Total Health Center

Internist and Medical Consultant
Conventional and Alternative Therapies

Oscar Ordonez, MD
Curtis Bow, ANP-BC

Dear patient,

Welcome to Total Health Center. Thank you for choosing us for your primary care. We're pleased to serve you.

Please fill out the new patient packet included with this letter. You can return your completed packet to us by mailing or dropping it off at the office located at 5091 East Jackson Street, Muncie, Indiana 47303.

Be sure to let us know if you have an urgent need. We'll schedule your appointment as soon as we can.

Please bring these items to your first appointment:

- Photo ID
- Insurance cards
- Prescription drug bottles or Pharmacy printed list
- Vitamins or over-the-counter medicines you may be taking
- List of any previous medical procedures, labs, etc, if possible

Please arrive 30 minutes before your appointment. to complete additional paperwork.

We're here to serve you.

- Regular business hours:
  - 12 p.m.–5 p.m., Tuesday
  - 8 a.m.–4 p.m., Wednesday to Friday

Questions?
Please call our staff at 1-765-468-6337. We look forward to seeing you soon.

Sincerely,

The Staff of Total Health Center

Total Health Center

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New patient information form Date: _____

Who was your last doctor?_____ When was your last visit?_____

Why are you changing?_____ Where was your last doctor? _____

Patient information			
Last name, first name and middle initial:	Sex:	Date of birth:	Full social security number:
Address:		City, State, ZIP:	
Home phone:	Work phone:		Mobile phone:
Email address:		Would you like to be able to email the office? [ ] Yes [ ] No	
Emergency contact person and relationship to you:		Contact phone:	
Employer: _____ Are you a student? [ ] Yes If yes, school name:			
Responsible party information (if different from above)			
Name:	Sex:	Date of birth:	
Address:		City, state, ZIP:	
Home phone:	Work phone:		Mobile phone:
Relationship to patient:		Employer:	
Primary insurance			
Company name:	Policy number:		Group number:
Subscriber name:	Date of birth:		Relationship to patient:
Secondary insurance (if any)			
Company name:	Policy number:		Group number:
Subscriber name:	Date of birth:		Relationship to patient:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION AND CONSENT FOR TREATMENT:

I hereby authorize payment directly to the Physicians of the medical benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment necessary to process any fees incurred in an attempt to collect amounts I may owe.

The signature below gives consent for medical treatment for the above patient. In the case of a minor, the signature is that of a parent or legal guardian.

_____ _____ _____

Printed Name **Patient Signature** **Date**

Health history questions

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For office use only:
Date and time of appointment: _____
Doctor: _____

Patient name: _____ Date: _____

Date of birth: _____

We'll keep all information given in this document private. It will become part of your medical record.

Please check all that apply to you:

- ☐ I have an urgent need. Details: _____
- ☐ I would like to be seen in the next 30 days.
- ☐ I would like to be seen for Primary Care.
- ☐ I would like to be seen for Weight Management.
- ☐ I would like to be seen for Hormone Replacement Therapies.
- ☐ I would like to be seen for Infusion Therapies.

Please list any family members or friends who are Total Health Center patients now:

_____

What health conditions do you have now or have you had in the past?

1)	5)
2)	6)
3)	7)
4)	8)

What medicines do you take? (Use another sheet, if needed.):

Name:	***Strength:***	***How often you take it:***
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

What pharmacy do you use?_____ Location:_____

FOR INTERNAL USE ONLY

Approved: _____
(date)
Declined: _____
(date)

Inspect Controlled Substance

Completed by: _____
Date:_____
Notes:

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Authorization to Release Medical Records

(This form can be used if another healthcare provider requires written pateint authorization to obtain patient records needed by Total Health Center)

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO TOTAL HEALTH CENTER

I. RECORDS TO BE RELEASED FROM:

Name of HealthCare Provider: _____

Address: _____
Street City State Zip

II. RECORDS TO BE RELEASED TO:

I hereby request and authorize the above named Healthcare Provider **to release my records to:**

Doctor_____ of Total Health Center located at address:

_____
Street City State Zip

Telephone #_____ Fax#_____

III. THE RECORDS OF (Patient name):

Last _____First_____MI_____

Date of Birth: _____ **ONLY LAST FOUR (4) DIGITS OF SS#:**_____

Address: _____
Street City State Zip

Telephone #: _____Fax#: _____

IV. RECORDS TO BE RELEASED:

a) Please release the following information (check those that apply):

☐	Provider notes	☐	X-ray reports
☐	Special Diagnostic test results	☐	Chemical/Alcohol Treatment records
☐	Lab reports	☐	**ALL Medical Records**
☐	Billing records	☐	Other (specify)

b) **Unless I HAVE LIMITED BELOW**, I understand that this **also** pertains to records regarding testing and treatment **for alcohol/substance abuse**, **human immunodeficiency virus (HIV) and/or AIDS**, and for **psychiatric treatment or counseling or communicable disease.**

c) **Limitations**: Confine to **summary information** from records regarding treatment for the following condition or injury: _____On or about (date(s) _____

d) **Other**: _____

I UNDERSTAND (1) Totall Health Center will not condition treatment, payment, enrollment, or eligibility for benefits on this whether you sign this authorization.(2) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT, AS DESCRIBED IN THE AHN PRIVACY NOTICE. (3) THAT THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, (4) THAT THE RECIPIENT OF THESE RECORDS MAY FURTHER DISCLOSE INFORMATION BECAUSE OF THIS AUTHORIZATION AND THEN IT MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT AHN WOULD NOT BE RESPONSIBLE FOR THIS ACTION, and (5) I AM ENTITLED TO ASK FOR AND RECEIVE A COPY OF THIS DOCUMENT.

Date _____ Patient Signature_____

Expiration (if none, at 60 days): _____ Signature if other than patient: _____
(Parent/Guardian/Legal Representative, if patient unable to sign- Relationship)

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Agreement of Financial Responsibility

Thank you for choosing Total Health Center as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- In the event that your insurance is not valid or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full amount of your office visit and/or any procedures rendered.
- In addition, if you're insurance plan determines a service or procedure to be "not covered", you will be responsible for the complete charge of such services.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

X_____ _____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

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Cancellation and No-Show Policy

Thank you for choosing our practice to assist you with your care. We appreciate your trust and are committed to providing you with high quality, compassionate care.

We value our patients and tailor their treatment plans according to their unique needs, in doing so, we allocate time for each appointment accordingly. We realize that circumstances may occur beyond your control that may not allow you to provide 24 hour notification. Failure of a patient to notify the office to cancel or change their appointment without 24 hour notice is considered a “No-Show”. To help remind patients of their appointments we have implemented an automated reminder system. Please assure we have your correct and most up to date phone numbers or email addres at all times throughout the course of your treatment to allow us to better serve you.

The “No-Show” appointments will be documented in the patient record.
Charges for appointment no shows are as follows:

- Office Visit $25.00

If there are two no-call/no-show appointments, you will be dismissed from our practice.

This letter will serve as notice about the office Cancellation and No-Show Policy, and by signing, I acknowledge that I have read and understand the policy.

X_____ _____

Signature of Patient or Parent, if a minor *Date*

**Apointment Confirmation Preference: Call: ☐ Text: ☐

We do send out ***courtesy*** appointment reminders. However, it is the patients responsibility to keep track of all appointments.

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Controlled Substance Contract

The following are expectations that you as a patient/caregiver are to be informed of and agree to comply with. Once signed, you as a patient/caregiver acknowledge understanding of these policies and are aware that any violation of these policies may result in discharge from our practice.

- **The patient agrees to provide a current and correct phone number and address.**
  - **If we are unable to contact you because we do not have your correct address or phone number, you may be dismissed.**
  - **If your voicemail is not set up or full, and we cannot reach you, you may be dismissed.**
- Patient agrees to take medication as prescribed. If you run out of your medications you may be dismissed.
- **The patient will be subject to random urine drug screens and pill counts at least once a year. Urine drug screens may be observed at Total Health Center discretion. Failure to comply with urine drug screen or pill count is automatic dismissal.**
- Any event related to controlled substances that results in the arrest of the patient will result in dismissal.
- Dosage reductions and alternative methods of pain relief will be trialled at Total Health Center discretion according to insurance and federal guidelines. The CDC guidelines for prescribing opioid's recommends less than 50 MME's per day. Patients may be referred to a pain specialist for pain requiring doses over the CDC guidelines.
- Patient who are receiving prescriptions for controlled substances are required to see a licensed behavioral addictions counselor per federal guidelines.
  - It is the patient's responsibility to schedule an appointment with a licensed addictions counselor and provide documentation that this requirement has been met. Failure to comply will result in prescriptions being held or dismissal.
- Receiving prescriptions for controlled substances from other healthcare providers without Total Health Center knowledge will result in dismissal.
- **Prescriptions that are lost, stolen, or destroyed will not be replaced regardless of the circumstances.**
- **Patient agrees to meet all financial obligations associated with treatment. Failure to meet payment obligations will result in holding prescriptions. Appointments will not be scheduled until account is paid in full.**
- Patient agrees to keep scheduled appointments. Missed appointments will be rescheduled at the office's discretion.
- One prior authorization will be completed by our staff once a year for a controlled substance. Be prepared and make arrangements for paying out of pocket if the prior authorization is denied. Insurance companies are requiring documentation of alternate treatments for pain control as well as physical therapy, injections, exercise programs and dose reduction programs.
- Insurance companies, pharmacies and federal guidelines prohibit the prescribing of opioids and benzodiazepines together.
- **Total Health Center will not prescribe controlled substances for patient who have accidental or intentional drug overdose. For patient safety, Narcan (Naloxone) will be prescribed and expected to be filled and obtained by the patient.**
- We will send your prescription to the pharmacy of your choice. **Total Health Center will not send the prescription to a different pharmacy once it has been sent the first time.**
  - **Plan ahead: *If your pharmacy is out of your medication, we will not send the order to another pharmacy.***
  - ***The Drug Enforcement Agency (DEA) has greatly decreased the availability of prescription pain medications due to the high number of overdoses.***
  - ***Some manufactures have stopped the production of pain medications.***
  - ***There is a global shortage of ingredients used to make medications.***

I have read the controlled substance contract contained above, and my signature below serves as acknowledgement of a clear understanding of my responsibility.

_____	X_____	_____
Printed Name of Patient / Minor	*Signature of Patient or Parent, if a minor*	*Date*

EXPECTATIONS OF PATIENT / CAREGIVER

The following statements are expectations that we as a practice would like you to be informed. Once signed, you as a patient/caregiver acknowledge understanding of these policies and are aware that any violation of these policies may result in discharge from our practice.

a. I understand that opiates are not generally prescribed on the initial consultation.

initials_____

b. I understand that the medications I may receive from this practice are provided for their therapeutic value; however, they may have serious side effects. These side effects may be accentuated by the concurrent use of other medications and/or alcohol. It is unsafe to combine any medications and/or alcohol without first consulting with my physician. I also understand that I will need to take steps to prevent any pregnancy while on these medications due to the potential impact on the fetus.

initials_____

c. I understand that any medication that I receive from this practice may affect my ability to operate a motor vehicle, boat, or heavy machinery. I am accountable for determining whether my ability to do these things is impaired. I will be solely accountable for my decision regarding this as outlined under Indiana State Law, Title 9, Chapter 30, Article 5, Section 1: “A person who operates a vehicle with a controlled substance listed in schedule I or II of IC 35-48-2 or its metabolite in the person's blood commits a Class C misdemeanor” In Indiana, this may be grounds for prosecution of a Driving While Intoxicated (DWI) offense.

initials_____

d. I am expected to be respectful of the physicians and staff, and I understand that inappropriate behavior will not be tolerated and may result in my dismissal from Total Health Center.

initials_____

x_____ _____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

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HEALTH AND PAIN HISTORY FORM

Patient Name: _____ **DOB**:_____

Pharmacy:_____**Cross Streets**:_____

☐ Male ☐ Female ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

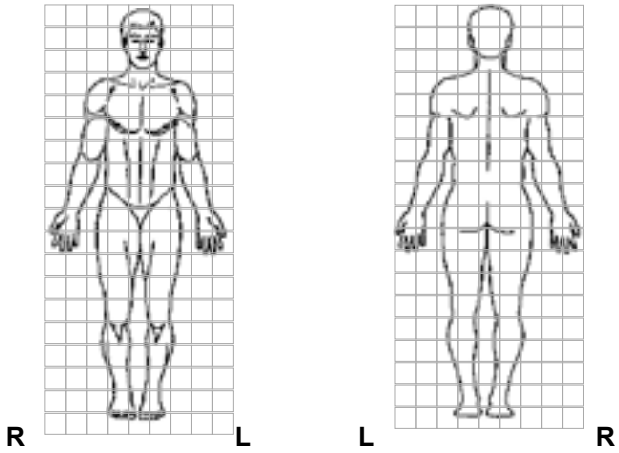
History of Problem (for which you are being seen):

Reason for visit: _____
By whom were you referred to our practice?_____
Expectations from treatment:_____
Type of injury: ☐ Job Accident ☐ Sports Injury ☐ Other: _____
Car accident: ☐ Driver ☐ Passenger Seatbelt: ☐ Yes ☐ No Airbag: ☐ Yes ☐ No
Date injury/symptoms started: _____
Do you have cancer? ☐ Yes ☐ No If Yes, Cancer Type: _____
Stage of cancer: _____

How would you describe your mood in a word or two?_____

On the diagram below, shade the areas where you feel pain. **Put an "x" where it hurts the most**;
Check all terms that apply:

☐ Aching ☐ Mild
☐ Burning ☐ Moderate
☐ Stabbing ☐ Severe
☐ Shooting ☐ Unbearable
☐ Constant ☐ Numbness
☐ Transient ☐ Tingling
☐ Sharp
☐ Dull



1. What number best describes your **pain on average** in the past week**?**

No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

2. What number best describes your **pain at its least**?

No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

3. What number best describes your **pain at its worst**?

No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

What makes pain **worse**: _____

What makes pain **better**: _____

Time of the day when pain is worse:_____

Do you have the following:

Weakness in your:	☐	Arms	☐	right	☐	left	☐	Legs	☐	right	☐ left
Numbness in your:	☐	Arms	☐	right	☐	left	☐	Legs	☐	right	☐ left

New or recurrent problems with bowel or bladder control? ☐ Yes ☐ No

Change in pain with cough/sneeze/bowel movements? ☐ Yes ☐ No

Medication History Indicate what you have used ***for your current pain condition:***

Do you have a history of the following with regards to Opiates/Narcotics:

Side-effect? ☐ Yes ☐ No explain:_____

Adverse reaction? ☐ Yes ☐ No explain:_____

Overdose? ☐ Yes ☐ No explain:_____

If you have tried any of the listed medications, please indicate whether it helped with your pain or not by checking the appropriate box. If you have not tried an agent, check "never tried"

Narcotics/Opiates Did it help?	Yes/No	Never tried
Butrans Patch	☐☐	☐
Codeine (Tylenol #3)	☐☐	☐
Fentanyl Patch (Duragesic)	☐☐	☐
Hydrocodone (Vicodin)	☐☐	☐
Hydromorphone (Dilaudid)	☐☐	☐
Methadone	☐☐	☐
Morphine (Kadian, MS Contin)	☐☐	☐
Nucynta	☐☐	☐
Oxycodone (Percocet)	☐☐	☐
Oxycontin (Xtampza)	☐☐	☐
Oxymorphone (Opana)	☐☐	☐
Tramadol (Ultram)	☐☐	☐

Other:_____

Anti-Inflammatory Did it help?	Yes/No	Never tried
Acetaminophen (Tylenol)	☐☐	☐
Aspirin	☐☐	☐
Celecoxib (Celebrex)	☐☐	☐
Diclofenac (Voltaren)	☐☐	☐
Etodolac (Lodine)	☐☐	☐
Ibuprofen (Advil, Motrin)	☐☐	☐
Indomethacin	☐☐	☐
Meloxicam (Mobic)	☐☐	☐
Nabumetone (Relafin)	☐☐	☐
Naproxen (Aleve)	☐☐	☐

Other:_____

Muscle Relaxants Did it help?	Yes/No	Never tried
Baclofen	☐☐	☐
Carisoprodol (Soma)	☐☐	☐
Chlorzoxazone (Lorzone)	☐☐	☐
Cyclobenzaprine (Flexeril)	☐☐	☐
Metaxalone (Skelaxin)	☐☐	☐
Methocarbamol (Robaxin)	☐☐	☐
Tizanidine (Zanaflex)	☐☐	☐

Other:_____

Antineuropathics: Did it help?	Yes/No	Never tried
Amitriptyline	☐☐	☐
Duloxetine (Cymbalta)	☐☐	☐
Gabapentin (Neurontin)	☐☐	☐
Milnacipran (Savella)	☐☐	☐
Nortriptyline	☐☐	☐
Pregabalin (Lyrica)	☐☐	☐
Topiramate (Topamax)	☐☐	☐

Other:_____

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Treatment History (for your current pain condition)

If you have tried any of the listed treatments, please indicate whether it helped with your pain or not by checking the appropriate box. If you have not tried an agent, check "never tried"

Treatment

Did it help?	Yes/No	Never tried		Yes/No	Never tried
Physical Therapy	☐☐	☐	Facet Block/ Medial Branch Block	☐☐	☐
Chiropractic	☐☐	☐	Epidural Steriod Injection	☐☐	☐
TENS Unit	☐☐	☐	Radiofrequency Ablation	☐☐	☐
Acupuncture	☐☐	☐	Spinal Cord Stimulator	☐☐	☐
Trigger Point Injection	☐☐	☐	Psychiatric/Psychological Care	☐☐	☐
Joint injections	☐☐	☐	Other:_____		

***Name of prior Pain Physican(s)*:_____ *Phone:*_____**

Do you currently have a Pacemaker or an AICD? Yes ☐ No ☐

Are you currently taking Anticoagulants/Blood Thinners? Yes ☐ No ☐

If yes, what type?

☐ Warfarin/Coumadin	☐ Aspirin	☐ Lovenox	☐ Pacemaker/AICD
☐ Plavix	☐ Eliquis	☐ Heparin	☐ Other_____
☐ Pradaxa	☐ Arixta	☐ Herbals (Garlic, Ginko, Ginseng, Vitamin E)	

What doctor manages the blood thinner?_____

Why are you taking a blood thinner?_____

Current Medications (Include vitamins, antacids, birth control, etc. – **attach list if necessary**):

	Name:	Dose:	How often:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

Diagnostic Studies:

X-Ray	☐Yes ☐No	MRI Scan	☐Yes ☐ No
CT Scans	☐Yes ☐No	Bone Scan	☐Yes ☐ No
EMG	☐Yes ☐No	Other _____	

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Past Medical History (check all that apply)

Cardiac

- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Rheumatic Fever
- ☐ Angina
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Vascular Disease
- ☐ Pacemaker
- ☐ Blood Thinners
- ☐ Valvular Disease

Pulmonary

- ☐ Pneumonia
- ☐ Emphysema
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Bronchial Disease
- ☐ Tobacco

Renal

- ☐ Dialysis
- ☐ Renal Insufficiency
- ☐ Kidney Stone
- ☐ Prostate Problems

Neurological

- ☐ Stroke
- ☐ Transient Ischemic Attack
- ☐ Seizures
- ☐ Nerve Damage

Infectious

- ☐ Valley Fever
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Polio

Hepatic

- ☐ Jaundice
- ☐ Cirrhosis
- ☐ Hepatitis
- ☐ Gall Bladder

Gastrointestinal

- ☐ Hiatal Hernia
- ☐ GERD
- ☐ Gastric Ulcers
- ☐ Colitis

Endocrine

- ☐ Thyroid Disease
- ☐ Parathyroid Disease
- ☐ Diabetes Mellitus

Psychological

- ☐ Depression
- ☐ Bipolar
- ☐ Addiction
- ☐ Schizophrenia

General

- ☐ Anemia/Bleeding
- ☐ Arthritis
- ☐ Obesity
- ☐ Alcoholism

Allergies to Medications: ☐ Yes ☐ No (if yes, indicate below drug and reaction)

Drug	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical History (be as specific as possible, including surgery type and year of surgery):

	Date	Surgery		Date	Surgery
1.	_____	_____	4.	_____	_____
2.	_____	_____	5.	_____	_____
3.	_____	_____	6.	_____	_____

Serious Injury (list injuries you have sustained)

Date	**Injury**
_____	_____
_____	_____
_____	_____

Family History (Mark all appropriate diagnosis as they pertain to your family members only)**:**

	Diabetes	Hypertension	Heart Disease	Neurological	Psychiatric	Cancer
Father	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐	☐	☐
Son(s)	☐	☐	☐	☐	☐	☐
Daughter(s)	☐	☐	☐	☐	☐	☐
Paternal Grandfather	☐	☐	☐	☐	☐	☐
Paternal Grandmother	☐	☐	☐	☐	☐	☐
Maternal Grandfather	☐	☐	☐	☐	☐	☐
Maternal Grandmother	☐	☐	☐	☐	☐	☐

☐ I Have No Significant Family Medical History

☐ I Am Adopted (No Medical History Available)

Social History:

Are you currently working? ☐ Yes ☐ No ☐ Part-time ☐ Full-time

Occupation: _____

Education: ☐ Elementary ☐ High school ☐ College ☐ Graduate school

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other

Children: ☐ Yes ☐ No If yes, how many? _____

Do you have any lawsuits pending? ☐ Yes ☐ No

Are you on disability? ☐ Yes ☐ No

Workmen's Comp? ☐ Yes ☐ No

Do you use illicit substances? ☐ Yes ☐ No

*If yes, please describe: _____

Do you use tobacco? ☐ Yes ☐ No

# of packs/ day _____ How many years?_____

Do you use alcohol? ☐ Yes ☐ No

# of drinks/ day _____ How many years?_____

Do you have a history of drug/alcohol abuse/addiction? ☐ Yes ☐ No

Have You ever been treated with Buprenorphine (Suboxone) or Methadone for opioid abuse/addiction? ☐ Yes ☐ No

Is there any history of drug/alcohol abuse/addiction in your family? ☐ Yes ☐ No

Do you currently use Medical Marijuana? ☐ Yes ☐ No

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Review of Systems (List Only Current or Very Recent Symptoms)

General:	☐ Weight Change	☐ Fatigue	☐ Weakness
	☐ Fever	☐ Loss of Appetite	☐ Chills
	☐ No Problems		
Cardiac:	☐ Chest pain/Angina	☐ Shortness of Breath	☐ Palpitations
	☐ Peripheral Edema	☐ No problems	
Endocrine:	☐ Heat intolerance	☐ Excessive sweating	☐ Excessive urination
	☐ Cold intolerance	☐ Excessive thirst	☐ No problems
Gastrointestinal:	☐ Diarrhea	☐ Reflux	☐ Constipation
	☐ Change in appetite	☐ Abdominal pain	☐ Nausea
	☐ Loss of bowel control	☐ Blood or Black Stool	☐ Vomiting
	☐ No Problems		
Genitourinary:	☐ Difficulty Urinating	☐ Painful Urination	☐ Blood in urine
	☐ Loss of Bladder Control	☐ No Problems	
HEENT:	☐ Sinus Problems	☐ Difficulty Swallowing	☐ Headache
	☐ Jaw Problems	☐ Dry Mouth	☐ Migraines
	☐ Mouth Problems	☐ No Problems	
Hematology/ Oncology:	☐ Chemotherapy History	☐ Bleeding Disorder	☐ No Problems
	☐ Radiation History	☐ Anticoagulation Therapy	
Musculoskeletal:	☐ Muscle Cramps	☐ Joint Stiffness	☐ Muscle atrophy
	☐ Joint Redness	☐ Joint Swelling	☐ No Problems
	☐ Joint Heat		
Neurological:	☐ Blackouts	☐ Weakness	☐ Numbness
	☐ Fainting	☐ Paralysis	☐ Gait Difficulties
	☐ Hallucinations	☐ Dizziness	☐ No Problems
	☐ Tremors	☐ Confusion	
Opthalmology:	☐ Blurrred Vision	☐ Eye Pain	☐ No Problems
	☐ Double Vision	☐ Photophobia (light is painful)	
Psychiatric:	☐ Depression	☐ Suicidal Ideation	☐ Anxiety
	☐ Drug Abuse	☐ Homicidal Ideation	☐ No Problems
Respiratory:	☐ Cough	☐ Shortness of Breath	☐ Wheezing
	☐ Hemoptysis	☐ No Problems	
Skin:	☐ Dry Skin	☐ Changes in Hair or Nail	☐ Eczema
	☐ Changes in Skin Color	☐ Recurrent Rashes	☐ No Problems
	☐ Itching		
Toxins:	☐ Asbestos	☐ Industrial Chemicals	☐ Lead
	☐ Pesticides	☐ Drug Use	☐ No Problems

X_____ _____

Patient Signature *Date*

Reviewed by: _____ _____

Provider Signature *Date*

Total Health Center
Internist and Medical Consultant
Conventional and Alternative Therapies

Annual PQRS Questionaire

Patient Name: _____ **DOB**:_____

1. Do you have little or no interest in doing things? Yes ☐ No ☐

   If yes, please check one: ☐ Several Days ☐ More than half the days ☐ Everyday

2. Are you feeling down, depressed or hopeless? Yes ☐ No ☐

   If yes, please check one: ☐ Several Days ☐ More than half the days ☐ Everyday

*If you answered **YES*** to question 1 or 2, then complete the following table.

*If you answered **NO*** to both question 1 and 2 then you **DO NOT** have to complete the table below.

Please answer the following questions (please place a check mark in the box) ✓	Not at All (0)	Several days (1)	More than half the days (2)	Everyday (3)
3. Do you have trouble falling or staying asleep or sleeping too much?				
4. Do you feel tired or having little energy?				
5. Do you have poor appetite or overeating?				
6. Do you feel bad about yourself, feel like a failure, or feel you have let yourself or your family down?				
7. Do you have trouble concentrating on things, such as reading the newspaper or watching television?				
8. Do you move or speak so slowly that other people could have noticed? Or the opposite? Are you fidgety or restless and move around more than usual?				
9. Do you have thoughts that you would be better off dead and/ or have thoughts of hurting yourself in some way?				

Have you fallen in the past year? (Answer ony if 65 years and older.)

☐ **No**

☐ **Yes** ☐ 1 fall with injury ☐ 2 or more falls with injury

☐ 1 fall without injury ☐ 2 or more falls without injury

Patient Demographics

In order to participate in federal and state healthcare programs, our practice requests the demographic information below. The terms below are the federal government's standards for classification of race and ethnicity.

Race (please check one box)

☐ **American Indian or Alaska Native.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **Black or African American.** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **White.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Hispanic or Latino.** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

☐ **More than one race**

☐ **I prefer to not provide this information**

Ethnicity (please check one box)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Undefined

☐ **I prefer to not provide this information**

Preferred Language (please check one box)

☐ Spanish
☐ English
Other (please list) _____

☐ **I prefer to not provide this information**

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AUTHORIZATION AND RELEASE OF INFORMATION TO INSURANCE

I authorize the release of any Protected Health Information information including the diagnosis and the records of any treatment rendered to me during the period of such care to third party payors and/or other health practitioners.
I authorize and request my insurance company to pay directly to Total Health Center insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of services rendered on my behalf or my dependents.

X_____ _____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

CONSENT TO RELEASE INFORMATION TO FAMILY AND OTHERS

I hereby give my consent to release Protected Health Information information from my medical and/ or financial records from Total Health Center to anyone specifically listed below.

Name Relationship

_____

_____

_____

☐ I specifically **DENY** permission to release information to anyone.

X_____ _____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

CONSENT TO RELEASE INFORMATION TO PHYSICIAN

I hereby give consent to release Protected Health Information information regarding my treatment and/or copies of my medical record to my referring physician and/or primary care physician as listed on the Patient Registration Sheet.

X_____ _____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

CONSENT TO TREAT

I further authorize and consent to the Practice's physicians and their assistants and other Practice professional staff providing outpatient medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

X_____ _____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor

****I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Total Health Center's Notice of Privacy Practices explains the process for revocation, which includes a request in writing. Unless I revoke this authorization earlier, this *Consent for Release of Protected Health Information* will remain in effect until terminated by me in writing.**

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Insurance Acknowledgement

Dear Patient,

Due to all of the various HMO and PPO insurance plans now available in the marketplace, it has become a very complicated process to become familiar with each plan. All of the various companies and plans have their individual requirements for various procedures.

It has therefore become necessary to request that all patients provide all information needed from their insurance company, and that they assume responsibility for providiing this information to our office, and to any other health facility involved in their particular treatment or illness, including hospitals. Patients must also notify their insurance company of any changes in their care or treatment so that proper handling and payment will be made by their insurance company.

You may receive a pre-certification or authorization number from your insurance company. Please remember that this does not guarantee that your insurance company will pay for the procedure. It is your responsibility to call your insurance benefits department to see if you have any pre-existing or routine testing clauses in your contract which would prevent your insurance company from paying the bill.

We have always filed and will continue to file claims for patients, but you must share equal responsibility for obtaining and giving the doctor or insurance company the necessary information needed to get your claim processed and paid within a reasonable time period.

We realize that patients are not always given all the information required by their insurance company or agent, but it is still your responsibility to call and obtain this information before receiving treatment and before filing claims for treatment. We cannot emphasize enough how important this is, in order for you to receive the proper benefit you are entitled to under your insurance plan or contract.

We are requesting your cooperation so that we may better serve you and give you the health care you deserve, without having to spend an exorbitant amount of time dealing with your insurance company. You should have and know all the information required by your individual plan(s) of insurance to avoid any confusion on your behalf of what services are covered by your insurance policie(s).

Thank you for your cooperation.

X_____ _____

Signature of Patient or Parent, if a minor *Date*

_____

Printed Name of Patient / Minor