Luke Medical Clinic, P.A
125 W. Catawba Ave
Mount Holly, NC 28120
P: 704-827-3014 F: 704-822-9114

Gregory L. Glass, M.D
Shelby Fields, FNP-C
Katelyn Phillips, FNP-C
Christina Pawlish, FNP-C

Social Security #: _____ Address: _____
First Name: _____ City: _____ State: _____ Zip: _____
Middle Initial: _____ Home Phone: _____
Last Name: _____ Cell Phone: _____
Sex: _____ Date of Birth: _____ Work Phone: _____
Marital Status: _____ Race: _____ Pharmacy: _____City: _____
Email: _____
*May Luke Medical Clinic leave medical information on your voicemail? Yes or No
*If yes, what phone number will be best? _____

Emergency Contact:

Name: _____ Phone #: _____Relationship: _____
Name: _____ Phone #: _____Relationship: _____

Insurance/Policy Holder Information

Primary Policy:
Insurance Name: _____
ID Number: _____
Group Number: _____
Copay Amount: _____
Address: _____
City, State, Zip: _____

Policy Holder Information:
Name: _____
Address: _____
City, State, Zip: _____
Social Security Number: _____
Date of Birth: _____
Phone Number: _____

Secondary Policy:
Insurance Name: _____
ID Number: _____
Group Number: _____
Copay Amount: _____
Address: _____
City, State, Zip: _____

Policy Holder Information:
Name: _____
Address: _____
City, State, Zip: _____
Social Security Number: _____
Date of Birth: _____
Phone Number: _____

Insurance Authorization and Assignment

I hereby authorize my physician to furnish information concerning my present illness to insurance companies, referring physicians and for my insurance company to pay any medical/surgical benefits due to my physician.

Patient/ Guardian Signature: _____ Date: _____

Past Medical/Surgical/Family/Social History and Allergies

Patient Name: _____ D.O.B: _____ Date: _____

Migraine	Yes	No	Sexually transmitted disease	Yes	No
Recurrent headaches	Yes	No	If yes, please list:_____		
Epilepsy or seizures	Yes	No	Chemical or drug poison		
Neuralgia or Neuropathy	Yes	No	Any other disease?		
Brain tumor	Yes	No	Are you allergic to:	Yes	No
Stroke	Yes	No	Penicillin	Yes	No
Other disease brain or nerves	Yes	No	Sulfa	Yes	No
Eye problems	Yes	No	Aspirin	Yes	No
Ear problems	Yes	No	Codeine	Yes	No
Allergy/sinus symptoms	Yes	No	Any other antibiotics? _____		
Throat/ mouth disease	Yes	No	Shrimp	Yes	No
Heart attack	Yes	No	Any other foods? _____		
Rheumatic fever	Yes	No	Adhesive tape	Yes	No
High or low blood pressure	Yes	No	Tetanus antitoxin/serums	Yes	No
Asthma	Yes	No	Dyes/contrast used in medical tests	Yes	No
Chronic bronchitis	Yes	No	Broken bones	Yes	No
Other lung disease	Yes	No	Sprains	Yes	No
Ulcers	Yes	No	Dislocations	Yes	No
Treatment for H Pylori: _____	Yes	No	Concussion/head injury	Yes	No
Heartburn requiring a Dr. visit	Yes	No	Ever knocked unconscious	Yes	No
Gallbladder disease	Yes	No	Have you ever been given blood or plasma	Yes	No
Liver disease/ Jaundice	Yes	No	If yes, when? _____		
Colitis or other bowl disease	Yes	No	Any surgeries?	Yes	No
Hemorrhoids or rectal disease	Yes	No	If yes, describe? _____		
Bladder disease	Yes	No	Any Hospitalizations?	Yes	No
Disease (Female/Male organs)	Yes	No	If yes, describe? _____		
Arthritis or rheumatism	Yes	No	Do you smoke?	Yes	No
Any bone or joint disease	Yes	No	If yes, How many packs per day? _____		
Hives or eczema	Yes	No	Do you drink alcohol?	Yes	No
Frequent boils	Yes	No	If yes, how often: Daily_____ Weekly____		
Other skin problems	Yes	No	Special occasions_____		
Back problems	Yes	No	Ever used illegal drugs?	Yes	No
Diabetes	Yes	No	Ever had an addiction problem	Yes	No
Cancer	Yes	No	Familial or genetic disease	Yes	No
Depression	Yes	No	Nervous breakdown	Yes	No
Thyroid	Yes	No	Anemia	Yes	No

*Has any family member had any of the following: If yes, please indicate what family member.

Cancer	Yes	No	_____
Tuberculosis	Yes	No	_____
Diabetes	Yes	No	_____
Heart trouble	Yes	No	_____
High blood pressure	Yes	No	_____
Stroke	Yes	No	_____
Epilepsy	Yes	No	_____
Insanity	Yes	No	_____
Depression/anxiety	Yes	No	_____

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Patient Name: _____ DOB: _____

___I hereby authorize Luke Medical Clinic, P.A. to release information from my health records to:
_____
_____
_____

___I hereby authorize Luke Medical Clinic, P.A. to receive records from:
_____
_____
_____

I understand that the medical records, which I have requested to be released, may contain information regarding mental illness, HIV / AIDS and / or substance abuse. I further understand that my records are protected under the Health Insurance Portability and Accountability Act of 1996 protecting confidentiality and cannot be disclosed without written consent unless otherwise provided for in the regulations.

The specific health information to be released includes ___entire chart (excluding records of other providers), ___hospital admission, history and discharge summaries, ___X-ray reports, ___Lab reports.
___Other_____

Date of Service: _____
The above information released for the following purposes and that purpose only. Any other use is prohibited without the specific written consent of the patient or authorized legal representative.

___Transfer of Medical Care___ Physician Request___ Insurance ___ Personal ___Legal
___ Other (please specify) _____
I hereby acknowledge this consent is voluntary and is valid until such request is fulfilled but not to exceed 90 days from the date signed. I release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information authorized above. I may revoke this request, in writing, at any time except to the extent that action based on this consent has taken place. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Date Signed Date Sent and employee Initials

Medical Information Release Form

Patient Name: _____
Date of Birth: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Luke Medical Clinic, P.A, Gregory L. Glass, M.D. and his staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship:_____

Name: _____ Relationship: _____

Conditions for disclosure (Check the item(s) that apply):

☐ The practice may disclose medical information to the individual(s) above in discussion in my presence and when I am not physically present, including disclosure by telephone, facsimile, e-mail or regular mail.

☐ Other conditions of disclosure:

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____
Date: _____
Witnessed by: _____ Title/ Position: _____

Office Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff. **BEFORE BECOMING A PATIENT, PLEASE CALL YOUR INSURANCE COMPANY TO MAKE SURE WE ARE IN NETWORK WITH YOUR PLAN. YOU ALSO NEED TO LIST DR. GLASS AS YOUR PCP WHILE DOING SO.**

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your behalf. **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. **A PORTION OF DEDUCTIBLES WILL BE DUE AT THE TIME OF THE VISIT.**
4. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
5. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit**. FOR SCHEDULED APPOINTMENTS, PRIOR BALANCES MUST BE PAID PRIOR TO THE VISIT.**
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
7. Co-payments are due at time of service.
8. **PATIENT BALANCES ARE BILLED IMMEDIATELY ON RECEIPT OF YOUR INSURANCE PLAN'S EXPLANATION OF BENEFITS. BALANCES MUST BE PAID IN FULL BEFORE A FUTURE OFFICE VISIT.**
9. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 60 days will be forwarded to a collection agency.
10. We require 24-hour notice for canceling any appointments. There is a **$50** charge for appointments if they are not canceled OR if 24-hour notice is not given.
11. Advance notice is needed for all non-emergent referrals, typically 5 to 10 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued**. No shows and cancellations of these appointments will result in a $35 charge by our office.** The reason for this charge is due to the time, paperwork and calls we must make to ensure your appointment.
12. **Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan OR IF YOU ARE OUT OF NETWORK will be your responsibility.**

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Date: _____

Patient Name(s): _____

Patient or Legal Guardian's Signature: _____

The Doctors and staff of Luke Medical Clinic want you to know how we will protect your private health information

When you visit our office, it is very important that you feel safe in telling your doctor personal information that may be required to fully diagnose or treat a problem. As medical professionals, please be assured that our practice has always had strict policies and procedures to protect the confidentiality of the information that you entrusted to us. However, on April 14, 2003, new regulations became effective under a federal law call the Health Insurance Portability and Accountability Act ("HIPAA"). HIPAA regulations cover physicians and all other health care providers, health insurance companies and their claims processing staffs. In general, HIPAA was enacted to established national standards to:

- Give patients more control over their health information
- Set boundaries for the use and release of health records
- Establish safeguards that physicians, health plans and other healthcare providers must have in place to protect the privacy of health information.
- Hold violators accountable with civil & criminal penalties; and
- Try to balance need for individual privacy with requirement for public health.

The HIPPA rules require that our practice provide all of our patients that we see after April 14, 2003 with the Notice of Privacy Practices. The Notice describes how the medical information we receive from you may be used or disclosed by our practice and your rights related to you access to this information.

Please sign below that we have provided you with a copy of the attached Notice to review. You are entitled to a personal copy of the Notice at any time to review and keep your records. If you have any questions about our Privacy Practices, please feel free to contact our office manager.

Thank you for your cooperation.

I acknowledge that I received Luke Medical Clinic Notice of Policy Practices and have been given an opportunity to ask questions. I may request a copy of the Privacy Practices for my records.

Patient Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

MEDICATION LIST:

Name: _____Date_____

Date of Birth: _____

Name of Medications from previous provider: Strength: Directions: Refill Needed:

01) _____Y____N___

02) _____Y____N___

03) _____Y____N___

04) _____Y____N___

05) _____Y____N___

06) _____Y____N___

07) _____Y____N___

08) _____Y____N___

09) _____Y____N___

10) _____Y____N___

11) _____Y____N___

12) _____Y____N___

Purpose for your office visit:

_____

_____

_____

Allergy Screening Questionnaire

Name: _____ DOB: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Insurance: _____

1. Choose all that apply:

Nose	Eyes	Throat	Head
☐ Stuffy nose	☐ Itchy eyes	☐ Sore throat	☐ Headache
☐ Runny nose	☐ Watery eyes	☐ Itchy throat	☐ Restless sleep
☐ Itchy nose	☐ Red eyes	☐ Throat clearing	☐ Snoring
☐ Postnasal drip		☐ Cough	☐ Daytime fatigue
☐ Frequent sneezing			
☐ Sinus pressure			

Other: _____

2. Are your symptoms:

☐ Occasionally ☐ Seasonal* ☐ All Year Round ☐ All Year Round with Seasonal Worsening*

*If seasonal, months symptoms occur: _____

3. Do you have regular upper respiratory infections? _____ Yes* _____ No *How many per year? _____

4. Have you been diagnosed with asthma? _____ Yes _____ No If yes, when? _____

5. How often do you use the following? Please circle.

Over-the-counter Antihistamine (Ex. Claritin, Zyrtec)	Never	Occasionally	Seasonal	Most of the Year/Daily
Prescribed Allergy Medications or Nasal Spray (Ex. Singulair, Astelin)	Never	Occasionally	Seasonal	Most of the Year/Daily
Over-the-counter Nasal Spray	Never	Occasionally	Seasonal	Most of the Year/Daily
Steroids	Never	Occasionally	Seasonal	Most of the Year/Daily

6. Are you currently on blood pressure medication? _____ Yes _____ No
If YES, what is the name? _____

7. Allergy testing is not recommended if you: are pregnant, have unstable asthma or have history of anaphylaxis.

FOR PROVIDER USE ONLY:

Order Allergy Test: ☐ Yes ☐ No

Provider Signature: _____ Date: _____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than 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 is 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

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

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

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	_____

A2663B 10-04-2005