Dr Patricia Hogan
Family Practice

MEDICAL HISTORY

Last name: _____ **First name:** _____ **Date of birth:** _____

Preferred Pharmacy: _____

Family History: If any blood relative has suffered any of the following please indicate whom it is or was. ( ) Adopted

( ) Alcoholism	( ) Asthma	( ) Arthritis	( ) Allergy
( ) Cancer	( ) Diabetes	( ) Gout	( ) Tuberculosis
( ) Glaucoma	( ) Migraine	( ) Hypertension	( ) Epilepsy
( ) Kidney Disease	( ) Suicide	( ) Heart Disease	( ) Thyroid Problem
( ) Stroke	( ) Mental Illness	( ) Seizures	

Hospitalizations: Please list the year and why you were hospitalized; include major surgeries and child birth.

Year	Reason

Medical Illnesses: Please list any chronic medical illness and length that you had them

Illness	Length

Medications: List all current medications with dosage, include **over the counter** medications

Medication	Dosage

Allergies: List all allergies and note reactions

Immunization: Check off the immunizations you have received

( ) Flu Shot	( ) Pneumonia
( ) Tetanus	( ) Other _____

Social History

( ) coffee/tea/soda _____ cups per day	( ) Alcohol _____ amount per day / week
Tobacco Use: _ Former _ Never _ Current: Amt:____	( ) Sexually Active? _____ # of Partners _____
Are you in danger of physical harm? _____	Do you have a living will? _____

MEDICAL HISTORY CONTINUED

Health Maintenance: Please give the date and location of each

Eye Exam: _____	Sigmoidoscopy: _____
Colonoscopy: _____	Complete Physical: _____
Pap Smear: _____	Lab Work: _____
DEXA: _____	Mammogram: _____

Childhood Illnesses: Check all illnesses you have had and give the age you were when they occurred.

( ) Chicken Pox Age: _____	( ) German Measles Age: _____
( ) Measles Age: _____	( ) Mumps Age: _____
( ) Scarlet Fever Age: _____	( ) Other _____ Age: _____

Symptoms Experienced in the Last Year

Skin	**Men**	**Neuromus**	**Kidney**
( ) Rash / Hives ( ) Changing Moles ( ) Skin Cancer ( ) Other Skin Problems	( ) Lump in Testicles ( ) Penis Discharge ( ) STD ( ) Sexual Concern	( ) Leg or Arm Weakness ( ) Balance Problems/Dizziness ( ) Fainting Problems ( ) Convulsions/Seizures ( ) Memory Loss	( ) Night Urination ( ) Blood in Urine ( ) Burning/Pain Urination ( ) Problems Urinating ( ) Kidney Stones
Psychological	**General**	**Bones / Joints**	**Women**
Is your life satisfactory? _____ ( ) Anxiety ( ) Depression ( ) Bipolar Illness ( ) Have you seriously considered suicide? ____	( ) Fever ( ) Weight Change ( ) Bleeding/ Bruise ( ) Swollen Glands ( ) General Weakness ( ) Aches / Pains ( )Blood transfusions	( ) Joint Pain ( ) Joint Swelling ( ) Muscle Strength Loss ( ) Gout ( ) Pains in Back ( ) Phlebitis ( ) Leg Cramps	( ) Breast Lump ( ) Nipple Discharge ( ) Vaginal Discharge ( ) Hot Flashes ( ) Change in Periods ( ) STD ( ) Abnormal Pap Smear ( ) Bloating / Irritability ( ) Sexual Concern
Head and Neck	**Chest / Heart / Lungs**	**Gastrointestinal**	**Other**
( ) Vision Changes ( ) Ear Pains ( ) Buzzing/Ringing Ears ( ) Sinus Problems ( ) Swallowing Problems ( ) Decrease Hearing ( ) Mouth Problems ( ) Persistent Hoarseness ( ) Severe Headaches	( ) Irregular Heartbeat ( ) Shortness of Breath ( ) Low Exercise Tolerance ( ) Chest Pain ( ) Frequent Coughs ( ) Coughing up Blood ( ) Wheezing ( ) Swollen Ankle ( ) Exposure to TB ( ) High Blood Pressure	( ) Indigestion/Heartburn ( ) Nausea ( ) Vomiting Blood ( ) Abdominal Pain ( ) Diarrhea/Constipation ( ) Bowel Habit Changes ( ) Rectum Blood Passage ( ) Black Tar-like Bowel Movements ( ) Hernia ( ) Hepatitis	_____ _____ _____ _____ _____

Dr Patricia Hogan
Family Practice

Patricia A. Hogan, M.D. *Family and Preventive Medicine*
Melissa Cabe, APRN-C, Sarah Alton, APRN-C, Shaelynn Flowers, APRN-C
2850 Capital Medical Blvd., Tallahassee, FL 32308
P: 850.309.1972 F: 850.309.1912 find us on the web: www.Hogan.Care

Patient Information

Full Name:	Date of Birth:
Social Security Number:	Ethnicity:
Phone Number (h): (c):	Marital Status:
Sex: Male Female	Primary Language:
Address:_____	Occupation: _____
_____	Employer Name & Address: _____
_____	_____

Spouse/Guardian Information

Full Name:	Date of Birth:
Social Security Number:	Ethnicity:
Phone Number: (h): (c):	Primary Language:
Sex: Male Female	
Address:_____	
_____	
_____	

Dependents

Name	Date of Birth	Sex

Emergency Contact

Full Name:	Relation:
Phone Number (h): (c): (w):	Address:

nsurance Information

Policy Holder:	Date of Birth:
Social Security Number:	Relation to Patient:
Insurance:	Insurance Phone Number:
Policy number:	Group Number:
Insurance Claim Address:_____	*Group Insurance, give name & address of employer:
_____	_____
_____	_____

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Authorization

I Authorize Patricia Hogan, MD., LLC to release medical information regarding myself and my family, necessary to process insurance claims.
Name:_____ Signature:_____ Patient or Legal Guardian Patient or Legal Guardian

Insurance Certification and Assignment / Authorization of Treatment

I hereby certify that the information given by me in applying for payments under Title XVIII and XIX of the Social Security Act or by any thirds party payers is correct. I assign payment to Patricia Hogan, MD., LLC of all benefits due me under the terms of said policies and programs. I assign payment to the Physician (s) rendering medical service, the in-hospital based Specialists, and the Physician (s) for whom the hospital is authorized to bill in connection with it's services. I understand that I am required to pay for any health insurance deductible, co-insurance or any other charges incurred which are not paid by my insurer or other third party payers together with all costs of collection, if necessary, including a reasonable attorney's fee if collected by or through an attorney at law.
The undersigned certifies that she/he has read the foregoing and is the patient or the parent/guardian of the patient or is duly authorized as patient's agent to execute the above and accept it's terms, including the provision of treatment authorization.
Patient Name: _____ Patient Signature: _____ Date: _____ Reason if unable to sign: _____ Minor (under 18 years) _____ Physical or Mental Condition
Parent/Guardian Name: _____ Parent/Guardian Signature: _____ Date:_____

Office Policies and Procedures

I have received a copy of the Office Policies and Procedures for Patricia Hogan, MD., LLC and understand that I must abide by the policies and procedures.
Patient Name: _____ Patient Signature: _____ Date: _____ Reason if unable to sign: _____ Minor (under 18 years) _____ Physical or Mental Condition
Parent/Guardian Name: _____ Parent/Guardian Signature: _____ Date:_____

A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL

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Patient's Communication Instructions, Patient's Release and Acknowledgment

Patient Name (PRINT): _____
Date of Birth: _____
Patient Address: _____

TELL US WHAT YOU WOULD LIKE TO AUTHORIZE OR LIMIT WITH THIS FORM (check all that apply):

____I would like to UPDATE or CHANGE my telephone and/or email contact information

____I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communication and disclosures concerning my healthcare

____I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communication and disclosures concerning my healthcare

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Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply)

____Home phone number - leave message to return call – no particulars NUMBER: _____

____Home phone number - leave message with particulars NUMBER: _____

____Work phone number - leave message to return call – no particulars NUMBER: _____

____Work phone number - leave message with particulars NUMBER: _____

____Cell number - leave message to return call – no particulars NUMBER: _____

____Cell number - leave message with particulars NUMBER: _____

____Email_____ (Please do not assume that email will be used by your physician for communication. Please talk to your physician about the use of email as a means of communication.)

____Other (EXPLAIN AND PROVIDE DETAILS)_____

____Other (EXPLAIN AND PROVIDE DETAILS)_____

Continued on next page

Who are you authorizing our office to discuss your health situation with? (Please list all names)

____Discuss with no one

____Spouse: circle AUTHORIZED or UNAUTHORIZED (Name: _____)

____Child: circle AUTHORIZED or UNAUTHORIZED (Name: _____)

____Sibling: circle AUTHORIZED or UNAUTHORIZED (Name: _____)

____Other: circle AUTHORIZED or UNAUTHORIZED (Name: _____)

____Other: circle AUTHORIZED or UNAUTHORIZED (Name_____)

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name_____Relationship_____Phone: _____

This authorization will expire on: _____(If no date is specified, it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

By signing below, I acknowledge that I have received and reviewed a copy of Patricia Hogan, MD., LLC's Notice of Privacy Policies.

_____ _____

Signature of Patient or Legal Guardian Date

If not the patient, explain relationship and legal authority:

_____

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Patricia Hogan, MD., LLC is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Patricia Hogan, MD., LLC is limited in its ability to release such information, known as Protected Health Information, without my authorization.
I understand I have the right to review the Notice of Privacy Practices of Patricia Hogan, MD., LLC prior to signing this document, and I acknowledge that the Patricia Hogan, MD., LLC Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Patricia Hogan, MD., LLC is also available on the website for Patricia Hogan, MD., LLC at www.Hogan.Care.
I hereby consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of Patricia Hogan, MD., LLC, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.
I also understand that Patricia Hogan, MD., LLC participates with and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including as an example www.Centralis.com, is included on page 2 of this document. The information exchanged in these activities may include my protected heath information. I hereby authorize such transmissions. I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of HIE activities directly to our Privacy Officer through email at or by mailing a written request to Privacy Officer at 2850 Capital Medical Blvd, Tallahassee, FL 32308.
Patricia Hogan, MD., LLC reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at www.hogan.care.
I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to Patricia Hogan, MD., LLC of all benefits due me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles, coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency and reasonable attorney's fee if collected by or through an attorney-at-law.

A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

The undersigned certifies that he/she has read the foregoing and is the patient or the parent or guardian of the patient and is duly authorized as patient's agent to execute the above and accept its terms, including the provision of treatment authorization.

Patient name:
Print: _____
Sign: _____
Date: _____ Patient Date of Birth: _____

Parent or legal guardian name:
Print: _____
Sign: _____
Date: _____
Explain Your Relationship to Patient: _____
Description of Personal Representative's Authority: _____

Dr Patricia Hogan
Family Practice

IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE

Recent important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange ("HIE").

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Patricia Hogan, MD., LLC participates in and provides patient information to HIE's in certain circumstances in order to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of a local resource of HIE in Tallahassee through BBRHIO.

BBRHIO is a Florida nonprofit, public benefit corporation organized and federally recognized 501(c)(3) of the Internal Revenue Code. Unless you specifically opt out as provided below your personal health information will be provided to BBRHIO. Tallahassee Primary Care Associates and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

A Regional Healthcare Information Organization ("RHIO") is a group of organizations and stakeholders that exchanges data electronically to improve the quality, safety, and efficiency of healthcare delivery. RHIOs are ordinarily geographically def ined entities that arrange for the means to exchange information electronically. They also develop and maintain HIE standards. To successfully exchange information, RHIOs must build their data exchange on sound principles and processes.

BBRHIO is locally owned and managed, and consists of numerous well-established and respected local health care organizations and stakeholders. The Board of the BBRHIO is comprised of local health care providers, and is solely under the control of the local Board. www.BigBendHealth.com, which is the website of the BBRHIO, is a first-of-its-kind health resource that creates economic benefits, a connected workforce, improved medical care and a breakthrough in records management. The purpose of www.BigBendHealth.com is to be the essential communication resource and HIE for health care in the Capital region. Additionally, www.BigBendHealth.com is the largest active Health Information Exchange ("HIE") in Florida, containing millions of patient records processing numerous health care messages between providers in the community.

STATEMENT OF PURPOSE: BBRHIO seeks to reduce the cost and improve the quality and efficiency of health care provided by the Participants through the electronic management and exchange of health information acquired or generated by them in providing, paying for, and reporting on patient care items and services. The Participants anticipate that the electronic management and exchange of such information will simultaneously help eliminate unnecessary repeat testing, increase the accuracy of medical diagnoses, improve medical treatment, and improve outcomes for patients. BBRHIO and Patricia Hogan, MD., LLC contract through Business Associate agreements with vendors who operate a Regional Health Information Network ("RHIN") to facilitate the electronic transmission, storage, and sharing of health information among participating providers of health care services, third-party payers for health care services, and other interested parties in their respective regions in a manner that complies with all applicable laws and regulations, including without limitation those protecting the privacy and security of health information. The intent for each of the organizations who participate in HIE with RHIN's and other HIE mechanisms, like Patricia Hogan, MD., LLC, is to share information to improve efficiency, enhance communication, secure data, facilitate claims and provide valuable medical treatment information broadly to assist in your health care. These efforts, which are encouraged through specific efforts of the government entities, are intended to provide a collaborative framework through which the parties can securely share information more efficiently and effectively for your benefit.

Dr Patricia Hogan
Family Practice

RELEASE OF PROTECTED HEALTH INFORMATION AND MEDICAL RECORDS

Patient's Name _____
(Last, First, Middle/Maiden)

Patient's Address: _____City _____State _____Zip_____

Date of Birth _____ Phone Numbers_____

I authorize my physician and/or administrative and clinical staff at Patricia Hogan, MD., LLC or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Receive Information:	**Person or Entity to Disclose Information:**
Name/Organization: Dr. Patricia Hogan	Name/Organization: _____
Address: 2850 Capital Medical Blvd.	Address: _____
City, State, Zip: Tallahassee, FL 32308	City, State, Zip: _____
Phone: (850) 309-1972 Fax: (850) 309-1912	Phone: _____ Fax: _____

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):

__ Complete Medical Record __ Billing Records __ Office Notes __ Ultrasound Reports
__ Lab Reports __ Surgery Records __ Mammogram Reports
__ Obstetrical (OB) Records __ Pap Smear / Biopsy Reports __ Other (specify): _____

DATES OF SERVICE: _____

PURPOSE: ___ Changing Physicians, ___ Personal Copy to Patient, ___ Attorney, ___ Insurance, ___ Workers' Comp.
Other _____

This authorization will expire on: _____(If no date is specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:

___I DO ___ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions**, and all medical records and clinical information relating thereto.
Initials of individual giving authorization:_____

___I DO ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions.**
Initials of individual giving authorization: _____

___I DO ___I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment.
*Initials of individual giving authorization.*_____

I have read and understand the nature of this authorization and I have been provided a copy of Patricia Hogan, MD., LLC s Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer 2850 Capital Medical Blvd, ***Tallahassee, Florida 32308, Attn: Compliance Officer.*** I understand that a revocation is not effective to the extent that my physician or Patricia Hogan, MD., LLC has taken action in reliance upon this authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that such revocation does not affect Patricia Hogan, MD., LLC's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

_____ _____
Signature of Patient or Patient's Representative Witness

_____ _____
Relationship to Patient Date

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OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

Effective March 2025

We realize that you have a choice in medical providers and we are pleased that you have chosen to seek care with us. The staff at Patricia Hogan, MD., LLC strives to exceed expectations in care and service in order to make your experience with us as comfortable and productive as possible. Please contact our office if you have any questions concerning our policies. We offer access to your medical records through *Athena* ask our staff for an invitation. Thank you for choosing our office for all your health care needs!

Office Hours

Our office staff is available Monday, thru Friday 8:00am to 5:00pm*, and may be reached by phone from 8:00am to 12noon and 1:00pm to 5:00pm at 850.309.1972. Please listen to all the options before making a selection. Dr. Hogan can be reached on call for *urgent matters at 850.309.1972*. In the event of an emergency, please call 911. If you need to make an appointment, please call during regular business phone hours. To help us better assist you please provide your name, date of birth, phone number and all information pertaining to your concerns.

**Office hours listed are with the exception of holidays and/or office closures.*

Appointments

We are committed to providing the best quality care to our patients. New patient appointments require new patient paperwork to be completed and returned to the office along with your insurance card and driver's license. We encourage you to schedule appointments well in advance of follow-up due dates to ensure an appointment time convenient for you. When calling for an appointment please provide your name, date of birth, chief complaint and any information/insurance updates. Please keep in mind that there is more than one provider seeing patients and emergencies do occur. If an emergency should occur you will be informed and given the option to wait, see another provider or reschedule.

Cancellations, Reschedules and No-Shows

Cancellations/reschedules need to be made at least 24 hours before your scheduled appointments. Please let us know if you are unable to make your appointment and we will be happy to reschedule it for you at your convenience. Messages left with the on-call doctor for appointment cancellations will not be honored.

If appointments are not cancelled or rescheduled more than 24 hours in advance or if you do not show up for a scheduled appointment a fee of $50.00 will be applied to your account.

Please be advised that less than 24 hour cancellation or no-show charges are patient responsibility and will not be billed to your insurance company. If you NO-SHOW your New Patient appointment our office reserves the right to dismiss you from the practice entirely so it is imperative that you attend that appointment.

Insurance

As a courtesy to our patients, we are happy to file insurance claims on your behalf. We are in Network with CHP, Aetna, BCBS Commercial. We are waiting on contract determinations with other major insurance companies. This information can be found on the website www.Hogan.Care.

If you do not see your insurance listed; or do not have insurance, please contact our office to discuss alternative options, discounts, and/or payment plans.

It is the patient's responsibility to inform our office of any changes in insurance coverage and to be aware of any changes made to their insurance policy. Failure to do so could cause delay or denial of insurance payment.

Payments

Patients are responsible for co-pays at time of service. If applicable, you will be billed for any deductible or co-insurance amounts, and/or fees for services not covered by your insurance (as stated in your insurance coverage). Our office accepts cash, Visa, Discover, American Express, MasterCard and personal checks. Checks can be made out to Patricia Hogan MD.

It is Patricia Hogan, MD., LLC's policy to make all reasonable attempts to collect outstanding patient balances should they accrue. We are able to offer prepayment plans so our patients are able to anticipate their healthcare needs for items such as large deductibles or uninsured services. We also offer the option for online payment including patients signing themselves up for payment plans meeting certain criteria. If you need a payment plan and are unable to meet the terms offered online, please contact our office to see if another option may be available.

No attempts from patients to address their balances for accounts in poor standing, may be outsourced to a third party for the purposes of collection at which time the patient could be discharged.

Forms/Letters

Except for few circumstances, ALL forms will need to be completed at office visits. Forms not completed at office visit are subject to minimum $20.00 charge.

Medical Records

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. Your medical records are also viewable on the Athena patient portal. Legally, medical offices have up to 30 days to complete requests for records. Our staff puts forth the effort to respond to these requests weekly. There may be a fee for medical records depending on circumstances/quantity of records requested.

Prescription Refills

We strongly recommend using only one pharmacy for all of your prescription needs. Please be sure pharmacists are aware of any possible drug allergies you may have.

If you need a prescription refill, please call your pharmacy and have them send an electronic refill request to our office. You may also request refills on the patient portal.

Please note that narcotic/controlled medications cannot be refilled over the phone. Chronic medication orders require an office visit every one to three months depending on type of medication; and an electronic prescription will be sent by Dr. Hogan. Acute pain medications require evaluation/reevaluation within 3 days. Early refills **WILL NOT** be authorized.

Changes and/or new prescriptions can only be completed by a provider. Please do not ask the staff to alter your medication(s) or dosing instructions.

Dr. Hogan's Things to Know About Our Office

CHECK-IN & CHECK-OUT

- Check-in with our front desk staff as soon as you arrive. Update information using the Patient Registration Sheet or Mobile Patient Check in. Make sure we have the correct address, phone number, pharmacy and insurance information. Please provide an e-mail if you wish to access our Athena portal.
- At the end of your appointment, make sure to check-out at the desk and schedule any follow-up appointments that may be needed.

LABS

- Make sure you complete your lab work within 2 weeks of your appointment as this could cause a delay in your prescriptions.
- Certain insurances have specific labs they will need to use. CHP requires LabCorp. BCBS requires Quest. Most other insurances can use either, inform us of your preferred location.

REFERRALS

- If we refer you to another office, you can expect a call from that office in 7 to 10 business days. *If you don't hear from that office within this time frame, please contact their office to schedule. We can provide you with their contact information.

RESULTS

- Results from lab work & diagnostic tests can take 3 to 14 business days. Results from cultures can take up to 14 business days. Results from Pap Smears & other pathologies can take up to 30 days.

PRESCRIPTIONS, REQUESTS & REFILLS

- Refill requests will be completed within 1 week if not requested at appointment
- Please call your pharmacy to check if you have refills left on your current prescription. Please allow 2 hours from the time you check out for your prescription to be sent to the pharmacy. Please call your pharmacy to check if your prescription has been filled and is ready.
- Prescriptions are electronically sent to the pharmacy we have on file for you. Each new prescription is assigned a new prescription number; therefore, if you call in an old prescription number from an old bottle, your pharmacy will call us for a new prescription, even if you have one on file at your pharmacy.
- Controlled Substance prescriptions are required to be sent electronically by Dr. Hogan ONLY. *Please do not call and/or leave multiple messages about these prescriptions as this will delay your prescription being sent in a timely manner.*
- To avoid interruptions in your medications, we recommend that you schedule your follow-up appointments when leaving our office. Make sure that you have addressed your prescription refills during appointment.

RE-OCCURING APPOINTMENTS

- Diabetics: require an office visit every 3-6 months with completed lab work.
- High cholesterol: requires an office visit every 6 months with lab work.
- Controlled Substance recipients: require an office visit every, 1 to 6 months depending on type of medication; labs may be requested.
- High blood pressure: requires an office visit every 6 months if controlled; sooner if uncontrolled & completed lab work prior to appointment.
- Chronic Issues: require an office visit every 3 months if uncontrolled and/or every 6 months if controlled.
- Depression: requires a follow-up office visit 1 month after new prescription, then 3 months, then every 6 months.
- Follow up from hospitalizations or Urgent care: within 7-10 days of discharge.

FYI

- We cannot refer you to another facility, call in antibiotic prescriptions or order diagnostic tests unless we have seen you for the problem.
- Physicals with labs work; once per year. If additional concerns are brought up at the visit, insurance will charge a copay.
- Pap Smears: every 3 to 5 years if normal. Repeat as instructed if a history of abnormal results.
- Mammograms: Annually for women 40 and over / Annually for women over 35 with strong family history.
- ***There is a $50 fee for no shows and cancellations less than 24 hours prior to scheduled appointments.*** We understand that occasionally an emergency may occur, in those cases we will not charge subject to the approval of the provider. It is important this is communicated in a timely fashion. Do not wait for your next appointment to address this sort of matter.