review.

We only contact patients regarding tests ordered by our practice. For tests ordered elsewhere, please contact the ordering provider.

Forms & Letters

Please allow 7 business days for completion of forms and letters. "Rush" forms (needed sooner than 7 business days) incur an additional $10 fee.

Fees for forms not completed during a visit:

- FMLA: $35
- Disability Forms: $30
- Handicap Placard: $10
- School/Camp/Sports Forms: $20
- Life Insurance Forms: $30
- Wellness Screening: $10
- Adoption/Foster Care: $20
- Driver License/Permit Forms: $10
- Letters (Jury Duty, Return to Work, Accommodations, etc.): $10
- Other Forms: $10 per page

Payment is required prior to completion.

These fees reflect administrative and provider time required.

Prescription Refills & Pharmacy Information

- Notify us of your preferred pharmacy and any changes.
- Contact your pharmacy first for refill requests.
- Please allow three business days for refills.
- Refills may also be requested through MyChart.
- We encourage reviewing medication needs ahead of your appointments.

Referrals / Pre-Certifications

If your insurance requires a referral, you must ensure it is completed before seeing a specialist. Failure to do so may result in out-of-pocket charges.

If requesting a referral for a new concern we have not evaluated, an office visit may be required.

Please notify our office at least 5 business days before your specialist appointment.

Transferring of Care

Patients who choose to leave the practice for reasons other than relocation or an insurance change may not re-enroll in the future.

A strong, trusting patient–provider relationship is essential for effective care. Leaving a practice often indicates a loss of trust and disrupts the therapeutic relationship, which can negatively affect care quality and outcomes.

Before making this decision, if you feel disconnected from your provider or feel misaligned, we strongly encourage you to schedule an appointment with another clinician within GSFP. Sometimes the right fit comes down to personality, and we want you to feel comfortable and supported.

If frustrations arise with scheduling, billing, or office processes, please reach out to our office manager so we may attempt to resolve concerns before you choose to leave.

If you ultimately decide to transfer care, we wish you the best in your future health.

Confidentiality & Medical Records

In accordance with HIPAA regulations, medical records must be requested in writing. A release-of-information form must be completed before records can be provided.

A paper copy of records is available for $30. By law, requests may take up to 30 days, though we make every effort to respond sooner.

Patient Portal: MyChart

We strongly encourage activation and use of MyChart, which allows you to:

- Communicate with our office
- Request, schedule, or cancel appointments
- Update medications
- Request refills
- Request referrals
- Review lab and test results

New patients will receive activation instructions.

Code of Conduct

At GSFP, we are committed to maintaining a safe, respectful environment for both patients and staff.

Our team members will never yell, scream, degrade, demean, use profanity, or threaten violence. Any employee who engages in such behavior will be subject to review and appropriate disciplinary action following a thorough investigation.

The same standards apply to our patients. Aggressive, abusive, or threatening behavior toward staff or other patients will not be tolerated. Any incident will be investigated, and appropriate action—including possible dismissal from the practice—may be taken based on the findings.

Respect is essential to a safe and supportive healthcare environment. We expect every interaction in our practice to be grounded in this value.

We are here to assist you with any questions, concerns, or comments. Our goal is to make your experience with our practice as comfortable and efficient as possible.

Thank you for choosing Green and Seidner Family Practice Associates.

Green and Seidner
Family Practice Associates, P.C.

Patient Acknowledgment & Receipt Form

By signing below, you acknowledge that you have received, reviewed, and understand the Green & Seidner Family Practice Associates Office Policies & Procedures for Patients, including your responsibilities related to appointments, billing, insurance, and laboratory services.

You understand that:

- You are responsible for knowing which laboratory services your insurance covers, any frequency limitations, and which laboratories are in-network.
- Green & Seidner Family Practice is not responsible for charges or outstanding bills from external laboratories.
- Completing labs prior to your visit allows for a meaningful discussion of results with your provider.
- The practice may assist with communication or corrections only when supported by accurate documentation.
- The practice cannot change, alter, or create information to obtain insurance coverage or payment.

Printed Name: _____ DOB: _____

Patient Signature: _____ Date: _____

OR

Patient Representative Signature: _____ Date: _____

Printed Name & Relationship: _____

Green and Seidner
Family Practice Associates, P.C.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

This acknowledgment confirms that Green and Seidner Family Practice Associates, P.C. may use and disclose my protected health information (PHI) for purposes of treatment, payment, health care operations, participation in Health Information Exchanges (HIEs), appointment reminders, and other uses permitted or required by law, as described in the Notice of Privacy Practices.

I understand that:

- I have received (or have been offered) a copy of the Notice of Privacy Practices, which explains how my PHI may be used and disclosed.
- I have the right to request restrictions on the use or disclosure of my PHI. Any request must be made in writing. The practice is not required to agree to all requests, but any accepted restriction will be binding.
- I may request confidential communications or opt out of certain communications, including automated appointment reminders, to the extent permitted by law.
- I may opt out of participation in any Health Information Exchange (HIE) by completing the required Request for Restriction of Protected Health Information form.
- I may revoke any prior authorization in writing. Revocation will not affect any use or disclosure that occurred before the practice received my written revocation.
- The practice may revise its privacy practices and will make the most current Notice available upon request.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for Green and Seidner Family Practice Associates, P.C.

(Please print clearly)

_____ _____

Name of Patient (Print) **Date of Birth**

_____ _____

Signature of Patient **Date**

If signed by a Patient Representative: *(Required if the patient is a minor or an adult unable to sign this form)*

Signature of Patient Representative

_____

Name of Patient Representative (Print)

_____

Relationship to Patient

NOTICE OF PRIVACY PRACTICES

Green and Seidner Family Practice Associates, P.C.

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

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment: We may use and disclose your health information to provide, coordinate, or manage your medical care with other healthcare providers involved in your treatment.

Payment: We may use and disclose your health information to obtain payment from your insurance plan or other responsible parties, including information related to your diagnosis, treatment, and dates of service.

Health Care Operations: We may use your information for activities that support the operation of our practice, including quality improvement, training, auditing, and compliance activities.

Law Enforcement and Government Requirements: We may disclose your information to government authorities or law enforcement when required by law.

Public Health and Research: We may disclose information to public health agencies as required. De-identified information may be used for research or public health purposes.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

Any use or disclosure of your information not described in this Notice requires your written authorization. You may revoke your authorization in writing at any time.

ADDITIONAL USES OF INFORMATION

Appointment Reminders: We, and any entities with whom we share your PHI for this purpose, may send appointment reminders by automated phone, text, or email unless you decline.

Information About Services and Treatment Options: We may provide information about treatment options or health-related services that may benefit you.

HEALTH INFORMATION EXCHANGES (HIEs)

We participate in Health Information Exchanges (HIEs), which allow secure electronic sharing of your health information with other participating healthcare providers for treatment, payment, healthcare operations, and other authorized purposes, as allowed by law.

Your Right to Opt Out: You may opt out of participation in any HIE we use. To opt out, you must complete a Request for Restriction of Protected Health Information form, available from our office.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- Right to request restrictions
- Right to request confidential communications
- Right to inspect and obtain copies of your records
- Right to request amendments
- Right to an accounting of disclosures
- Right to choose someone to act for you
- Right to receive a paper copy of this Notice
- Right to file a complaint without retaliation

OUR RESPONSIBILITIES: We are required by law to maintain the privacy of your health information, provide you with this Notice, follow the terms of this Notice, and notify you if a breach occurs involving your information.

We reserve the right to revise this Notice at any time, as permitted by law. Updated Notices will be posted in our office and provided upon request

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REQUESTS, QUESTIONS, AND COMPLAINTS

Access to Records: Requests to inspect or copy records must be submitted in writing. Forms are available from our Reception Desk or Medical Records Department.

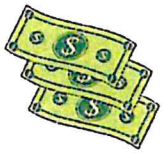
Complaints: If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer, care of this medical practice at our current address. You will not be penalized or retaliated against for filing a complaint.

Green and Seidner
Family Practice Associates, P.C.

Call Us First 24/7

215-855-1054

Doctor's Office or Emergency Room.... Which should I choose?

	**Your Providers** Green & Seidner	**Urgent Care or Emergency Room.**
Wait time: 	**Shorter!**	Can be significantly **higher.**
Out of pocket cost: 	**Lower!**	**Higher** copay-especially on a High deductible plan.
Comfort/Familiar: 	We know **you** better and have access to **your** medical records.	**Limited** access to your medical records. Provider that you will see, will not know you, or your history.

Get the right care at the right place and time.

CALL US FIRST. If you are unsure how to get a non-urgent medical issue evaluated. Our providers are available by phone 24/7 helping to avoid unnecessary visits to urgent care or the emergency room.

CALL: 215-855-1054
After hours our answering service will assist you in reaching a provider.

If you are experiencing a true medical emergency, Please CALL 911, or seek Emergency Care.

Remember we are available by phone 24/7 to help you decide! This call is free, and may help save you time & money!