WELCOME

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

A PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

B INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

C PHONE NUMBERS

Home (_____) _____

Cell Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____

Home Phone (_____) _____

Cell Phone (_____) _____

Work Phone (_____) _____ Ext _____

D FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

E MEDICAL HISTORY All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.
- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

_____

_____

HEALTH HABITS

Check (✓) which you use and how much:
- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:
- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

F SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including your demographic information, that may identify you and that related to your past, present or future physical or mental health or condition and related health services.

Uses of Protected Health and Disclosures Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care to a third party. For example, we would disclose your protected health information, as necessary, to a home health care agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred, to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospitalization.

Healthcare Operations: We may disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. The activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by your name in the waiting room when your physician is ready to see you. We may disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law,
Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation:
Research Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500

Other Permitted and Required uses and Disclosures: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy note: Information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information, This means you may ask us not to use or disclose any part of your protected for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosures of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy right has been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with the HIPPA Compliance Officer in person or by phone at our Main Office Phone Number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

HIPPA Privacy Rule of patient Authorization Agreement Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who may contribute to my health care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my protected health information to a covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my protected health information as specified below for the purposes and to the parties designated by me.

Privacy Rule Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

- I have the right to review this Practice's Notice of Information practices prior to signing this consent.
- That this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested.
- I have the right to object to the use of my health information for directory purposes
- I have the right to request restrictions as how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken reliance thereon

Consent to Treat

I hereby give my permission for Internal Medicine, Geriatrics & Oncology Group, PC to give me medical treatment.

I allow the Practice to file for insurance benefits to pay for the care I receive.I also authorize assignment of Medicare benefits.

I understand that:

- The Practice will have to send my medical record information to my insurance company
- I Must pay my share of the costs
- I must pay the cost of these services if my insurance does not pay or I do not have insurance

I understand:

- I have the right to refuse any procedure or treatment
- I have the right to discuss all medical treatments with my provider

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of the history. The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your insurance. Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and any other healthcare providers.

By signing this consent form:

1. You acknowledge the receipt of Two HIPPA notices
2. You are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled by any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.
3. You give consent to obtain your medication history
4. You give consent to treat
5. I authorize assignment of Medicare benefits directly to Internal Medicine Geriatrics & Oncology Group,PC

Signature:_____ Date:_____

Morse Fall Risk Assessment

Risk Factor	Scale	Points	Patient's Score
History of Falls	Yes	25	
	No	0	
Secondary Diagnosis (Two or more medical Diagnoses)	Yes	15	
	No	0	
Ambulatory Aid	Furniture	30	
	Crutches/Walker/Cane	15	
	None/Bedrest/Wheelchair/Nurse	0	
IV/Saline Lock	Yes	20	
	No	0	
Gait/Transferring	Impaired	20	
	Weak	10	
	Normal/Bed Rest/ Immobile	0	
Mental Status	Forgets limitations	15	
	Oriented to own ability	0	

Total Score: _____

High Risk = 45 and higher
Moderate Risk = 25-44
Low Risk = 0-24

(From Morse, J. M. (1997). Preventing Patient Falls. Thousand Oaks: Sage.)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns			+	+
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Do you use tobacco products? YES or NO. If so, how much?_____. Are you interested in quitting? YES. Or NO

If you are a female between ages of 45 and 65 have you had a mammogram within the past year and if so when and where_____

_____

If you are between the ages of 50 and 75 years old have you had a Cologuard or colonoscopy within the past 10 years? YES or NO

If so when and
where_____

_

If you are a female between the ages of 21 and 65 have you had a pap smear in the past 3 years. YES or NO. If yes, when and where?_____

If no, have you had a complete hysterectomy? YES or NO. If YES when and where?

_____

_____

PLEASE GIVE THE FRONT DESK A COPY OF YOUR INSURANCE CARD

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.