BLANKENSHIP FAMILY MEDICINE

Today is your well visit!

Please complete the attached documents to **reflect any changes in the past year.**

Please return the completed documents to the Receptionist.

If you would like a copy of any of the attached documents, please let us know.

Thank you!

BLANKENSHIP FAMILY MEDICINE
John David Blankenship, D.O. – 204 Lowe Ave SE, Suite 2, Huntsville, AL 35801
Office Phone: 256-534-7235 / Office Fax: 256-534-7268

Authorization to Release Protected Health Information

Date: _____

REGARDING YOUR CURRENT/PREVIOUS PATIENT: _____ **DOB:** _____

RELEASE INFORMATION FROM:
_____
_____
Phone: _____
Fax : _____

RELEASE INFORMATION TO:
BLANKENSHIP FAMILY MEDICINE
204 Lowe Ave SE, Suite 2, Huntsville, AL 35801
FAX: 256-534-7268

INFORMATION REQUESTING TO BE RELEASED: ANY AND ALL ☐

History & Physical ☐ EKG's ☐ Lab Reports ☐ Hospital Notes ☐ Immunization Records ☐
Pathology Reports ☐ Radiology ☐ Operative Reports ☐ Billing ☐ Clinic Notes/Encounters ☐

I understand the information to be released may include records related to behavior and/or mental healthcare, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form. If the patient is 18 years of age or older, the patient must sign and date the form. If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

☐ **Legal Guardian or Conservator** ☐ **Healthcare Agent (Healthcare Power of Attorney)**

If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under the state or federal law. Please indicate your relationship to the patient.

☐ **Parent** ☐ **Legal Guardian**

Signature (Required) _____ **Date Signed (Required)** _____

Printed Name of Person Signing _____ **Mailing Address** _____

JOHN DAVID BLANKENSHIP, D.O.

FAMILY PRACTICE

Patient: _____ DOB: _____ Date: _____

Anxiety Scale - GAD-7

Over the last TWO weeks, how often have you been bothered by the following problems?

QUESTION	Not At All	Several Days	More Than Half The Days	Nearly Every Day
Feeling nervous, anxious or on edge.	0 ☐	1 ☐	2 ☐	3 ☐
Not being able to stop or control worrying.	0 ☐	1 ☐	2 ☐	3 ☐
Worrying too much about different things.	0 ☐	1 ☐	2 ☐	3 ☐
Trouble relaxing.	0 ☐	1 ☐	2 ☐	3 ☐
Being so restless that it is hard to sit still.	0 ☐	1 ☐	2 ☐	3 ☐
Becoming easily annoyed or irritable.	0 ☐	1 ☐	2 ☐	3 ☐
Feeling afraid as if something awful might happen.	0 ☐	1 ☐	2 ☐	3 ☐
TOTAL SCORE*	0 ☐	1 ☐	2 ☐	3 ☐

***Score: 5-9 = mild anxiety; 10-14 = moderate anxiety; 15-21 = severe anxiety**

If you checked off any problems, 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?

Circle One	Not Difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

American Medical Association

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

PHQ-9
Depression Questionnaire

Over the last TWO weeks, how often have you been bothered by the following problems?				
QUESTIONS	**Not At All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
Little interest or pleasure in doing things.	0 ☐	1 ☐	2 ☐	3 ☐
Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
Trouble falling or staying asleep or sleeping too much.	0 ☐	1 ☐	2 ☐	3 ☐
Feeling tired or having little energy.	0 ☐	1 ☐	2 ☐	3 ☐
Poor appetite or overeating.	0 ☐	1 ☐	2 ☐	3 ☐
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	0 ☐	1 ☐	2 ☐	3 ☐
Trouble concentrating on things, such as reading the newspaper or watching television.	0 ☐	1 ☐	2 ☐	3 ☐
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.	0 ☐	1 ☐	2 ☐	3 ☐
Thoughts that you would be better off dead or of hurting yourself in some way.	0 ☐	1 ☐	2 ☐	3 ☐
TOTAL SCORE	_____ +	_____+	_____+	_____+

American Medical Association

PHQ9 **0-9 Normal** **10-19 Mild Depressive** **20-30 Severe Depressive**

LIFESTYLE PREVENTATIVE HEALTH

QUESTION	ANSWER
How many hours of sleep do you get per night?	
How often do you exercise per week?	
What is the duration of time?	
What type of exercise?	
What type of foods do you regularly eat? (i.e. low carb, plant-based, KETO, Mediterranean, or other)	
What do you do for your mental health, stress, and anxiety prevention? (i.e., exercise, yoga, counseling, meditation, prayer, other)	
How much water do you drink a day?	
If comfortable, describe any religious faith you may have, (Christian, Jewish, Muslim, atheist, non-religious, other, etc).	

If additional space is needed, please provide a separate list.

SOCIAL HISTORY

(Please answer each question, even if the answer is "0", "No", or "None")

Marital Status	Number of Children	Pets	
Are You a Current Smoker	Number of Packs Per Day	Are You a Previous Smoker	When Did You Start/Quit
Other Tobacco Products	What Kind of Tobacco	Amount Per Day	When Did You Start/Quit
Do You Drink Alcohol	How Often and How Much	Do You Use Recreational Drugs	What Type of Drugs

Permission to Discuss My Medical Concerns

John David Blankenship, D.O., LLC, or his affiliates can discuss my medical information or needs with the following individuals:

_____ _____ _____

Name ` Relationship Phone #

_____ _____ _____

Name Relationship Phone #

_____ _____

Signature of Patient or Representative Date

YES ☐ NO ☐

I give Blankenship Family Medicine and its affiliates permission to leave voicemail messages on any phone number listed within your New Patient Packet Paperwork regarding appointments, medication refills, or any other medical information.

YES ☐ NO ☐

I only want a voicemail message requesting to return your phone call. (No other information will be provided).

John David Blankenship, D.O.
Family Practice

Name: _____ DOB: _____ Date: _____

TESTING		
TEST	**YEAR**	**N/A**
AAA Screen		
Bone Density		
Fasting Cholesterol Panel		
Colonoscopy		
Cologuard		
Fasting Glucose		
Heart Cath		
Lung CT		
Men: PSA		
Stress Test		
Upper Endoscopy		
Women: Pap Smear		
Women: Mammogram		

IMMUNIZATIONS		
VACCINE	**YEAR**	**UNKNOWN**
FLU		
HEP B		
PNEUMONIA		
TETANUS		
WHOOPING COUGH		
SHINGLES		

BIRTHS	
Pregnancies	
Term	
Preterm	
Miscarriage	
Termination	
Living	
Menopause	

DIABETIC SUPPLIES

Do you require any diabetic supplies? (i.e., strips, needles, etc.):

YES ☐ **NO** ☐

If YES, please indicate what you need here:

_____

_____

_____

_____

SURGERIES			
ABG		Aortic Aneurysm	
Appendectomy		Breast Augment	
Breast Reduction		C-Section	
Carotid Endarterectomy		Cataract Extract	
Colectomy		Ectopic Pregnancy	
ESWL		Partial Hysterectomy	
Hysterectomy		Gallbladder	
Gastric Banding		Heart Valve	
Hernia		Hip – R L BIL	
Hip Fracture – R L BIL		Intestinal By-Pass	
Knee Arthroscopy – R L BIL		Knee Replacement - R L BIL	
Knee Surgery - R L BIL		Shoulder – R L BIL	
LS Spine Surgery		Mastectomy	
Oophorectomy		Pacemaker	
Prostatectomy		PTCA	
Lasik		Sinusectomy	
Splenectomy		Thyroidectomy	
Tonsillectomy		Tubal Ligation	
Vasectomy		No Surgeries	

John David Blankenship, D.O.
Family Practice

Name: _____ DOB: _____ Date: _____

Preferred Pharmacy:_____ Phone:_____
Location:_____

Marital Status: Never Married: ☐ Married: ☐ Widowed: ☐ Divorced: ☐
Name of your Spouse: _____ Cell Phone #: _____
Spouses Employer: _____ Employer Phone #: _____
Emergency Contact: _____ Cell Phone #: _____
What is their relationship to you? _____
Primary Insurance: _____ Policy #: _____
Secondary Insurance: _____ Policy #: _____

Patient Rights & Responsibilities

You and your family are our number one concern during your visit with us. The following statement of your Rights and Responsibilities is presented as the policy of this facility but does not presume to be a complete representation of all-mutual rights and responsibilities.

____ **YOU HAVE THE RIGHT TO:**
Initial

- Receive considerate, respectful care, which always recognizes your personal dignity, under all circumstances.
- Participate in decisions involving your care. Except in an emergency, you shall not be subjected to any procedure without your voluntary, competent, and understanding consent or the consent of your legally authorized representative.
- Refuse treatment to the extent permitted by law and be informed of the consequences of that refusal.
- Information about Advance Directives, such as a Living Will or Durable Power of Attorney for Health Care, that would allow you to make your own healthcare decisions for the future and to have your chosen representative exercise these rights for you if you are not able to do so.
- Instructional and educational information about your medical treatment in a language and terms that you understand.
- The confidential treatment of and personal access to your medical record.
- Know who is responsible for providing your direct care and receive information concerning your continuing healthcare needs and alternatives for meeting those needs.
- Have access to interpreter services, free of charge, to the patient.

___ **YOU HAVE THE RESPONSIBILITY TO:**
Initial

- Give Dr. Blankenship and the staff of Blankenship Family Medicine complete and accurate information about your condition and your care.
- Follow the instructions of Dr. Blankenship and the staff of Blankenship Family Medicine and keep appointments relative to your care.
- Make it known whether you clearly understand planned actions and treatment and what is expected of you.
- Accept responsibility for his/her actions should he/her refuse treatment or not follow Dr. Blankenship's orders.
- Report unexpected changes in your condition to Dr. Blankenship and the staff of Blankenship Family Medicine.
- Know your health insurance guidelines and accept any financial obligations associated with your care.
- Be considerate of other patients in the waiting area. Be considerate of Dr. Blankenship and his staff.
- Follow the policies and procedures of our Practice Information for Patients.
- Bring a current copy of any Advance Directives to be scanned in your medical chart.
- Notify Blankenship Family Medicine of a request for interpreter services required.

John David Blankenship, D.O.
Family Practice

Name: _____ DOB: _____ Date: _____

- Arrive for your scheduled appointment on time. Call reminders are a courtesy and are completed by a third party. We have no control over their system and if they experience any downtime or service interruptions. It is your responsibility to know the date and time of your scheduled appointments and to arrive on time for your scheduled appointments.

Practice Information for Patients

Welcome to the family practice of John David Blankenship, D.O. We are truly honored and grateful that you have chosen to trust us with your medical care. Blankenship Family Medicine was established to provide individualized care for families.

Dr. Blankenship was raised in Huntsville, AL. However, he has lived in various locations since leaving for college in Nashville in 1988. He graduated from Kirksville College of Osteopathic Medicine in 1997 and finished his Family Practice Residency in Montgomery, AL in 2001. After eight years in a family practice group in Corbin, Kentucky, he moved his family back to Huntsville in 2009. He spent three years working in emergency medicine and urgent care clinics in North Alabama. His experiences motivated him to open a family practice that combines the best of modern technology with a comprehensive, individualized approach to care in July 2012. By putting relationships at the forefront of the healthcare experience, BFM strives to produce high-quality integrative healthcare with measurable results and improved patient satisfaction. In order to provide this type of healthcare, it is essential that the practice limits cost, maintains a manageable volume of patients, and empowers patients to participate in all aspects of their healthcare.

APPOINTMENTS:

_____ Initial — It is important that you bring all your medicine bottles with you to each visit. All refills of daily medications should be handled at your visit. Please make your appointments 2 weeks prior to running out of your medications.

_____ Initial — To remain a patient at BFM, you must have an annual well visit at our office. Most insurances will pay for a yearly well visit, however, we encourage you to check with your insurance. Each insurance company has the right to deny services at any time, leaving the financial responsibility to the patient.

_____ Initial — Payment – Your co-pay or self-pay payments are expected at the time of your visit. For patients without insurance, you are considered a "Self-Pay" patient, and your office visit fee is $150.00 for each visit, plus any additional charges.

_____ Initial — For sickness or urgent complaints – We will try to see patients within 24 hours.

_____ Initial — Telemedicine – Will be performed phone visits when necessary, and standard co-payments will be required. It is your responsibility to verify with your insurance company regarding telemedicine coverage. You are financially responsible for any charges your insurance company does not cover. Self-pay patients will be charged $150.00 for telemedicine visits.

_____ Initial — Routine Visits for Chronic Problems – Are scheduled in a 3-6 month window.

_____ Initial — Cancelation/No Show – Please provide at least a 24-hour notice if you need to cancel your appointment. Failure to do so will results in a $35.00 fee. We have a 24/7 answering service that you can call and cancel your appointment.

_____ Initial — Please Be On Time – When an appointment is made for you, that slot is reserved for your health care. Being on time is crucial for the courtesy of our other patients and for Dr. Blankenship and his staff. If you are 15 minutes late for your scheduled appointment, we will ask that you reschedule. You will incur a $35.00 fee for a missed visit which will need to be paid prior to rescheduling your appointment.

_____ Initial — Please Silence Your Cell Phones – If you need to make or receive a call, please step outside for the courtesy of our other patients and the staff. Please do not partake in cell phone conversation, or speak on your speaker function, in the lobby, lab, exam rooms, or restrooms while you are in the clinic.

John David Blankenship, D.O.
Family Practice

Name: _____ DOB: _____ Date: _____

OFFICE HOURS: _____ Our Office Hours are as follows: (We are CLOSED for lunch daily from 12:00-1:00)
Initial Monday – 8:00 am – 5:00 pm
Tuesday – 9:00 am – 12:00 pm (The second Tuesday of every month we are closed.)
Wednesday – 8:00 am – 5:00 pm
Thursday – 8:00 am – 5:00 pm
Friday – 8:00 am – 5:00 pm

MEDICINE POLICY: _____
Initial
If possible, generic medicines will be prescribed. Medications that require prior authorization or higher co-pays will be avoided. unless they are deemed necessary for your well-being.

If a medication needs to be changed for any reason, (i.e., a cost increase, insurance change, pharmacy transfer, etc.), an appointment will be required.

Your medication refills should be requested at your office visit. You will need to schedule an appointment to receive a refill(s) of your medication. Please do not wait until you are out of medication to contact us. Phone calls will be returned within a 24-hour period.

Dr. Blankenship will not call-in antibiotics, pain, sleep medications or refills of routine medications after our normal daily business hours.

FORMS: _____
Initial
Please advise us if you are bringing a form to be filled out prior to your appointment. Please bring all forms that need to be completed by Dr. Blankenship, preferably before your appointment. Fees for forms vary from $50.00 - $150.00. This includes, but is not limited to, short-term disability, life insurance, insurance applications, sports physical, college physicals, FMLA, subpoenas for lawsuits, free medicine applications, auto insurance, etc. Please contact the office for specific charges.

PATIENT PORTAL: _____
Initial
Take control of your health information with our Patient Portal. The Patient Portal allows us to communicate more effectively with our patients. To set up your Patient Portal, we will provide you with a temporary username and password. Please go to www.yourhealthfile.com to begin setting up your Patient Portal. Your Patient Portal allows you to have access to your important medical information such as, lab results, test results, appointment date/time, etc. New Patients will be sent a Registration Link to set up your Patient Portal. Please contact us if you do not have a computer or internet access and we will provide you with the necessary paperwork to be completed.

SOCIAL MEDIA: _____
Initial
For the privacy of all our patients and staff, please do not take any photos while in the clinic and post them on any social media platform.

Please follow us and like us on Facebook: Blankenship Family Medicine.

Our website is always open! Please visit our website for current information and important notifications: www.blankenshipfamilymedicine.com.