Deodge M. Hill PA-C B.S., M.S **Dr. Tata, M.D** **Craig McClendon PA-C B.S., M.S**

Patient Demographic Form

Patient Information:

- Full Name: _____
- Date of Birth: _____ (MM/DD/YYYY)
- Gender:
  - ☐ Male
  - ☐ Female
  - ☐ Non-binary
  - ☐ Prefer not to say
  - ☐ Other: _____
- Address:

  Street: _____

  City: _____ **State:** _____ **Zip:** _____
- Phone Number: (Home) _____ (Mobile) _____

Emergency Contact:

- Name: _____
- Relationship: _____
- Phone Number: _____

Insurance Information:

- Insurance Provider: _____ Member ID_____
- Subscriber's Name (if different): _____
- Subscriber's Date of Birth: _____ (MM/DD/YYYY)

Authorization for Treatment

I authorize treatment and permit the provider to release information related to these services to my insurance carrier for payment. I also authorize benefits to be paid directly to the provider or to me. I understand that I am financially responsible for any charges not covered by my insurance.

Signature: _____ Date: _____

No-Show & Cancellation Policy

Dear Patient,

We value your time and strive to provide the best care possible. To maintain our schedule and serve all our patients efficiently, we have implemented a policy regarding missed appointments and cancellations.

Policy Details:

- A fee of **$25** will be assessed for any missed **primary care** appointments (no-shows) or cancellations made the same day of the scheduled appointment.
- A fee of **$50** will be assessed for any missed **mental health** appointments (no-shows) or cancellations made the same day of the scheduled appointment.
- If you need to cancel or reschedule an appointment, please notify us **24 hours** in advance.
- The fee will be billed directly to you and must be paid prior to rescheduling another appointment.
- This policy helps ensure that we can provide timely care to all of our patients.

Exceptions:

We understand that emergencies and unforeseen circumstances may arise. If you have an emergency or extenuating situation, please contact our office as soon as possible, and we will do our best to accommodate you. We appreciate your understanding and cooperation in helping us maintain efficient scheduling practices.

Acknowledgment:

I, the undersigned, acknowledge that I have read and understand the No-Show & Cancellation Policy, and I agree to the terms outlined above.

Patient Name: _____

Signature: _____

Date: _____

Phone Number: _____

Email: _____

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Behavioral Health Intake Screening Questionnaire

Patient Information:

- Full Name: _____ Date of Birth: _____ (MM/DD/YYYY)
- Phone Number: (Home) _____ (Mobile) _____
- Email Address: _____

Reason for Visit:

1. What brings you in for treatment?

   _____

2. How Long have you been experiencing these issues?

   _____

Current Symptoms:

3. Please check any symptoms you have experienced in the last month:
   - ☐ Sadness or depressed mood
   - ☐ Anxiety or excessive worry
   - ☐ Difficulty concentrating
   - ☐ Changes in appetite or weight
   - ☐ Sleep disturbances (insomnia, oversleeping)
   - ☐ Irritability or mood swings
   - ☐ Loss of interest in activities
   - ☐ Social withdrawal
   - ☐ Thoughts of self-harm or suicide
   - ☐ Substance use (alcohol, drugs)

Mental Health History:

4. Have you ever been diagnosed with a mental health condition? ☐ Yes ☐ No
   If yes, please specify: _____
   _____

5. Have you received any previous mental health treatment? ☐ Yes ☐ No
   If yes, please provide details: _____
   _____

6. Are you currently taking any medications for mental health? ☐ Yes ☐ No
   If yes, please list: _____
   _____

Substance Use:

7. Do you use any of the following substances? (Check all that apply)

   - ☐ Alcohol
   - ☐ Tobacco
   - ☐ Marijuana
   - ☐ Prescription medications (not as prescribed)
   - ☐ Illicit drugs
   - ☐ Other: _____

8. How often do you use these substances? _____

Family and Social History:

9. Do you have a family history of mental health issues? ☐ Yes ☐ No

   If yes, please specify: _____

   _____

10. Can you describe the people or resources in your life that provide you with support?

    _____

    _____

11. Are you currently in a relationship? ☐ Yes ☐ No

    If yes, please describe the relationship: _____

    _____

Additional Information:

12. Is there anything else you would like us to know? _____

    _____

Patient Signature: _____ **Date:** _____

Dodge M. Hill PA-C B.S., M.S Dr. Tata, M.D Craig McClendon PA-C B.S., M.S

NCMC Nutrition Questionnaire for Adult Weight Management

Patient Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** □ Male □ Female □ Other
- **Height:** _____
- **Weight:** _____
- **Date:** _____

Current Weight Management Goals

- What are your primary goals for weight management? (Select all that apply)

  □ Lose weight

  □ Maintain weight

  □ Gain weight

  □ Improve health markers (e.g., cholesterol, blood sugar)

  □ Other (please specify): _____

- How much weight would you like to lose/gain? _____

Dietary Habits

1. **How many meals do you typically eat per day?**

   □ 1 meal

   □ 2 meals

   □ 3 meals

   □ More than 3 meals/snacks

   □ I skip meals regularly

2. **How often do you consume snacks between meals?**

   □ Never

   □ Rarely (1-2 times per week)

   □ Sometimes (3-4 times per week)

   □ Often (5 or more times per week)

3. **What types of foods do you typically eat for breakfast?**
   (Please list typical items or meals)

4. **What is your typical lunch and/or dinner?**
   (Please list typical meals)

5. **Do you often eat food from fast food or restaurants?**

   □ Yes, regularly

   □ Occasionally

   □ Never

6. **How often do you consume the following types of foods?**

   Fruits:
   □ Daily □ 3-4 times/week □ Rarely □ Never

   Vegetables:
   □ Daily □ 3-4 times/week □ Rarely □ Never

   Whole grains (e.g., brown rice, quinoa, whole wheat):
   □ Daily □ 3-4 times/week □ Rarely □ Never

   Processed foods (e.g., chips, cookies, fast food):
   □ Daily □ 3-4 times/week □ Rarely □ Never

   Sugary beverages (soda, juice, energy drinks):
   □ Daily □ 3-4 times/week □ Rarely □ Never

7. **How much water do you drink daily?**

   □ Less than 1 cup

   □ 1-2 cups

   □ 3-4 cups

   □ 5 or more cups

8. **How often do you consume alcohol?**

   □ Never

   □ Occasionally (1-2 times/week)

   □ Frequently (3 or more times/week)

   □ Daily

9. **Do you follow any specific diet plan?**

   □ Yes (please specify): _____

   □ No

Medical History & Health Conditions

1. **Do you have any of the following health conditions?** (Select all that apply)

   □ Hypertension (high blood pressure)

   □ Type 2 diabetes

   □ High cholesterol

   □ Heart disease

   □ Thyroid conditions (e.g., hypothyroidism)

   □ Gastrointestinal issues (e.g., reflux, IBS)

   □ Sleep apnea

   □ Other (please specify): _____

2. **Are you currently taking any medications?**

   □ Yes (please list medications): _____

   _____

   □ No

3. **Have you ever had surgery related to weight or health (e.g., bariatric surgery)?**

   □ Yes (please specify): _____

   □ No

Physical Activity & Lifestyle

1. **How often do you exercise or engage in physical activity?**

   □ Never

   □ Rarely (1-2 times/month)

   □ Occasionally (1-2 times/week)

   □ Regularly (3 or more times/week)

2. **What type of exercise do you engage in?** (Check all that apply)

   □ Walking

□ Running or jogging

□ Strength training (e.g., weightlifting)

□ Yoga or Pilates

□ Sports or recreational activities (e.g., swimming, tennis)

□ Other (please specify): _____

3. **How many hours of sleep do you get on average per night?**

□ Less than 5 hours

□ 5-6 hours

□ 7-8 hours

□ More than 8 hours

4. **Do you experience any barriers to exercising regularly?**

- □ Yes (please specify): _____

_____

- □ No

Psychological & Behavioral Factors

1. **Do you often feel stressed or anxious?**

□ Yes

□ Sometimes

□ No

2. **Do you eat due to emotional reasons (e.g., stress, boredom)?**

□ Yes, often

□ Occasionally

□ No

3. **How do you feel about your current weight and body image?**

□ Very dissatisfied

□ Somewhat dissatisfied

□ Neutral

□ Somewhat satisfied

□ Very satisfied

4. **What factors do you think are contributing to your difficulty with weight management?** (Check all that apply)

   □ Poor eating habits

   □ Lack of time for cooking or exercise

   □ Emotional eating

   □ Medical conditions

   □ Lack of support

   □ Other (please specify): _____

Readiness for Change

1. **On a scale of 1-10, how motivated are you to make changes to your eating habits?**
   - 1 (Not motivated) to 10 (Extremely motivated) _____
2. **Are you willing to make changes to your diet and exercise habits to achieve your goals?**

   □ Yes

   □ No

   □ Maybe

3. **What kind of support would help you succeed in your weight management goals?**

   □ Nutrition counseling

   □ Exercise plan or trainer

   □ Emotional or psychological support

   □ Regular follow-ups with a healthcare provider

   □ Other (please specify): _____

Additional Comments or Concerns: _____

_____

_____

Patient Signature: I confirm that the information provided above is accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Gretchen's Place

Dodge M. Hill PA-C B.S., M.S **Dr. Tata, M.D** **Craig McClendon PA-C B.S., M.S**

Notice of Privacy Practices

Revised December 24, 2024

Gretchen's Place ("we," "us," or "our") is committed to protecting your privacy. This Notice of Privacy Practices describes how your Protected Health Information (PHI) may be used and disclosed and how you can access and control this information. Please read it carefully.

OUR PRIVACY COMMITMENT TO YOU

Gretchen's Place collects information about your physical and behavioral health when you start receiving care and services with us. This information may include, but is not limited to, your date of birth, gender, assigned beneficiary numbers from public or private health plans, your past, present, and future physical and behavioral health conditions, diagnoses, service plan, and address. We train our staff to comply with privacy and confidentiality requirements and recognize that your medical information is personal, and we are dedicated to safeguarding your privacy. This information is referred to as "Protected Health Information" or "PHI."

HOW WE MAY USE AND DISCLOSURE PHI ABOUT YOU

We use and disclose your health information for the following purposes:

- **Treatment:** To provide, coordinate, or manage your healthcare and related services.
- **Payment:** To obtain reimbursement for your healthcare services.
- **Healthcare Operations:** To improve our services and business operations.
- **Required by Law:** We may disclose health information when required by law, such as for public health purposes or reporting certain diseases.
- **For Health Information Exchange (HIE):** An HIE is a community-wide information system used by participating health care providers to share health information about you for treatment purposes.
- **Research:** With your consent, we may use or disclose health information for research purposes.
- **Appointment Reminders:** We may use and disclose your information to remind you of appointments or provide other related communications.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **To Provide Breach Notification:** We are required by law to notify affected individuals following a breach of unsecured PHI. We may use and disclose your PHI, if necessary, to tell you and regulatory authorities or agencies of unlawful or unauthorized access to your PHI.

YOUR RIGHTS REGARDING PHI ABOUT YOU

You have the following rights with respect to your PHI we maintain about you:

- **Right to Inspect and Copy:** You have the right to request access to your health records

- **Right to Amend:** You may request corrections to your health information if you believe it is incorrect or incomplete.
- **Right to an Accounting of Disclosures:** You may request a list of certain disclosures made by us.
- **Right to Request Restrictions:** You may request that we limit how your information is used or disclosed.
- **Right to Confidential Communications:** You may request to receive communications of your health information in a certain way (for example, by email or at a specific address).
- **Right to File a Complaint:** You have the right to file a complaint with us or with the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.
- **Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice.

OTHER USES OF YOUR PHI

Any other uses or disclosures of your Protected Health Information (PHI) that are not covered by this notice or applicable laws will only occur with your written consent. If you grant us permission to use or disclose your PHI, you have the right to revoke that consent in writing at any time. Upon revocation, we will no longer use or disclose your PHI for the purposes specified in your written authorization. However, you understand that we cannot undo any disclosures that have already been made with your consent, and we are required to keep records of the care we have provided to you.

Authorization Required: Psychotherapy Notes:

We must obtain an authorization for any use or disclosure of psychotherapy notes, except: To carry out the following treatment, payment, or health care operations.

- Use by the author of psychotherapy notes for treatment.
- Use of disclose by us for our own training programs in which students, trainees, or practitioners in mental health learn under the supervision to practice of improve their skill in group, joint, family or individual counseling/treatment; or
- Use or disclosure by us to defend ourselves in a legal action or other proceeding brought by the individual.

Authorization Required: Marketing

We must obtain an authorization for any use or disclosure of PHI for marketing, except if the communication is in the form of:

- A face-to-face communication made by us to an individual.
- A promotional gift of nominal value provided by us.
- If the marketing involves a third party, the authorization must state that such remuneration is involved.

Gretchen's Place

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Authorization Required: Sale of Protected Health Information

We must obtain an authorization for any disclosure of protected health information which is a sale of protected health information. The authorization must state that the disclosure will result in remuneration to us.

HOW TO CONTACT US

If you have any questions about this Notice or need assistance with your health information, please contact us at:

Gretchen's Place
[A] 25 Owen Street, Belleville, MI 48111
[P] 734.699.5400
[F] 734.699.5455
[E] gretchenscommunity@gmail.com

CHANGES TO THIS NOTICE

We may change our privacy practices from time to time. We will post any changes to this Notice on our website, office and provide a copy to you upon request.

By signing below, you acknowledge that you have received and understand this Notice of Privacy Practices.

Printed Name: _____

Signature: _____

Date: _____