# *Progressive Medical Associates, PLLC*
## PATIENT REGISTRATION INFORMATION

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

ADDRESS: _____CITY: _____ STATE: ____ ZIP _____

BIRTHDATE: ___/_____/_____ SSN: _____ 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): _____

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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: _____

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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 _____

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**NOTICE OF PRIVACY PRACTICES:**

❑ You were provided with a document entitled "Notice of Privacy Practices." It is required that all medical facilities provide you with this notice. Please check the box to acknowledge that you have read (or had the opportunity to read if you choose) and understand the notice. This is a copy of the notice that is yours to keep. If you do not want the copy, you may return it to the receptionist.

**INSURANCE INFORMATION & OFFICE POLICIES:**

❑ Please check the box to acknowledge that you have been given a copy of our insurance information & office policies.

*I understand my insurance coverage is a relationship between my insurance company and myself, and I agree to accept financial responsibility for charges incurred that are not reimbursed by my insurance company. I understand that I may be billed for "no-shows" or late cancellations. If I am signing on behalf of a patient under the age of 18, I understand that my financial responsibility will remain in force until I notify the practice in writing that I am no longer financially responsible.*

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? _____

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*** | ____ | ____ | _____ |
| ***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, substance abuse, 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*): _____

Do you have any concerns about, or 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 an organ donor? ❑Yes ❑No

Do you agree with the following statement? ❑Yes ❑No ❑Not Sure

> *If I had a readily reversible condition like a bad pneumonia, I would want to be placed on life support temporarily; however, I would not wish to remain on life support if I had no chance for a quality of life.*

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. You can also fill out a healthcare proxy form.

Name: _____Phone No: _____Relationship to You: _____

Name: _____Phone No: _____Relationship to You: _____

**HEALTH MAINTENANCE:**

| ***Have you ever had:*** | ***Yes*** | ***No*** | ***If Yes, date of last*** |
|---|---|---|---|
| Physical Exam | ___ | ___ | _____ |
| Cholesterol Checked | ___ | ___ | _____ |
| Colonoscopy/Sigmoidoscopy | ___ | ___ | _____ |
| Flu Shot | ___ | ___ | _____ |
| Pneumonia Shot | ___ | ___ | _____ |
| Tetanus Shot | ___ | ___ | _____ |
| MMR Shot (*Measles/Mumps/Rubella)* | ___ | ___ | _____ |
| Hepatitis Shot | ___ | ___ | _____ |
| Skin Test for TB (*PPD*) | ___ | ___ | _____ |
| Do you see a dentist at least once a year? | ___ | ____ | _____ |

| ***Female Patients:*** | ***Yes*** | ***No*** | ***Date of Last*** |
|---|---|---|---|
| Physician Breast Exam | ___ | ___ | _____ |
| Pap Smear | ___ | ___ | _____ |
| Mammogram | ___ | ___ | _____ |

| ***Male Patients:*** | ***Yes*** | ***No*** | ***Date of Last*** |
|---|---|---|---|
| Prostate Exam | ___ | ___ | _____ |
| PSA Blood Test | ___ | ___ | _____ |
| Testicular Exam | ___ | ___ | _____ |

**Name:** _____ **Date:** _____

**ANNUAL HEALTH SCREENINGS:**

| PHQ-9<br>**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 | Somewhat difficult | Very difficult | Extremely difficult |

S: _____ Dx: _____

| AUDIT-C<br>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? | 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
Phone: 704-766-0320 Fax: 704-766-0407

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient: _____ D.O.B. _____

Social Security Number: _____

I hereby request that my Medical Records be released to: Progressive Medical Associates, PLLC
13220 Rosedale Hill Avenue
Huntersville, NC 28078

Information to be disclosed:

□Complete Medical Records
□Progress Notes
□Diagnostic Records Pertaining to _____
□Lab Results
□X-ray Reports
□Hospital Records of Admission on _____
□ Other: _____

*I understand that I have the right to revoke this authorization at any time by sending a written notification to Progressive Medical Associates. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective immediately upon receipt of written notification by this Practice. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.*

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Name of Patient (or Representative) Relationship of Representative to Patient
*(if signed by someone other than the patient)*

*Progressive Medical Associates, PLLC*

## Authorization for Release of Information to Family and/or Friends

**Name of Patient:**_____**Date of Birth:**_____

*I authorize Progressive Medical Associates to release protected health information to the entities named below:*

**Give information to spouse/partner:** Yes No N/A

***Name of spouse/partner:*** _____

**Give information to the following family members or friends:**

| ***Name*** | ***Relationship*** | ***Phone Number*** |
|---|---|---|
| | | |
| | | |
| | | |

**Nature of information to be released to family/friends authorized above:**

***Financial/Billing:*** Yes No

***Medical Information:*** Yes No

**Please list any restrictions regarding information to be released:**_____

_____

*I understand that I have the right to revoke this authorization at any time by sending a written notification to Progressive Medical Associates. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective immediately upon receipt of written notification by this Practice. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditional on signing this authorization. This authorization shall be in force and effect until revoked by the patient or representatives signing the authorization.*

_____ _____

Signature of Patient or Representative Date

_____ _____

Print Name of Patient (or Representative) Relationship of Representative to Patient (*if signed by someone other than the patient)*

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

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**WHAT IS THE DIFFERENCE BETWEEN AN ANNUAL PHYSICAL 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 insurance billing regulations. Insurance companies sometimes request documentation of the visit and we must adhere to appropriate billing guidelines.

An **ANNUAL PHYSICAL** (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, 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. All of these things are not included in a an annual preventative exam.

We believe in treating the whole person and are happy to address any new concerns, follow-up on all chronic conditions, and refill your medications at the time of your annual preventative exam, which saves you time and eliminates the need for scheduling an extra appointment. However, please be aware that this is considered **combining** an office visit and a preventative visit and may result in billing for both, and you may have a co-pay and/or deductible responsibility for the portion of the visit that is not preventative. If there is not sufficient time to address both in one visit, the provider may decide to address any new problems and chronic conditions today and ask you to reschedule your preventative visit.

**LABS ORDERED AT ANNUAL PHYSICAL:** Generally, only a few select "screening" labs are included in the preventative benefit (such as cholesterol screening if you have never been diagnosed with high cholesterol). In the past, many insurance companies would still allow other 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 getting a lab bill, we can offer you the option of paying for your labs at a reduced self-pay price rather than billing them to your insurance company. Our lab, Lab Corp., offers us a discounted rate that we can pass on to you. The most common set of labs ordered at an annual preventative visit (CBC, CMP, Lipids, and TSH) would cost $29.00 if you elect to self pay (*please ask for complete price list*). **If you choose this option, please let us know prior to having your labs drawn. Once Lab Corp. submits the claim to your insurance company, we can no longer make changes.**

**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 financially responsible party)*** **PRINTED NAME OF REPRESENTATIVE**
***(if signed by someone other than patient)***