DIRECTIONS TO OUR MORGANTOWN ALLERGY CLINIC

165 SCOTT AVENUE, SUITE 102
MORGANTOWN, WV 26508
304-554-0440

INTERSTATE- 79 NORTH OR SOUTH: MERGE ONTO INTERSTATE -68(EXIT 148) TOWARDS CUMBERLAND. TAKE EXIT 1 OFF OF I-68, THE US-119 EXIT. TURN LEFT ONTO US-119 NORTH (YOU WILL TRAVEL ABOUT 3/10th OF A MILE TO SCOTT AVE.)TURN LEFT ONTO SCOTT AVE. CR-119-33.TRAVEL PAST THE ENTRANCE TO THE RAMADA INN. WE ARE LOCATED ON YOUR *LEFT* NEXT TO KOVAL AND ACROSS FROM CINTAS.

INTERSTATE- 68 WESTBOUND (MARYLAND): TAKE EXIT 1, THE US-119 EXIT. TURN LEFTONTO US-119-NORTH (YOU WILL TRAVEL ABOUT 1/10TH OF A MILE TO SCOTT AVE.) TURN LEFT ONTO SCOTT AVE. CR-119/33. TRAVEL PAST THE ENTRANCE TO THE RAMADA INN. WE ARE LOCATED ON YOU *LEFT* NEXT TO KOVAL AND ACROSS FROM CINTAS.

US ROUTE 50: EASTBOUND (PARKERSBURG/OHIO) OR WESTBOUND BRIDGEPORT TAKE ROUTE 50 TO INTERSTATE 79 NORTH AND FOLLOW DIRECTIONS FROM I-79 ABOVE.

US ROUTE 119: NORTHBOUND (GRAFTON) OR SOUTHBOUND (MORGANTOWN). SCOTT AVENUE IS LOCATED JUST NORTH OF I- 68 INTERCHANGE.

ROUTE 857: CHEAT LAKE/PENNSYLVANIA. FOLLOW DIRECTIONS FROM I-68 WESTBOUND ABOVE.

DIRECTIONS TO OUR WAYNESBURG CLINIC

Dr. Paul Ogershok
1150 7th Street
Waynesburg, Pa 15370
(724)627-2395

From either North or South I-79: Take Exit 14 and make a **right** at the end of the exit ramp onto W-21. Go approximately 1 mile to the 5th stop light and make a **right** following W-21 N-19. At the second light turn **right** onto Bonar Avenue. Go up the hill and make a **right** onto 7th Street. We are located in the Medical Arts Building. Our office is on the top floor on the left.

Remember to follow the blue hospital signs as we are located across from The Southwest Regional Medical Center.

Please do not mail paperwork

Avoid these following medications for 5 – 7 Days prior to allergy testing UNLESS YOU ARE EXPERIENCING HIVES OR A RASH:

1. **Zyrtec (cetirizine hcl)**
2. **Allegra (fexofenadine)**
3. **Claritin (loratadine)**
4. **Alavert (loratadine)**
5. **Clarinex (desloratadine)**
6. **Astelin**
7. **Astepro**
8. **Patanase**
9. **Benadryl (diphenhydramine)**
10. **Cold and Cough medications**
11. **Sinus medications**
12. **Hydroxyzine (atarax)(vistaril)**
13. **OTC night time sleep aids**
14. **Ambien**
15. **Lunesta**
16. **Tylenol PM**
17. **Advil PM**
18. **Xyzal (levocetirizine dihydrochloride)**
19. **Dramamine (dimenhydrinate)**
20. **Meclazine (anivert)**
21. **Anything containing antihistamines, diphenhydramine, brompheniramine, chlorpheniramine, dimenhydranate or doxylamine.**

You may take:

Saline nose sprays/washes, plain Ibuprofen or Tylenol, Singulair

MOUNTAIN STATE MEDICAL SPECIALTIES, INC.

***Patient Name** _____
Last First Middle

***Mailing Address**_____
Street City State Zip

*** Date of Birth** _____ /_____ /_____ **SS #** _____ *** Gender** M F **Marital Status :** SG M W D SP

*** Home phone ( )**_____ **Cell # ( )** _____

*** Race** ☐ *Asian* ☐ *White* ☐ *More than one race* ☐ *Black or African American* ☐ *Other* _____ *** Ethnicity** ☐ *Hispanic or Latino* ☐ *Not Hispanic or Latino* *** Preferred Language** _____

E– Mail Address :_____ *** Best form of contact** : Phone E-Mail

Employer _____ **Phone ( )**_____

Spouse's Name _____ **Best # to contact them: ( )**_____

Nearest friend/relative not living with you :_____**Best # to contact them: ( )**_____

Reason for Appointment (Optional)_____ **Referring Physician** _____

Guarantor Name _____ **Relation to Patient**_____
Last First Middle

Address: _____
Street City State Zip

Home Phone ( )_____ **SS#**_____ **Date of Birth** _____/_____/_____ **Sex :** M F

Cell Phone # ( ) _____ **E-Mail Address** _____

Employer _____ **Phone #** ( ) _____ **Marital Status:** SG M W D SP

Insured's Name : _____**Relation to Patient** _____
Last First Middle

Address :_____
Street City State Zip

Home Phone ( ) _____ **SS#** _____ **Date of Birth**_____/_____/_____ **Sex :** M F

Cell Phone # ( ) _____ **E-Mail Address** _____

Employer _____**Phone # ( )**_____ **Marital Status:** SG M W D SP

Primary Ins Name _____ Secondary Ins _____

PLEASE NOTE: PAYMENT FOR SERVICES IS REQUIRED AT THE TIME OF SERVICE, AT WHICH YOUR PRIMARY INSURANCE WILL BE BILLED. INSURANCE CO-PAYMENTS AND DEDUCTIBLES MUST BE PAID WHEN SERVICES ARE RENDERED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR FINANCIAL RESPONSIBILITY, PLEASE ASK A MEMBER OF OUR STAFF. THANK YOU FOR ALLOWING MOUNTAIN STATE MEDICAL SPECIALTIES TO CARE FOR YOU. **ALL INFORMATION IS CONFIDENTIAL. THE FOLLOWING NOTICE IS REQUIRED AND IMPERATIVE FOR YOUR RECORDS. THIS IS A LIFETIME AUTHORIZATION UNLESS REVOKED IN WRITING.**

☆ I authorize Mountain State Medical Specialties, Inc. and its physicians and providers to diagnose and provide medical care for the above named patient. I am aware that this consent includes all procedures including treatment and surgery. I am aware that if I have a surgical procedure my specimen will be sent for histopathology and I consent to the release of my information for this purpose.

*Patient /Guarantor Signature_____Date:_____

☆ I authorize payment of medical benefits to the above mentioned provider(s) for all services rendered. Please accept a photocopy of my signature as the original on file. I am aware that any changes by my insurance are my responsibility. I authorize the release of my medical information for the processing of my claims. I understand that if I have a surgical procedure I will have additional charges for the pathology. I am aware that if I have an HMO/MC plan that I am responsible for obtaining any authorization for my visits. If I do not follow the guidelines set by my insurance company I will be fully responsible for any and all charges. I understand that I am responsible for any remaining balance. I understand that payment is due in full within 90 days of the date of my first statement (REGARDLESS OF INSURANCE) unless other financial arrangements have been made. As a courtesy, your first statement will be mailed to you free of charge, any additional statements will incur a $1.50 statement processing fee. Workers Compensation is not accepted.

*Patient /Guarantor Signature_____Date: _____

Patient	Last Name	First Name	M.I.	D.O.B.	Medical Record #

MOUNTAIN STATE MEDICAL SPECIALTIES, INC.

MAIN OFFICE LOCATION: 120 MEDICAL PARK DRIVE, SUITE 200 • BRIDGEPORT, WV 26330

PHONE: (304) 624-7200 • FAX: (304) 624-0026

Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health, the health care you receive or payment for that care is considered confidential and protected by our practice. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

Sign below or acknowledge that you have received a copy of our Notice of Privacy Practice.

_____

Date

_____

Signature of patient or patient's representative

_____

Printed name of patient or patient's representative

_____

Relationship to the patient

There are times we may need to contact you about your medical care but cannot reach you personally. Please indicate below if we may leave a message for you.

Please mark yes or no to all questions listed below.

If we are unable to contact you, may we leave a message:

☐ YES ☐ NO Home answering machine/voicemail?
☐ YES ☐ NO Work answering machine/voicemail?
☐ YES ☐ NO Cell Phone?

☐ YES ☐ NO May we leave a message with your spouse?
☐ YES ☐ NO May we leave a message with your family members?
☐ YES ☐ NO Is there a person you would like to list with whom we may leave a message concerning your medical information or appointments?

_____ _____
Name/Relationship to you Phone #

_____ _____
Name/Relationship to you Phone #

_____ _____
Name/Relationship to you Phone #

☐ YES ☐ NO Do you understand you may make changes to these directives at any time by providing written instruction to this office?

Please return this acknowledgment as soon as possible If you received this form when you arrived at our practice for service, return this form in person before you leave. If you do not return the form in person you may return this form by mail to our privacy officer at the following address:

Mountain State Medical Specialties Inc.

120 Medical Park Drive, Suite 200, Bridgeport, West Virginia 26330

For use ONLY by a representative of the Practice

A good faith effort was made to obtain a written acknowledgment of receipt of our Notice of Privacy Practices that was provided to (circle one) the patient/the patient's representative on ____/____/____

The acknowledgment was not obtained for the following reason(s) _____

_____

Additional information about all of our providers and all of our locations may be found at

www.msmswv.com

Paul Ogershok, M.D. **Allergy, Asthma, & Immunology**

INITIAL EVALUATION **MEDICAL INFORMATION SHEET**

Patient:_____ DATE:_____ Birthdate:_____ AGE:____

Name of Referring Physician:_____

Do you wish a consultation letter sent to the referring physician? ( )Yes ( )No

Welcome to our medical practice.

Please complete this three page questionnaire in as complete a manner as possible. Feel free to make additional notes in the margins or on Page 4. This information will help Dr. Ogershok during his evaluation and treatment of your medical condition. ***THANK YOU!***

BRIEFLY DESCRIBE YOUR REASON(S) FOR THIS VISIT
(for example, asthma, hay fever, hives etc.):

_____

_____

HOW LONG HAVE YOU BEEN HAVING THESE PROBLEMS?

_____

Doctor's Notes:

SYMPTOMS: Please check all that apply.

NOSE:
( ) Frequent sneezing
( ) Runny nose
( ) Congestion / blockage
( ) Itching
( ) Nose bleeds
( ) Loss of smell
( ) Nasal polyps

SINUSES:
( ) Frequent infections
( ) Pressure in facial bones
( ) Pressure around eyes
( ) Throat drainage
( ) Clearing throat

EARS:
( ) Pain
( ) Itching
( ) Plugging / popping
( ) Loss of hearing

EYES:
( ) Itching / tearing
( ) Burning
( ) Redness
( ) Swelling of eyelids
( ) Dark circles
( ) Infections

LUNGS:
( ) Asthma
( ) Wheezing
( ) Cough-daytime
( ) Cough-nighttime
( ) Productive cough
( ) Dry cough
( ) Wheeze/exercise

GASTOINTESTINAL
( ) Nausea / vomiting
( ) Diarrhea
( ) Constipation
( ) Heart Burn

SKIN:
( ) Contact rash
( ) Eczema
( ) Hives
( ) Itching

HEADACHES:
( ) Sinus
( ) Tension
( ) Migraine

OTHER SYMPTOMS:_____

ASTHMA

Have you been diagnosed with asthma? ( ) Yes ( ) No
How many years ago? _____
Hospitalizations for asthma? _____
ER visits for asthma? _____
School/work days missed? _____
Night awakenings per month? _____
Albuterol use per week? _____
Courses of oral steroids? _____

TRIGGERS OF YOUR SYMPTOMS: Please check all that apply.

When do you have symptoms? ( ) Spring ( ) Summer ( ) Fall ( ) Winter

Which of the following exposures seem to worsen your symptoms?

( ) Yard work	( ) House work	( ) Aerosols	( ) Dry weather	( ) Stress
( ) Mowing lawn	( ) Vacuuming	( ) Perfumes	( ) Wet weather	( ) Foods: (?)
( ) Barns	( ) Exercise	( ) Smoke	( ) Change weather	( ) _____
( ) Cats	( ) Humidity	( ) News print	( ) Cold weather	( ) Latex
( ) Dogs	( ) Other animals	( ) Mold	( ) Aspirin	( ) Bee sting

BIN #1454

CURRENT MEDICATIONS: Please list all medications which are currently being used, either regularly or intermittently.

Medication: Dose / Frequency:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____

Doctor's Notes:

ADVERSE REACTIONS TO MEDICATIONS: Please list all medications to which you have had an adverse reaction, as well as the nature of the reaction:

Medication: Adverse reaction:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

PAST MEDICAL HISTORY: Please list significant medical conditions for which you have seen a doctor in recent years, as well as the form of treatment required.

Medical Condition When? Treatment?

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____
5. _____ _____ _____
6. _____ _____ _____

PREVIOUS ALLERGY EVALUATION & TREATMENT:

Do you have any serious reactions to bee stings? ( ) Yes ( ) No _____
Have you had a previous allergy evaluation? ( ) Yes ( ) No _____
Did you have allergy skin testing? ( ) Yes ( ) No _____
Did you receive immunotherapy (allergy shots)? ( ) Yes ( ) No _____
Did your symptoms improve while on injections? ( ) Yes ( ) No _____
Did you experience any adverse reactions? ( ) Yes ( ) No _____

ENVIRONMENTAL / SOCIAL HISTORY:

Where were you born and raised? _____
How long have you lived in this area? _____
How long have you lived in your present home? _____
How old is your home? _____
What is your occupation? _____
Please check all that apply to your daily environment:
( ) Indoor pets. What pets do you have? _____
( ) Central heat / air conditioning. ( ) Wall-to-wall carpeting
( ) Inner spring mattress ( ) Feather pillow
( ) Upholstered bedroom furniture ( ) In-home air filters
( ) Frequent exposure to smokers ( ) Unusual chemical exposures

SMOKING HISTORY:

( ) Life long non-smoker
( ) Former smoker
How many years? ___
When quit? _____
( ) Current smoker
How many years? ___
Packs/day? _____
( ) Daily exposed tosmoke
( ) Interested in quitting?

FAMILY HISTORY: Please check all conditions that occur in your family and indicate who is/was affected.

Medical Condition Who? (for example, father, brother, etc.)

( ) Asthma _____
( ) Eczema _____
( ) Allergies _____
( ) Hives / swelling _____
( ) Headaches _____
( ) Emphysema _____
( ) High blood pressure _____
( ) Cancer _____
( ) Diabetes _____
( ) Insect allergy _____

Doctor's Notes:

IMMUNIZATION HISTORY:

Are your immunizations up-to-date? ( ) Yes ( ) No If you have had any adverse reaction to any routine immunizations, please describe: _____

Last Flu vaccine:_____ Last pneumonia vaccine:_____

BIRTH HISTORY: Term or Premature, Vaginal delivery or C-section_____

REVIEW OF SYSTEMS: Please check any symptoms or diseases that have been a recurrent or chronic problem for you.

( ) Frequent / severe headaches ( ) Eye problems
( ) Fainting / dizziness ( ) Dental problems
( ) Neck injury / disease ( ) Heart disease
( ) Lung disease other than asthma ( ) Stomach / liver disease
( ) Urinary / bladder problems ( ) Bowel difficulties
( ) Orthopedic disease or injury ( ) Skin disorders
( ) Diabetes ( ) Hypertension
( ) Arthritis ( ) Fatigue
( ) Recent weight gain or loss of more than 10 pounds.
( ) Pregnancy or Pregnancy planned
( ) Any severe infections _____

Doctor's Notes:

If there is any additional information that you think would be helpful to Dr. Ogershok, please note this on the next page. Thank you for completing this form. **Please return the clipboard and all papers to the receptionist or nurse.**

Signature of person completing form: _____

FOR OFFICE USE ONLY:

ADMISSION DATA:

VITALS: T:_____ P:_____ R:_____ BP:_____ HT:_____ WT:_____

Remarks: _____

BIN #1454B

Continuation Notes – Initial Evaluation

Patient:_____ No:_____ Date: _____

Billing & Patient Accounts

As a courtesy to our patients we will bill your insurance company for you. We participate with most plans. Please check with your insurance company for specific coverage , especially for any prior authorization requirements. Our office is not responsible for obtaining prior authorization. However, we will assist you in any way we can. You are responsible for any services not covered by your insurance. If you have any questions about your financial responsibility please call your insurance company for detailed payment information before you contact our office. If you need assistance with your account please contact our main office.

We ask that all co-pays and deductibles be paid at the time of service.

For our patients without insurance we require a photo ID and a minimum payment of $55.00 for your visit prior to service. If your services exceed this fee we will send you a statement for your balance due.

Our patient statements are mailed monthly. Patients are responsible for resolving any balance due within 4 months unless other arrangements are made. Accounts not paid within this time may be subject to interest and service fees.

If we are unable to make payment arrangements with you or if we do not receive a response to our statements your account may automatically be turned over to our collection agency.

At Mountain Air we strive for excellent customer service. Please let us know if there is any way we can better meet your needs.

Thank you for allowing us to care for you and your family.
We are here for you.

If you suffer from...

- Allergic Rhinitis
- Childhood Asthma
- Adult Asthma
- Allergic Skin Conditions
- Atopic Dermatitis
- Contact Dermatitis
- Outdoor Allergies
- Indoor Allergies
- Sinusitis
- Stinging Insect Allergy
- Nonallergic Rhinitis
- Anaphylaxis
- Cough in Children
- Exercise Induced Asthma
- Food Allergies
- Asthma and Pregnancy
- Asthma triggers & Management
- Immunologic Problems
- Other Allergic Problems

...Mountain Air Allergy and Asthma has a treatment for you.

Mountain State Medical Specialties, Inc.

Mountain Air Allergy and Asthma

W. Thomas Corder, M.D., RPh.

Paul R. Ogershok, M.D.

Certified by
The American Board of Allergy & Immunology

About Our Physicians

W. Thomas Corder, MD

Dr. Corder is an extremely well educated physician with an extensive medical background.

In 1977 he received his pharmacy degree from West Virginia University School of Pharmacy (Magna Cum Laude, Rho Chi). He received his medical degree in 1981 from West Virginia University School of Medicine. From 1985 to 1988 he completed a combined Internal Medicine / Pediatrics Residency and served as Chief Resident in Pediatrics during his final year of residency at WVU. His Fellowship in Allergy / Immunology was completed at WVU in 2003 and 2004.

Other than his extensive education Dr. Corder has held many faculty appointments such as Assistant Professor, Associate Professor and Clinical Associate Professor of the Department of Pediatrics at WVU. He is also licensed by the West Virginia Board of Medicine, the West Virginia Board of Pharmacy and the North Carolina Board of Medicine. He is a Diplomat of the National Board of Medical Examiners. He is board certified by the American Board of Pediatrics and the American Board of Allergy and Immunology.

Dr. Corder worked at WVU Department of Pediatrics and their Allergy Partners of Fayetteville, North Carolina before coming back to West Virginia and forming Mountain Air Allergy and Asthma (Mountain State Medical Specialties, Inc.). His first official day with his new group will be May 1st, 2007.

Paul R. Ogershok, MD

Paul Ogershok, M.D. practices medicine in the field of allergy, asthma, and immunology. He is extensively trained and triple board certified in pediatrics, internal medicine, and allergy & immunology.

Dr. Ogershok graduated Summa Cum Laude from the University of Pittsburgh for his undergraduate degree. He attended West Virginia University School of Medicine from 1990 to 1994, and then went on to complete a combined internal medicine and pediatric residency in 1998. He distinctly served as chief resident for both pediatrics and internal medicine at the West Virginia University School of Medicine. After his training he taught both medical students and residents as an attending physician and Associate Professor of Medicine at WVU. Dr. Ogershok has published multiple peer reviewed articles in his field.

In 2006 he completed an allergy, asthma, and immunology fellowship at WVU and now practices with clinics in both Waynesburg, Pennsylvania and Morgantown, West Virginia. Dr. Ogershok cares for both pediatric and adult patients.

About Our Practice

We have three convenient locations:

165 Scott Ave, Suite 102
Morgantown, WV
(304) 554-0440

120 Medical Park Drive, Ste. 200
Bridgeport, WV
(304) 624-7200

1150 7th Street
Waynesburg, PA
724-627-2395

Emergency walk-ins are accepted when possible. For the best service please call ahead to check our availability.

For directions and additional information about our practice please visit ...
www.MSMSWV.com

What We Do

At Mountain Air Allergy and Asthma we proudly offer services to patients of all ages. We provide State-of-the-Art diagnoses and treatment at all of our facilities and are happy to bill both your primary and secondary insurances. We have evening and weekend hours to best meet the needs of our patients. Some of our services include :

- ☆ Complete exams for all allergy issues
- ☆ Allergy skin testing
- ☆ Patch testing and RAST testing
- ☆ Immunotherapy
- ☆ Asthma diagnostics & treatments
- ☆ Education of patients about the treatment and management of asthma and allergies
- ☆ Pulmonary function testing

Your Next Appointment:

_____
Patient Name

_____ _____
Date Time

M T W Th Fri

Mountain State Medical Specialties, Inc.

Our Mission

To improve the health status of West Virginia and Pennsylvania residents by providing high-quality health and wellness services, expanding access to care, and participating in the education of healthcare professionals.

Our Vision

To be the first choice for patient-centered care and the best place for staff and physicians to practice.

Our Values

Respect
- Appreciate your colleagues
- Be professional
- Value your patients
- Take care of yourself and each other

Teamwork
- Support a positive work environment
- Share your knowledge with others
- Take initiative

Integrity
- Maintain confidentiality
- Be open, direct and honest
- Keep your word
- Do the right thing

Excellence
- Be a continual learner
- Be the best at what you do
- Provide compassionate, superior care
- Provide exceptional customer service

Quality
- Pursue continuous improvement
- Suggest service enhancements
- Keep your patients safe

Stewardship
- Be accountable when using resources
- Be fiscally responsible

Mountain State Medical Specialties Associates & Services

Mountain State Dermatology

David C. Carlisle , MD
Jeffrey A. Dodson, MD
C. Bradley Franz, MD
Jeffrey B. Jackson, MD
Janelle M. King, MD
B. Asher Louden, MD
Amy B. Norton, MD
Georgia D. Daniel, CRNP
Megan A. Fluharty, PA-C
Kayla A. Gouzd, PC-C
Dayna L. Hrovath, PA-C
Kristin B. Smucker, PA-C

Mohs Micrographic Skin Cancer Surgery Center

David C. Carlisle, MD
John Hancox, MD

Mountain Air Allergy and Asthma

W. Thomas Corder, MD
Paul R. Ogershok, MD

Woofter Family Medicine

Dominick R. Woofter, MD
Isha Woofter, MD

Mountain State Primary Care

Casey Fryer, II, DO
Haeley E. Harman, DO
James E. Malone, DO
Frances B. Murray, MD
Erin Hawkins, FNP-BC
Elise Mossallati, FNP-BC

Mountain State Diagnostic Services

Allergy Testing
Bone Density
Echocardiogram
Full Service Blood Lab
Pulmonary Function Test
Stress Test
Ultrasound

Mountain State Medical Specialties, Inc.

Patient Responsibility Notice

www.MSMSWV.com

Your Financial Responsibility

ALL patients must provide a copy of the following documentation during the registration process:

- Insurance Card
- Valid Drivers License or some form of Photo ID

Payment is due at the time of service regardless if the patient has insurance , or is private/self pay.

All co-payments, co-insurance and/or deductibles will be collected at the time of service. As a courtesy MSMS Inc. will bill your insurance company; however, you are responsible for any non-covered service and/or patient responsibility after payment from your insurance company.

All private/self-pay patients must place an $85.00 deposit prior to services being rendered by a MSMS, Inc. provider. The remainder of the balance will be billed to you.

Statements are mailed monthly and we request your account be resolved promptly to avoid statement fees and collection procedures. For questions or to make payment arrangements call our billing office at: (304)624-7200 Ext 1295.

You may make a payment online with your VISA, Discover, American Express, Bank Debit card, or your PayPal account. Please visit our website for additional information regarding all services available to our patients.

Your Prescription Refills

Please bring all prescription and non-prescription medications with you to each appointment (a complete list or your prescription bottles).

MSMS Inc. Physicians will prescribe enough medications and refills to meet your treatment needs until your next scheduled appointment.

If you need a prescription change or refill before your next appointment please allow 24-48 business hours for us to complete your request.

Please have complete medication name and dosing information available as well as your pharmacy name and phone number when you call in to request a refill .

Your Privacy

It is the policy of MSMS Inc. that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients.

Policies and Procedures are in place to protect all medical records both paper and electronic used to treat our patients, financial information provide in person or via internet used for payments, and demographic information used to properly identify our patients. At MSMS Inc. we are compliant with all federal and state laws/regulations pertaining to our patients protected health information.

Your Laboratory Results

Laboratory (blood specimen), Pathology (skin specimen), and all other diagnostic services are billed as a separate charge from your office visit or procedure. Results will not be mailed to you. Both usually will be available at your next scheduled appointment.

Our office will call you if the results require further treatment or are serious in nature. If you are concerned about your results please feel free to call our Pathology secretary at (304)624-7200 ext. 2171, our Blood Lab at (304)423-5202, and Diagnostic testing at (304)624-7200 ext. 3126.

Your Appointment

MSMS Inc. physicians' office hours vary depending on location and provider. Typical business hours are Monday thru Friday 8:00 am to 4:00 pm. Please call your specific location to confirm.

As a courtesy please provide 2 days notice of any cancellation; otherwise a fee may be assessed.

Your Next Appointment:

_____

Patient Name

_____

Physician Name

_____ _____

Date **Time**

_____