Patient Paperwork Packet

- ✓ Please complete ALL forms and return them to the clinic ASAP. The clinic will call you to schedule your first appointment. If you fail to complete all the forms, this will delay scheduling your appointment.
- ✓ Please bring your driver's license/photo ID and your insurance card to your appointment.
- ✓ Please arrive 15 minutes early for your appointment.
- ✓ If you arrive LATER than 10 minutes from your set appointment time, you may be deemed as a "NO SHOW". You will be charged a $25.00 NO-SHOW FEE; payment will be expected before you schedule your next appointment.
- ✓ Please bring a list of current medications or medication bottles to your appointment.
- ✓ You may want to bring a sweater or jacket with you as the office is usually cold.
- ✓ We ask that you wear a mask if you are feverish, sick, or not feeling well. The clinic will provide you with a mask if you do not have one.
- ✓ ALL COPAYS MUST BE PAID AT THE TIME OF CHECK-IN. If you have a previous balance, you will be asked to pay in FULL before your next scheduled appointment.
- ✓ We DO NOT ACCEPT new pain management.

PATIENT INFORMATION

LAST NAME		FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH	SEX ☐M ☐F	SSN	
MAILING ADDRESS	APT. #	CITY	STATE / ZIP
EMAIL		PRIMARY CARE PHYSICIAN	
LANGUAGE PREFERRED	RACE	ETHNICITY	
CELL PHONE NUMBER	EMERGENCY CONTACT NAME	EMERGENCY CONTACT RELATIONSHIP	
EMERGENCY CONTACT PHONE NUMBER	EMERGENCY CONTACT ADDRESS	GUARANTOR NAME	
GUARANTOR RELATIONSHIP	GUARANTOR PHONE NUMBER	GUARANTOR ADDRESS	

PREFERRED METHOD OF CONTACT? ☐ PHONE ☐EMAIL ☐MAIL   MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? ☐ YES ☐ NO

MAY WE COMMUNICATE WITH YOU THROUGH THE PATIENT PORTAL? ☐ YES ☐ NO

REASON FOR VISIT ____
(List Symptoms)

ARE YOU OR IS THERE A POSSIBILITY YOU COULD BE PREGNANT? ☐YES ☐NO

HOW DID YOU HEAR ABOUT US?
☐ Employer ☐ Google ☐ Mailer ☐ Personal Referral ☐ Road/Building sign ☐ Social Media ☐ Website ☐ Existing Patient

PRIMARY INSURANCE POLICYHOLDER

POLICY HOLDER'S NAME		SSN	DOB
INSURANCE NAME		INSURANCE I.D. #	
GROUP #	ADDRESS IF DIFFERENT THAN PATIENT'S		RELATIONSHIP TO POLICYHOLDER

SECONDARY INSURANCE POLICY HOLDER (if applicable)

POLICY HOLDER'S NAME		SSN	DOB
INSURANCE NAME		INSURANCE I.D. #	
GROUP #	ADDRESS IF DIFFERENT THAN PATIENT'S		RELATIONSHIP TO POLICYHOLDER

Signature of Patient/Guardian ______________________________ Date ____________________

Cohesive Family Medicine
2508 N. Harrison St. | Shawnee, OK 74804 | Ph: (405) 585-2030 | Fax: (405) 857-3122 | acclaimedfamilymedicine.com

Patient Health History Form

Today's Date: ______________________

Patient Name:____ Birth Date:_________________________________

Pharmacy Name:____

Pharmacy Location:____________________________________ Pharmacy Phone Number:________________________________

Reason for today's visit: ____

Please describe this problem:____

Do you have any food, environmental, or drug allergies? ☐ YES ☐ NO (Please explain below)

Allergies	Type	Reaction(s)

Please list ALL medications (prescription and non-prescription) that you take (i.e. herbal remedies, vitamins, over-the-counter, street drugs, etc.)

Medication	Dosage	Frequency

Please list all current/prior illnesses

Medical History	Year

Please list all prior injuries/surgeries

Injuries and Surgeries	Year

Cohesive Family Medicine
2508 N. Harrison St. | Shawnee, OK 74804 | Ph: (405) 585-2030 | Fax: (405) 857-3122 | acclaimedfamilymedicine.com

Patient Health History Form Continued

Today's Date: ______________________

Patient Name:____ Birth Date:_______________________________

Family History

Please describe any family health issues below:

Relatives	Illnesses/Reason for Death	Death Age	Unknown
Mother			
Father			
Sibling(s)			

Other Hereditary Illnesses: ____

Social History:

Occupation: ____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Who do you live with: ☐ Alone ☐ Spouse ☐ Children ☐ Parents ☐ Significant Other ☐ Friends/Relatives ☐ Other________

Do you drink alcohol: ☐ No & Never Have ☐ Socially Only ☐ Daily ☐ Beer/Wine ☐ Hard Liquor

Do you smoke: ☐ No & Never Have ☐ Yes (Please explain below) ☐ Quit (What year?)________________

Do you have a history of drug abuse: ☐ Yes (What kind?)______________________ ☐ No

Type of Smoking (Cigarette, pipe, marijuana, chew, etc)	How Much?	How Long?

Health Screening:

List the year of your last health screening below	Year
Colonoscopy	
Mammogram	
Pap Smear	
DEXA Scan	
PSA/Prostate	

Patient Health History Form Continued

Today's Date: ______________________

Patient Name:____ Birth Date:__________________________

Do you have or have you ever had any of the following?

Symptoms/Illness		No	Yes, Explain
Weight Loss			
Hepatitis			
HIV/Other Blood Diseases			
Bleeding Disorders			
Thyroid Problems			
Diabetes			
Rheumatoid Arthritis			
Mobility/Joint Problems			
Constipation/Diarrhea			
Blood in Stool			
Liver Problems			
Heart Problems			
Blood clots in legs or lungs			
Asthma			
Sleep Apnea			
COPD			
Breast Abnormalities			
Nipple Discharge			
Change in Moles			
Headaches			
Genital or Oral Herpes			
History of STD's			
Prostate Problems			
Kidney Problems			
Wears Glasses/contacts			
Wears Hearing Aids			
Anxiety/Depression			
Cancer, if yes what cancer?			

HIPAA Notice of Privacy Practices

Patient Name:____ Date of Birth:________________

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

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

Uses and Disclosure of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment to provide healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third-party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; OR 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 and/or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations: We may use or disclose, as needed, your protected health information to conduct normal operations of the physician's practice. These activities include, but are not limited to:

- Quality control
- Licensing
- Employee reviews
- Training of medical students

For example, we may disclose your protected health information to medical students who see patients in 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 use or disclose your protected health information, as necessary to contact you for test results or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, public health issues, communicable disease, 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, underlay, we must make a disclosure 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 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 concerning the use or disclosure indicated in the authorization.

Your Rights:

The following is a statement of your rights concerning your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, you may not inspect or copy the following records – psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

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 health information for 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 and for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions and to whom they apply.

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

You have the right to request and 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 or by fax.

You may 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.

Consent to email, cellular telephone, or text usage for appointment reminders and other healthcare communications: I consent to receive text messages, phone calls, or emails reminding me of my appointments. **Note:** You may opt out of these communications at any time. The clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This clinic uses an Electronic Health Record that will update your demographics and consent to the information that you just provided.
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 the U.S. Department of Health and Human Services, 200 Independence Ave. S.W. Room 509F, HHH Building, Washington D.C. 20201. If you believe your privacy practices have been violated by us, you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was revised, published, and becomes effective on January 16, 2023. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices concerning protected health information. If you have any objections to this form, please ask to speak with our privacy officer.

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

Patient Name:____ Today's Date:_______________________

Patient or Guardian Signature:____ Pt. Date of Birth: _______________

Consent to Treatment, Release and Acknowledgement

Patient Name:____ Date of Birth: __________________

Consent to Treatment:

I request those physicians and other healthcare professionals who care for me to perform routine exams, diagnostic procedures, hospital care, and therapeutic treatments which in their judgment become necessary while I am a patient of Cohesive Family Medicine. Routine diagnostic procedures and medical treatments include but are not limited to ECGs, x-rays, physical therapy, blood tests, and administration of medications. I also consent to medical recording, or filming, when necessary, in the judgment of my physician to document the course of my injury or illness and to provide appropriate medical care, performance improvement, and education. I acknowledge that I have the right to request the stopping of any recordings during and up until a reasonable time before the recording or film is used. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatment or examinations. I authorize the practice to retain, preserve, and for scientific or educational purposes, dispose of any specimen or tissue taken from my body at their convenience. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes. In order to deliver quality healthcare, I understand that Cohesive Family Medicine, including its providers, develops and maintains health information which may include physician notes (both history and physical), medication reports, tests, test results, and treatment plans. I concur that this health information is used for the following: care and treatment plans, billing statements, communication between interdisciplinary healthcare providers, and verification of services (by both third-party payers and government payers), for quality control by the physician practice.

Reason of Responsibility:

I understand that if I leave the practice without the consent of the physician and/or fail to carry out instructions for follow-up care, I do so at my own responsibility. I further understand that any injury or harm I may suffer while away from Cohesive Family Medicine will be my responsibility.

Consent to Appeal:

In the event that my insurance denies payment for any services rendered during this episode of care, I authorize the practice to file a grievance for payment on my behalf. I understand that I have the right to rescind my consent to appeal at any time during the appeal process. If I consent to the practice of filing a grievance on my behalf, I understand that I will not be able to file my own grievances concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing. This consent will be automatically rescinded, and I may file my grievance if my healthcare provider does not file a grievance or stops grieving my case.

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patients:

I request that payment of authorized Medicare benefits be made on my behalf to the practice for any services furnished to me by that provider of service. I authorize any holder or medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Statement to Permit Payment of Medicaid Benefits to Provider and Physicians

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information needed for this or related Medicaid claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician, the organization furnishing the services, the authorizing physician, or the organization to submit a claim to D.P.W. for payment.

Assignment of Insurance or Payor Benefits

I recognize that I am primarily liable for payments for services rendered; however, in the event that I am entitled to medical care benefits of any type whatsoever, I hereby assign those benefits to Cohesive Family Medicine and any of its contracted healthcare providers. I authorize the practice and the appropriate healthcare providers to apply for benefits of services rendered during this admission for visit. I certify that the insurance or other coverage benefits information supplied by me is correct in accordance with applicable practice, provider, insurance policies, or agreements. If my insurance carrier requires pre-authorization for services I will receive, I understand that it is my responsibility to contact my personnel office and/or insurance carrier to obtain it. If I fail to do so, I will be liable for all or part of otherwise covered expenses.

Acknowledgment of Responsibility for Payment of Medical Bill

I guarantee payment of all charges incurred for services rendered by Cohesive Family Medicine for the patient's name on the opposite side of this page, less any amounts paid by any third-party payer. I guarantee the amount due for the non-insurable charges including co-payment, deductibles, etc., should my account be referred to an attorney for collections, I agree to pay reasonable attorney's fees and collection expenses.

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have received a copy of the "HIPAA Notice of Privacy Practices". I understand that the information Cohesive Family Medicine acquires or creates about me will only be disclosed to others for treatment, payment, and healthcare operations as outlined in the notice or as authorized by me in writing.

I certify that I have read this form and that I understand its contents.

Patient Name:____ Today's Date:____________________

Patient or Guardian Signature: ____ Pt. Date of Birth: ________________

Authorization to Disclose Health Information

_______Yes, I authorize Cohesive Family Medicine to leave me voice messages regarding my protected health information as stated below.

______ No, I do **NOT** want Cohesive Family Medicine to leave me voice messages.

Patient or Guardian Signature:____ Date:________________

I hereby authorize Cohesive Family Medicine to release my health information as described in: Medical or Billing

Name:____ Relationship:__________________________________

Phone:____

Name:____ Relationship:__________________________________

Phone:____

Protected health information may include info/documents regarding medical treatment of the patient including but not limited to diagnosis, procedures, treatment plans, appointments, and test results. As well as account and billing information, including but not limited to, account balances, payment arrangements, insurance claims status, and third-party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and its implementing regulations govern the terms of the authorization. I understand that I have the right to revoke this authorization at any time prior to the practice's compliance with the request set forth herein, provided that the revocation is in writing.

Signature of Patient or Guardian:____

Relationship of the Guardian:____Date:____________________

Returned Check Policy

It is our policy that a patient check returned due to insufficient funds will be charged twenty-five ($25) dollars in addition to the check amount. This fee will be paid to Cohesive Family Medicine separately from all other payments and must be paid in full before your next appointment. This fee is out of pocket and not paid by insurance.

I understand I must pay the returned check amount plus the $25 fee in addition to any current co-pays or charges for current services before my appointment.

I fully understand this policy and I agree to pay the $25 returned check fee should my check not clear due to insufficient funds.

Patient Name: ____ Today's Date: ___________________

Patient or Guardian Signature: __________________________________ Pt. Date of Birth: ___________

Cancellation/No Show Policy

Our goal is to provide every patient with quality medical care in a timely manner. Late cancellations and "No Shows" inconvenience not only our patients who require medical attention but also our entire clinical staff.

Cancellation of an Appointment:

In order to be respectful of the needs of other patients and our medical provider's time, it is our policy that you call to cancel or reschedule your appointment **at least twenty-four (24) hours in advance**. Appointments are in high demand and your early cancellation will allow another patient the opportunity to be seen promptly.

As a courtesy, our staff will send you appointment confirmations and reminders via text, email, and/or phone call, two days in advance. If you are unable to keep your appointment, we will be happy to reschedule it for you.

NO SHOW:

A "No Show" is someone who is not present at the time of their scheduled appointment and fails to give a 24-hour cancellation notice. While we understand that emergencies may occur, when you "No Show" for an appointment you are not only preventing another patient from receiving medical care, but you are also disrespecting our medical provider's time and the time of our entire clinical staff. Three (3) NO SHOW appointments are subject to termination from our clinic. In addition, a new patient who misses their first new patient appointment will only be allowed one more "No Show" before potential termination from the clinic.

*Please note that being more than ten (10) minutes late for your scheduled appointment may result in a "No Show" and you may be asked to reschedule.

Charges for Late Cancellations and No Shows:

We understand that unforeseen situations occur, however, it is our right to charge a non-refundable fee of $25 for late cancellations and no-shows. This fee will not be covered by your insurance company and must be paid for before scheduling your next appointment. Three (3) no-show appointments may result in dismissal from Cohesive Family Medicine. If you have questions or concerns regarding our policy, please ask our staff and we will gladly clarify your concern.

Print Name:____ Today's Date:____________________

Patient or Guardian Signature:______________________________ Pt. Date of Birth:______________

Cohesive Family Medicine
2508 N. Harrison St. | Shawnee, OK 74804 | Ph: (405) 585-2030 | Fax: (405) 857-3122 | acclaimedfamilymedicine.com

State Law Regarding Narcotic Prescriptions

House Bill 2931

Effective January 1, 2020

Today's Date: ______________________

Patient Name:____ Birth Date:___________________________

Due to a new State of Oklahoma law, all narcotic medications MUST be sent to pharmacies in electronic form ONLY. Written narcotic scripts are no longer acceptable under this new law.

Please provide your pharmacy information below. **This is the only pharmacy we will use for your medications.**

It is your responsibility to update us on pharmacy changes at least 24 hours before medicines are prescribed. Once your prescription has been sent, it must be picked up at the pharmacy accordingly.

Pharmacy Name:____

Pharmacy Address:____

Pharmacy Phone Number:____

Confirm the above information is correct. As this is where you will be required to pick up your prescriptions.

Patient or Guardian Signature:____

Authorization for Release of Medical Record Information

Patient Name:______________________________ Today's Date:__________________

Date of Birth:____________________ Patient Phone Number:________________________

Address:____________________________ City/State/Zip:______________________

Please Note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name:___________________________ Facility Phone Number:________________

Facility Address:_________________________ City/State/Zip:______________________

Facility Fax Number:______________________

Dates and Type of Information to disclose:

☐ 2 years before last date seen
☐ Dates Other: __________________
☐ Specific Information Requested:
____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care
☐ Referral
☐ Other _________________________

RESTRICTIONS: Only medical records originating through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated before and including the dates on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted diseases acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Cohesive Family Medicine
Address: 2508 N. Harrison City/State/Zip: Shawnee, OK 74804 ☐ Please mail records
Fax: 405-857-3122 Phone: 405-585-2030 ☒ Please fax records

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will apply to information that has already been released in response to this authorization. I understand that the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________________. If I fail to specify an expiration date, event, or condition, this authorization will expire one (1) year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information being used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Patient/Guardian:____________________________________ Date:______________

Consent to Treat Minor Children

I, ________________________________ parent or legal guardian of, ____, born on ________________________________. Do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is under the care of any physician or APRN, and I am not reasonably available by telephone to give consent.

This authorization is effective during the following dates from ____________________ to ______________________.

____

Signature of Parent or Legal Guardian

____ ____

Witness Signature **Witness Name** (please print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.

This additional information will assist in treatment if it can be furnished with consent but is not required.

Family Address:____

Telephone: Father's Name:___________________________ Father's Phone Number:___________________

Mother's Name:__________________________ Mother's Phone Number:___________________

Child's Birthdate:_____________________________________ Last Tetanus:_____________________________

Allergies to drugs or foods: ____

____.

Special Medications, Blood Type, or Pertinent Information:

____

____

Preferred Hospital: ____

Cohesive Family Medicine
2508 N. Harrison St. | Shawnee, OK 74804 | Ph: (405) 585-2030 | Fax: (405) 857-3122 | acclaimedfamilymedicine.com

Medical Home Agreement

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient and treat you with dignity and respect.
2. We will focus on listening to your concerns and educating you on your healthcare needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally, and emotionally.
4. Focus on providing you with ongoing, quality, and safe medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls, and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialists as deemed medically necessary by your PCP.
9. Provide you with treatment, medications, equipment, and any other resources deemed medically necessary by your PCP.

As a Medical Patient, your responsibility is the following:

1. Work with us, as your PCP, to meet all your healthcare needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report any changes related to your health, treatments, medications, etc.
   a. This includes the use of all medications-prescription, over-the-counter, herbal, and street drugs.
   b. This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us before going to the Emergency Room unless it is life-threatening.
5. Notify us after any Emergency Room, Urgent Care Clinic, or hospital visit.
6. Schedule medical appointments in a timely manner, including follow-up appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment, call before your appointment time to cancel, or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your healthcare is a TEAM approach involving BOTH YOU and YOUR PROVIDER.

Patient Name:____ Today's Date:______________________

Patient Signature:____ Date of Birth:__________________

Witness Name:____ Today's Date:______________________

Witness Signature: ____ Date of Birth:__________________

Patient Health Questionnaire and General Anxiety Disorder

(PHQ-9 and GAD-7)

Today's Date: ______________________

Patient Name:____ Birth Date:___________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	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, 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 notice or the opposite, being so fidgety 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 hurting yourself in some way.	0	1	2	3
Add the score for each column →				

Total Score (add your column scores altogether):__________

• **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?** (Circle one)

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult

---

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD - 7	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 altogether):__________

• **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?** (Circle one)

Not difficult at all   Somewhat difficult   Very difficult   Extremely difficult

---

Epworth Sleepiness Scale

Today's Date: ______________________

Patient Name:____ Birth Date:__________________________

Patient Sex: ☐ Male ☐ Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to decide how they would've affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation:	**Chance of Dozing:**
Sitting and reading	☐
Watching TV	☐
Sitting, inactive in a public place (e.g. a theater or a meeting)	☐
As a passenger in a car for an hour without a break	☐
Lying down to rest in the afternoon when circumstances permit	☐
Sitting and talking to someone	☐
Sitting quietly after a lunch without alcohol	☐
In a car, while stopped for a few minutes in traffic	☐
Total	☐

Currently on CPAP therapy: ☐ Yes ☐ No

---

0 – 5 Lower than Normal Daytime Sleepiness
6 – 10 Higher Normal Daytime Sleepiness
11 – 12 Mild Excessive Daytime Sleepiness
13 – 15 Moderate Excessive Daytime Sleepiness
16 – 24 Severe Excessive Daytime Sleepiness

Anything above a 10 would be recommended for a sleep consultation

Please note that this is a GUIDE ONLY. Ultimately, the decision to refer a patient for a sleep consultation may be the result of a variety of factors and is at the sole discretion of the provider.