Progressive Medical Associates, PLLC
Medicare & Medicare 65+ New Patient

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, paid (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 of PATIENT: (*Patient or if patient is under the age of 18, must be signed by financially responsible party*)

Progressive Medical Associates, PLLC

Medicare & Medicare 65+ New Patient

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?

_____

_____

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NAME: _____ DATE: _____

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	___	___	_____

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NAME: _____ DATE: _____

HEALTH MAINTENANCE, Continued:

Have you ever had:	***Yes***	***No***	***If Yes, approximately when was the last time:***
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	___	___	_____
Bone Density	___	___	_____
Pap Smear	___	___	_____
Mammogram	___	___	_____

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

NAME: _____ DATE: _____

SOCIAL DETERMINANTS OF HEALTH

Personal Characteristics:

Have you been discharged from the Armed Forces of the United States?

Do you receive care from a VA clinic?

What is the name and address of the VA clinic you attend?

Name: Address:

State: City: Zip: Phone:

Do you need more assistance at home than you currently receive?

Family & Home:

What is your living situation today?

Money & Resources:

In the past year, have you or any family members you live with been unable to get any of the following, when you really needed them? Choose any that apply.

- ☐ Food/Groceries
- ☐ Housing
- ☐ Medications
- ☐ Money
- ☐ Transportation
- ☐ Healthcare/Treatment
- ☐ Other _____

In the past 2 months, did you or others you live with eat smaller meals or skip meals because you did not have money for food?

Are you confident using a computer, tablet, or phone for healthcare visits or finding information?

Has a lack of transportation kept you from medical appointments, meetings, work, or from getting items you need for daily living? If yes, please explain.

Do you feel physically and emotionally safe where you currently live?

Social Needs:

To help determine if you may be eligible for government-sponsored financial assistance programs, I need to ask about your income. Are you ok with this?	☐ Yes ☐ No
Is your monthly income less than $1500.00 per month ($2000.00 per married couple), including Social Security?	☐ Yes ☐ No
☐ Support Groups – Alzheimer's	
☐ Support Groups – Cancer	
☐ Respite Care	

NAME: _____ DATE: _____

FALLS RISK ASSESSMENT

Clinician to ask the following questions and check "Yes" or "No" accordingly:

☐ Reviewed, no change		
☐ Yes	☐ No	Have you fallen in the past year?
☐ Yes	☐ No	Do you use or have you been advised to use a cane or walker to get around safely?
☐ Yes	☐ No	Have you lost some feeling in your feet?
☐ Yes	☐ No	Do you feel unsteady when walking?
	Total	_____

1: If score is less than 3: Low Risk

- Document on AYPCP and advise patient to communicate with provider if fall risk worsens
- Provide Falls & Fractures education brochure
- No other assessment needed at this time

2: If score is 3 or 4: Moderate to High Risk

- Document on AYPCP and in the non-urgent collaboration section
- Provide member education
- Provide Falls & Fractures education brochure
- Call PCP if clinically indicated

3: If score is 5 or greater: High Risk

- Document on AYPCP and in the urgent referral section
- Provide member education
- Provide Falls & Fractures education brochure
- Call PCP **

☐ PCP not called

Reason:

** If patient is successfully using an assistive device, call to PCP is not required and is based on clinical judgment.

Education Topics: bone density screening, vision screening, medication review, physical therapy, exercise, home safety measures such as grab bars and tripping hazards, feet and footwear check.

NAME: _____ DATE: _____

COMPREHENSIVE PAIN ASSESSMENT

☐ Reviewed, no change		
☐ Unable to assess	**Reason:**	
☐ Pain?	☐ Yes	☐ No **(If you answered No, please skip the remaining questions)**

Type of Pain:

Acute Pain – Pain comes on quickly, can be severe, lasts a relatively short period of time	☐ **Yes**
Chronic Pain – Pain that extends beyond the expected period of healing, usually greater than 6 months	☐ **Yes**
Location(s) of Pain:	

Description of Pain:

On a scale of 0-10:

- ☐ 0 – No pain
- ☐ 1-3 – Mild pain
- ☐ 4-7 – Discomforting-Moderate pain
- ☐ 8-10 – Distressing, Intense, Unbearable – Severe pain

Pain Score:

Now: _____ At Best: _____ At Worst: _____ Pain Goal: _____

Pain Evaluation:

1. What makes your pain better? _____
2. What makes your pain worse? _____
3. How would you describe how much your pain has been relieved in the past week?
   _____
4. Is the amount of relief you are receiving high enough to make a real difference in your life?
   - ☐ Yes
   - ☐ No
5. Are you meeting your pain goals?
   - ☐ Yes
   - ☐ No

Practitioner Assessment of Pain:

- ☐ Controlled the best it can be
- ☐ Controlled with medications
- ☐ Controlled without medications
- ☐ Uncontrolled and needing further pain management evaluation

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	Extreme ly 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
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

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)***

Progressive Medical Associates, PLLC
13220 Rosedale Hill Ave.
Huntersville, NC 28078
Phone: 704-766-0320 Fax: 704-766-0407

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name of Patient (Last, First): _____ Date of Birth: _____

Social Security Number: _____

I hereby request that my Medical Records be released to my Primary Care provider as follows:

Progressive Medical Associates, PLLC
13220 Rosedale Hill Ave.
Huntersville, NC 28078
Phone: (704) 766-0320
Fax: (704) 766-0407

Information to be Disclosed:

□ Complete Medical Record

OR

□ Progress Notes
□ Mental Health Records
□ Diagnostic Records Pertaining to _____
□ Lab Results
□ X-ray Reports
□ Hospital Records of Admission for Dates: _____to_____
□ Other: _____

I understand:

- This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.
- Authorization for disclosures shall not condition treatment, payment, or eligibility for benefits. I may refuse to sign this authorization.

_____ _____
Signature of Patient Date

_____ _____
Printed Name of Patient Representative (If signed by someone other than the patient) Relationship of Patient Representative