Progressive Medical Associates, PLLC
PATIENT REGISTRATION INFORMATION

PATIENT NAME: _____ ❑ M ❑ F
(Last) *(First)* *(Middle)*

PREFERRED NAME: _____ GENDER: _____ BIRTHDATE: _____/_____/_____ SSN: _____

ADDRESS: _____CITY: _____ STATE: ____ ZIP _____

EMAIL ADDRESS: _____

CELL PHONE: _____ HOME PHONE: _____

MARITAL STATUS: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widow PREFERRED LANGUAGE: _____

RACE: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaskan Native ❑ Native Hawaiian or Pacific Islander
❑ White Hispanic or Latino ❑ Black Hispanic or Latino

DO YOU HAVE ANY SPECIAL COMMUNICATION REQUIREMENTS (hearing, vision, trouble understanding)? ❑Yes ❑No

EMERGENCY CONTACT PERSON _____ RELATIONSHIP _____

ADDRESS: _____ TELEPHONE: _____

PREFERRED LOCAL PHARMACY: _____ Address: _____

MAIL ORDER PHARMACY: (If you have one): _____

PRIMARY INSURANCE _____ NAME OF POLICY HOLDER _____
INSURED'S ID # _____GROUP # _____ BIRTHDATE OF POLICYHOLDER: _____
SECONDARY INSURANCE _____ NAME OF POLICY HOLDER _____
INSURED'S ID # _____ GROUP # _____ BIRTHDATE OF POLICYHOLDER: _____

WILL THE PATIENT BE THE FINANCIALLY RESPONSIBLE PARTY: ❑Yes ❑No

IF NO, WHO WILL BE THE FINANCIALLY RESPONSIBLE PARTY? _____

RELATIONSHIP TO PATIENT: _____ SSN # :_____ PHONE_____

ADDRESS _____

Are you interested in joining Dr. Stacy Le's personalized (concierge) healthcare service or would you like more information?
❑ Yes ❑ No

I understand my insurance coverage is a relationship between my insurance company and myself, and Progressive Medical is unable to quote or guarantee my benefits. I agree to accept financial responsibility for charges incurred that are not reimbursed by my insurance company. I understand that I will be billed for "no-shows" or late cancellations.

PRINTED NAME of PATIENT: _____ DATE: _____

SIGNATURE (*Patient or financially responsible party)*:

_____
(If patient is under the age of 18, must be signed by financially responsible party)

Progressive Medical Associates, PLLC
NEW PATIENT HEALTH QUESTIONNAIRE

Room: ____

NAME: _____ DATE: _____

What is the reason for your visit today *(Check all that apply)*:
☐ Get established with the practice ☐ Annual Wellness ☐ Sick/Medical Concerns: _____

Please list any current or past medical problems along with the approximate year they occurred: _____
_____
_____

Please list any hospitalizations and the year they occurred, including surgeries: _____
_____
_____

Please list any other physicians you are currently seeing:

Physician	***Location***	***Reason***
_____		
_____		
_____		

MEDICATIONS: Please list the medications you are taking (including over-the-counter, vitamins, herbs & birth control):

Medication	***Dosage***	***How often you take it***
_____		
_____		
_____		
_____		
_____		
_____		

ALLERGIES: Do you have any allergies to any medications? ❑Yes ❑No

Medication	***Reaction***
_____	
_____	
_____	

FAMILY HISTORY:

	Living	**Deceased**	**Medical conditions and the age that they occurred**
Father	____	____	_____
Mother	____	____	_____
Siblings **(Male/Female)**	____	____	_____
Maternal Grandmother	____	____	_____
Maternal Grandfather	____	____	_____
Paternal Grandmother	____	____	_____
Paternal Grandfather	____	____	_____

Is there anyone else in the family that has suffered from high blood pressure, diabetes, high cholesterol, heart disease, prostate cancer, breast cancer, colon cancer, alcoholism, mental health issues, or anything else you feel is important?

_____
_____

SOCIAL HISTORY:

Occupation: _____ Highest Level of Education/Degree_____
Spouse's occupation?_____ Highest Level of Education/Degree _____
Who lives at home with you? _____ # of children & ages: _____
Sexual orientation ❑Heterosexual ❑Homosexual ❑Bisexual
Religion: _____ Do you have any religious/spiritual beliefs we need to know about for your healthcare? _____
Are you currently a smoker? ❑Yes ❑No If yes, how much do you smoke daily? _____
If you do not currently smoke, have you ever been a cigarette, pipe, or cigar smoker? ❑Yes ❑No
If yes, how many packs per day did you smoke? _____ How many years did you smoke? _____ Year Quit _____
Any exposure to secondhand smoke (others smoking around you) either currently or in the past? ❑Yes ❑No
If yes, please explain: _____
Do you currently use recreational drugs (like marijuana, etc)? ❑Yes ❑No
Do you wear a seatbelt? ❑Yes ❑No ❑Occasionally
Do you exercise regularly? ❑Yes ❑No If yes, what do you do for exercise and how often? _____
Please describe your diet? _____
What do you and your partner use for contraception (*if applicable*): _____
Would you like to be tested for, STDs or HIV? ❑Yes ❑No

HEALTHCARE WISHES:

Do you already have a healthcare proxy or living will? ❑Yes ❑No Are you willing to be an organ donor? ❑Yes ❑No
Most healthy patients would like to be treated aggressively (such as CPR, respirator, ICU, etc) if they had a potentially curable condition. If you had a condition that had no chance of recovery, would you wish to remain on life support? ❑Yes ❑No ❑Not Sure

If you were unable to make your own healthcare decisions *(for instance, you were in a coma from a car accident)*, whom would you like us to ask about what your wishes would be? Please name one person and one alternate.
Name: _____Phone No: _____Relationship to You: _____
Name: _____Phone No: _____Relationship to You: _____

HEALTH MAINTENANCE:

Have you ever had:	***Yes***	***No***	***If Yes, approximately when was the last time:***
Physical Exam	___	___	_____
Cholesterol Checked	___	___	_____
Colonoscopy/Sigmoidoscopy/Cologuard	___	___	_____
Flu Shot	___	___	_____
Covid-19 Vaccine	___	___	_____
Pneumonia Shot	___	___	_____
Tetanus Shot	___	___	_____
MMR Shot (*Measles/Mumps/Rubella)*	___	___	_____
Hepatitis Shot	___	___	_____
Skin Test for TB (*PPD*)	___	___	_____
HIV Screening	___	___	_____
Hepatitis C Screening	___	___	_____
Eye Exam	___	___	_____
Do you see a dentist at least once a year?	___	____	_____

Female Patients:	***Yes***	***No***	***Date of Last***
Physician Breast Exam	___	___	_____
Pap Smear	___	___	_____
Mammogram	___	___	_____
Bone Density	____	____	_____

Male Patients:	***Yes***	***No***	***Date of Last***
PSA Blood Test	___	___	_____

Name: _____ Date: _____

ANNUAL HEALTH SCREENINGS:

PHQ-9 **Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?** ***(Please ✓ the appropriate box)***	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off <u>any</u> problems listed above, 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? *(Please **circle** your answer)*	Not difficult at all	Somewh at difficult	Very difficult	Extremel y difficult

S: _____ Dx: _____

AUDIT-C Please **circle** your answers:	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times a month	2 - 3 times a week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day when you drink?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

S: _____ Dx: _____

NEW PATIENT – MEDICARE 65+

Name: _____ DOB: _____ Date**:** _____ Sex Assigned At Birth: _____ Gender: _____

Has anything changed in regard to your health in the past year? *(new illness, surgeries, new medication allergies or intolerances, etc.)*

_____

Have there been any significant changes in your life in the past year such as i*ncreased stress, new job, home, relationship, children, ill relatives,*
*etc.?*_____

Have any of your blood relatives developed any new illnesses in the past year? If any blood relative has had cancer, please list their relation to you, what they had, and how old they were when diagnosed:

_____

If you have had any vaccines in the past year, please list them & the approximate date(s): _____

What is (or was) your occupation: _____ Spouse's occupation:_____
If you are retired, what year did you retire? _____
If you have children, what are their names & ages? _____
Do you currently use tobacco? ❑Yes ❑No What kind(s)? ❑Cigarettes ❑Cigars ❑Pipe ❑Vape ❑Chew
If yes, how much do you smoke (use) daily? _____
If no, have you ever used tobacco? ❑Yes ❑No What kind(s)? ❑Cigarettes ❑Cigars ❑Pipe ❑Vape ❑Chew
If yes, how many packs per day did you smoke? _____ How many years did you smoke? _____ Year Quit_____
Any exposure to secondhand smoke (others smoking around you) currently or in the past? ❑Yes ❑ No
If yes, please explain: _____
Do you currently use recreational drugs (like marijuana, etc)? ❑Yes ❑ No
Do you wear a seatbelt? ❑Yes ❑No ❑Occasionally
Do you exercise regularly? ❑Yes ❑ No If yes, what do you do for exercise and how often?

_____

Please describe your diet

_____

Have you had a new sexual partner in the past year? ❑Yes ❑ No Would you like to be tested for HIV or other STDs? ❑Yes ❑ No
Do you have any difficulties with hearing that limits your personal life? ❑Yes ❑No
Do you see a dentist at least once a year? ❑Yes ❑ No
During the past 4 weeks, how would you rate your health? ❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor
Do you have any difficulties driving your own car or getting transportation if you do not drive? ❑Yes ❑No
During the past 4 weeks, was someone available to help you if you needed and wanted help? ❑Yes ❑No
Have you fallen 2 or more times in **the past year**? ❑Yes ❑No Are you afraid of falling? ❑Yes ❑No
Are you able to handle the following activities without help?

Shopping for groceries or clothes :	❑Yes ❑No	Preparing your own meals:	❑Yes ❑No
Doing housework:	❑Yes ❑No	Handling your money:	❑Yes ❑No
Keeping track of medications:	❑Yes ❑No	Bathing or dressing:	❑Yes ❑No

HEALTHCARE WISHES:

Do you already have a healthcare proxy or living will? ❑Yes ❑No Are you willing to be an organ donor? ❑Yes ❑No
Most healthy patients would like to be treated aggressively (CPR, respirator, ICU, etc) if they had a potentially curable condition. If you had a condition that had no chance of recovery, would you wish to remain on life support? ❑Yes ❑ No ❑Not Sure
If you were unable to make your own healthcare decisions *(for instance, you were in a coma from a car accident)*, whom would you like us to ask about what your wishes would be? Please name one person and one alternate.
Name: _____Phone #: _____Relationship to You: _____

Name: _____Phone #: _____Relationship to You: _____

NAME: _____ **DATE:** _____

Please list any other physicians you are currently seeing:

Name of Physician **Location** **Reason**

_____

_____

ANNUAL HEALTH SCREENINGS:

PHQ-9 **Over the last 2 weeks, how often have you been bothered by any of the following problems?** ***(Please ✓the appropriate box)***	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off any problems listed above, 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? *(Please **circle** your answer)*	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

S: _____ Dx: _____

AUDIT-C Please **circle** your answers:	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times a month	2 - 3 times a week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day when you drink?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

S: _____ Dx: _____

PROGRESSIVE MEDICAL ASSOCIATES, PLLC
13220 Rosedale Hill Avenue
Huntersville, NC 28078

WHAT IS THE DIFFERENCE BETWEEN AN ANNUAL WELLNESS EXAM AND AN OFFICE VISIT?

We would like to clarify some common misunderstandings regarding when a visit is considered a preventative visit, an office visit, or both. Determining how to bill a visit is not an elective decision by the physician and must be made in compliance with government and commercial insurance billing regulations. Insurance companies sometimes request documentation of the visit and we must adhere to appropriate billing guidelines.

An **ANNUAL WELLNESS EXAM** (also known as a "preventative" or "wellness" visit) is a yearly visit for the sole purpose of preventative care which includes a review of your general well being, including a physical exam, discussions of risk factors, health screenings, assessments and counseling regarding alcohol, depression, obesity, cardiovascular risks, tobacco, etc, as well as recommendations for age appropriate immunizations and screenings such as colonoscopies and mammograms and screening lab work.

Most health plans will pay for one preventative visit, per year, with no deductible or co-pay. **Your plan may consider this to be once per calendar year OR one year and one day since the date of your last preventative exam.** If you have had any other visit billed as preventative during this time period (including a well-woman gynecologist visit), your plan is likely to deny your preventative exam. It is the patient's responsibility to check with their plan to ensure they are eligible prior to scheduling an annual preventative exam.

An **OFFICE VISIT** is an appointment to discuss new or existing problems. This may include addressing new symptoms or follow-ups for managing chronic conditions such as diabetes, hypertension, etc., prescribing medications, discussing treatment options, ordering additional tests such as an EKG or diagnostic labs and referrals to specialists. These items are **NOT** included in an annual wellness/preventative exam.

In the past and out of convenience to our patients, our office worked to offer the option to combine a patient's annual wellness exam with an office visit. However, insurance companies have made this combining of visit types extremely difficult as pertains to billing and payment for services rendered. Therefore, **our office will no longer offer the option to combine an annual wellness exam with any other kind of visit type or concern.** Should you need to address outstanding concerns, a separate appointment with your provider to allow for adequate time and attention is **required**.

LABS ORDERED AT ANNUAL PHYSICAL:

Generally, a few select "screening" labs are included in your preventative benefit. Previously, many insurance companies would allow additional labs to be processed as screening labs, when done with a preventative visit. However, many have begun to strictly apply the preventative guidelines, which may result in some of your labs having co-insurance or deductibles applied, depending on your plan.

There are too many health plans with different guidelines and exceptions for us to know with 100% certainty how each patient's benefits will be applied. Therefore, if you are concerned about receiving a lab bill, we can offer you the option of paying for your labs at a reduced self-pay charge, rather than billing your insurance company. The most commonly ordered labs for an annual wellness exam (CBC, CMP, Lipids and TSH) would cost $68.00, if you elect to self pay. **This cost is subject to change, annually.** If you choose this option, please let us know **prior** to having your labs drawn. **Once LabCorp submits the claim to your insurance company, we can no longer make changes.**

- ❑ Please check the box to acknowledge that you have been given a copy of our **NOTICE OF PRIVACY POLICIES**.
- ❑ Please check the box to acknowledge that you have been given a copy of our **INSURANCE INFORMATION & OFFICE POLICIES**.
- ❑ Please check the box to acknowledge that you have been given a copy of **ABOUT OUR PRACTICE** which describes our concierge practice model.

NUMBER TO LEAVE PRIVATE MEDICAL MESSAGES:

Please indicate whether we may leave voice mail messages that may contain private medical information *(such as lab or test results, medications, etc):*

❑ **YES, I agree to receive private medical messages at the following phone number: _____**

❑ **NO, do not leave voice mail messages containing private medical information.**

By my signature below (or the signature of my representative), I agree that I have read and understand the above notification and that I accept financial responsibility for any services deemed "patient responsibility" by my insurance company.

_____ _____

PRINTED NAME OF PATIENT **DATE**

_____

SIGNATURE OF PATIENT ***(or patient's representative)***