



## **Patient Paperwork Packet**

- Please complete ALL forms and return 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 in scheduling your appointment.
- Please bring your driver's license/photo ID and your insurance card to your appointment.
- Please arrive 15 minutes early to 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 for 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 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.

### **Acclaimed Family Medicine**

2508 N. Harrison St.

Shawnee, OK 74804

Phone: 405.585.2030

Fax: 405.857.3122

[acclaimedfamilymedicine.com](http://acclaimedfamilymedicine.com)



## PATIENT INFORMATION

LAST NAME		FIRST NAME			MIDDLE INITIAL	
DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> PHONE <input type="checkbox"/> EMAIL <input type="checkbox"/> MAIL			MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
MAY WE COMMUNICATE WITH YOU THROUGH THE PATIENT PORTAL? <input type="checkbox"/> YES <input type="checkbox"/> NO						
REASON FOR VISIT _____ (List Symptoms)						
ARE YOU OR IS THERE A POSSIBILITY YOU COULD BE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO						

### HOW DID YOU HEAR ABOUT US?

Employer  Google  Mailer  Personal Referral  Road/Building sign  Social Media  Website  Existing Patient

## PRIMARY INSURANCE POLICY HOLDER

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

## 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 POLICY HOLDER	

Signature of Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Acclaimed Family Medicine**  
2508 N. Harrison St.  
Shawnee, OK 74804  
Phone: 405.585.2030  
Fax: 405.857.3122  
acclaimedfamilymedicine.com



## Patient Health History Form

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Today's 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?  NO  YES (Please explain below)

ALLERGY	TYPE	REACTION

Please list ALL medications (prescription and non-prescription) that you take (include 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:



**Patient Health History Form Continued:**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

Please describe any family health issues below:

Family History:	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 and Never Have  Socially Only  Daily  Beer/Wine  Hard Liquor

Do you smoke:  NO and Never Have  Yes (Please explain below)  Quit (What year?) \_\_\_\_\_

Do you have a history of drug abuse:  NO  YES (What kind?) \_\_\_\_\_

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

**Health Screening:**

Please list the year of last health screening below:	YEAR:
Colonoscopy	
Mammogram	
Pap Smear	
DEXA Scan	
PSA/Prostate	



**Patient Health History Form Continued:**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Today's 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 that are involved in your care and treatment for the purpose of providing 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 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 in order 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 that 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, under law, 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 in relation to 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, 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 the purpose 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 and for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions and 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 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 receiving 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 consents 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; OR 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 with respect to protected health information. If you have any objections to this form, please ask to speak with our privacy officer.

**ACKNOWLEDGEMENT**

Signature below is only 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 judgement become necessary while I am a patient of Acclaimed 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 judgement 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 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 Acclaimed Family Medicine, including its providers, develop and maintain health information which may include physician notes (both history and physical), medication reports, tests, tests 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 Acclaimed 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 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 own 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 and 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 Pavor 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 Acclaimed 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 required 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 could be liable for all or part of otherwise covered expenses.

**Acknowledgement of Responsibility for Payment of Medical Bill**

I guarantee payment of all charges incurred for services rendered by Acclaimed 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.

**Acknowledgement 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 Acclaimed Family Medicine acquires or creates about me, will only be disclosed to others for treatment, payment, and healthcare operations as set forth in the notice or as authorized by me in writing.

**I certified 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: \_\_\_\_\_

**Acclaimed Family Medicine**  
2508 N. Harrison St.  
Shawnee, OK 74804  
Phone: 405.585.2030  
Fax: 405.857.3122  
acclaimedfamilymedicine.com



**Authorization to Disclose Health Information:**

\_\_\_\_\_ Yes, I authorize Acclaimed Family Medicine to leave me voice messages regarding my protected health information as stated below.

\_\_\_\_\_ No, I do **NOT** want Acclaimed Family Medicine to leave me voice messages.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize Acclaimed 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, 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: \_\_\_\_\_

**Acclaimed Family Medicine**  
2508 N. Harrison St.  
Shawnee, OK 74804  
Phone: 405.585.2030  
Fax: 405.857.3122  
acclaimedfamilymedicine.com



### **Returned Check Policy:**

It is our policy that a patient check returned due to non-sufficient funds, will be charged twenty-five (\$25) dollars in addition to the check amount. This fee will be paid to Acclaimed 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: \_\_\_\_\_

**Acclaimed Family Medicine**  
2508 N. Harrison St.  
Shawnee, OK 74804  
Phone: 405.585.2030  
Fax: 405.857.3122  
acclaimedfamilymedicine.com



## **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 are in need of 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 in a timely manner.

As a courtesy, our staff will send you an appointment confirmation and reminder 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 failed to give 24 hours 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 no show appointments may result in dismissal from Acclaimed 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: \_\_\_\_\_

### **Acclaimed Family Medicine**

2508 N. Harrison St.

Shawnee, OK 74804

Phone: 405.585.2030

Fax: 405.857.3122

acclaimedfamilymedicine.com



**State Law Regarding Narcotic Prescriptions:**

House Bill 2931

Effective January 1, 2020

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_ / \_\_\_ / \_\_\_ Today's 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: \_\_\_\_\_

**Acclaimed Family Medicine**

2508 N. Harrison St.

Shawnee, OK 74804

Phone: 405.585.2030

Fax: 405.857.3122

acclaimedfamilymedicine.com



**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 prior from 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 originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the dates on this authorization unless other dates 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: Acclaimed Family Medicine

Address: 2508 N. Harrison City/State/Zip: Shawnee, OK 74804

Fax: 405-857-3122 Phone: 405-585-2030

Please mail records

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 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 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 \_\_\_\_\_, 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  
\_\_\_\_\_ and I am not reasonably available by telephone to give consent.

This authorization is effective 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 the 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: \_\_\_\_\_



**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, 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 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)

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**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 of hurting yourself in some way.	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? (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): \_\_\_\_\_

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:**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ 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.....	<input type="checkbox"/>
Watching TV.....	<input type="checkbox"/>
Sitting, inactive in a public place (e.g. a theater or a meeting).....	<input type="checkbox"/>
As a passenger in a car for an hour without a break.....	<input type="checkbox"/>
Lying down to rest in the afternoon when circumstances permit.....	<input type="checkbox"/>
Sitting and talking to someone.....	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol.....	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic.....	<input type="checkbox"/>
<b>Total</b> .....	<input type="checkbox"/>

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 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.