Gilbert Medical Center PLLC

We are pleased to welcome you to our practice, please fill out paperwork completely. If you have any questions we will be glad to assist you.

PATIENT INFORMATION (Please Print)

Patient's Legal Name: _____ ____ _____ ss#:_____
First MI Last

DOB:_____ Age:_____ **Marital Status:** M S W O **Sex:** M F

Address:_____ _____City:_____ State:_____

Zip Code:_____ Home Phone:_____ Cell Phone:_____

Email address:_____ Preferred Pharmacy:_____

Race: _____ American Indian or Alaska Native _____ White
_____ Asian _____ Hispanic
_____ Black or African American _____ Other
_____ Hawaiian or Other Pacific Islander

Ethnicity: _____ Hispanic or Latino
_____ Not Hispanic or Latino

Language: _____

Employer:_____ Phone:_____

Employer Address:_____ _____ _____ _____
Address City State Zip Code

EMERGENCY CONTACT

Name: _____ Phone:_____

Relationship to patient: _____

INSURANCE INFORMATION (Please give receptionist your insurance card to copy)

Primary: _____ ID#: _____ Group#:_____

Subscriber Name:_____ s#: _____

DOB:_____ Employer:_____

Secondary: _____ ID#: _____ Group#:_____

Subscriber Name: _____ ss#:_____

DOB: _____ Employer: _____

WORK COMP/MVA INFORMATION- Please note that if you answer yes to any of the following questions, we must have all the information before you can be seen.

Is your injury work related? ☐ Yes ☐ No
Has a claim already been filed? ☐ Yes ☐ No
Is your injury due to a motor vehicle accident? ☐ Yes ☐ No

PERSON RESPONSIBLE FOR BILL (If patient is a minor)

Name: _____ DOB:_____ ss#:_____

Address: _____ Phone: _____
(If different than patient)

AUTHORIZATION:

I herby authorize my insurance benefits to be paid directly to the facility and the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge I have access to a copy of the Gilbert Medical Center/TPG/HPI Privacy Notice.

Print Name: _____ Signature:_____

Date: _____

PATIENT FINANCIAL RESPONSIBILITIES AND OBLIGATIONS

Thank you for choosing Gilbert Medical Center as your health care provider. Your clear understanding of our patient's financial responsibility is important to our professional relationship. **It is your responsibility to notify our office of any patient information changes (address, name, insurance information, etc).**

Co-pays/Balances: **All co-pays and balances are due at time of check-in. If your deductible has not been met you will be required to pay for your visit upfront until your deductible has been satisfied. Failure to pay all amounts due will subject you to collections efforts. Overdue accounts may be assigned to a third party debt collector.** We accept cash, check, money orders, Visa, MasterCard, and Discover.

Insurance Claims: In order to properly bill your insurance company, we require that you disclose all insurance information including: primary, secondary, as well as any change of insurance. Failure to provide complete insurance information may result in nonpayment by your insurance, thus you will be responsible for the entire bill.

Returned checks: The charge for a returned check is $35. This amount plus the amount of the check will be due. You will receive a notice from Checks Inc. regarding your account.

Personal Disclosures: The patient consents to the use and the release of their personal financial records to third party agencies for payment of medical claims.

I have read and understand the above Patient Financial Responsibilities policy and by signing this page I agree to the terms and conditions stated above.

_____ _____ _____

Print Name Signature Date

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

By state law you must be advised that: **The information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease, which may include, but are not limited to diseases such as Hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).**

I hereby authorize the physicians and staff of Gilbert Medical Center to release any and all medical records and also consent to having test results mailed for:

_____ _____

Patient's full name (PRINT) Date of Birth

_____

Social Security No.

_____ _____ _____ _____

Address City State Zip Code

All information is to be released to: _____

_____

_____

I understand this consent can be revoked at any time, except that disclosure is made in good faith has already occurred in reliance on this consent. Gilbert Medical Center, all employees and officers, and attending physicians are released from legal responsibility or liability for the release of the above requested information.

_____ _____

Patient or Legal Representative (Print Name) Signature

_____ _____

If other than patient, provide relationship to patient Date

PATIENT HISTORY FORM

Patient Name _____ Age_____ Sex_____ Patient Date of Birth_____

Social Security Number_____ Today's Date_____

Past Medical History

Previous Physician's name_____ Date of last exam _____

Have you ever been hospitalized? □ Yes □ No If yes, what for?_____

Have you ever been tested for hepatitis A,B or C? □ Yes □ No Which hepatitis virus?_____

Have you been vaccinated for hepatitis B? □ Yes □ No If yes, date vaccine series completed_____

Have you been vaccinated for hepatitis A? □ Yes □ No If yes, date vaccine series completed_____

Last Tuberculosis (TB) screening?_____ Result of TB screening □ Positive □ Negative

If positive TB screen, date of last chest x-ray_____ Result of chest x-ray □ Positive □ Negative

Have you had a sexually transmitted disease? □ Yes □ No Diagnosis_____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

□Heart disease/Murmur/Angina	□ Shortness of breath	□ Eye disorder/Glaucoma	□ Diabetes
□ High Cholesterol	□ Asthma	□ Seizures	□ Kidney/Bladder problems
□ High blood pressure	□ Lung problems/cough	□ Stroke	□ Liver problems/Hepatitis
□ Low blood pressure	□ Sinus problems	□ Headaches/Migraines	□ Arthritis
□ Heartburn (reflux)	□ Seasonal allergies	□ Neurological problems	□ Cancer
□ Anemia or blood problems	□ Tonsillitis	□ Depression/Anxiety	□ Ulcers/colitis
□ Swollen ankles	□ Ear problems	□ Psychiatric care	□ Thyroid problems

Please describe any current or past medical treatment not listed above

_____

_____

Please list your past surgeries

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? □ Yes □ No

Please list_____

Medications

Please list_____

_____

PLEASE COMPLETE REVERSE SIDE ⇨

Social and Preventative History

Do you currently smoke or chew tobacco? □ Yes □ No If no, have you in the past? □ Yes □ No
How many packs per day?_____

Do you drink alcohol, beer, or wine? □ Yes □ No If no, have you tried in the past? □ Yes □ No
How many drinks per week?_____

Do you currently drink coffee and /or tea? □ Yes □ No If yes, how many cups per day?_____

Do you exercise daily/weekly? □ Yes □ No

Do you use seatbelts while driving? □Yes □ No Do you wear a helmet while riding a bike? □ Yes □ No

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	□ Yes □ No	_____	_____
Father	□ Yes □ No	_____	_____
Sisters	□ Yes □ No	_____	_____
	□ Yes □ No	_____	_____
	□ Yes □ No	_____	_____
Brothers	□ Yes □ No	_____	_____
	□ Yes □ No	_____	_____
	□ Yes □ No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	**Which family member?**
Anemia or blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heat disease	_____
High blood pressure	_____
HIV disease/AIDS	_____
Mental Illness/Depression	_____
Stroke	_____
Other serious Illness	_____

Females: Gynecological History

How many times have you been pregnant?_____ Date of last Pap Smear_____

Have you had an abnormal Pap Smear? □ Yes □ No Diagnosis_____ Follow up_____

Have you had a sexually transmitted disease? □ Yes □ No Diagnosis_____

Date of last mammogram_____ Mammogram results_____

Have you ever had a biopsy? □Yes □ No Biopsy results_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature_____ Date_____

SoonerCare
Oklahoma Health Care Authority

INFORMATION FOR YOUR DOCTOR

Physical and emotional health go together. You can help us provide you with the best health care possible by answering these questions. Please circle the box that best describes you. If you do not wish to answer a question, you can leave it blank.

Your Name: _____ Date: _____

PHQ-2+1 *Please circle the answer that best describes you during the past two weeks*	**Not At All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	(0)	(1)	(2)	(3)
2. Feeling down, depressed, or hopeless	(0)	(1)	(2)	(3)
3. Thinking that you would be better off dead or that you want to hurt yourself in some way	(0)	(1)	(2)	(3)

AUDIT, NM-ASSIST *Please circle the answer that best describes your use of alcohol or drugs. Drugs include all kinds of street drugs, marijuana, meth, cocaine, or prescription drugs such as tranquilizers or painkillers that are not taken as directed by your doctor.*					
1. How often do you drink alcohol?	Never 0	Monthly or less 1	2-4 times a month 2	2-3 times a week 3	4 or more times a week 4
2. How many drinks of alcohol do you have on a typical day (leave blank if you don't drink alcohol)	1 or 2 drinks a day 0	3 or 4 drinks a day 1	5 or 6 drinks a day 2	7 to 9 drinks a day 3	10 or more drinks a day 4
3. In the <u>past year</u>, did you have 6 or more drinks* of alcohol in one day if you are male; 5 or more if you are female? **one drink means 12 oz. of beer, 1.5 oz. of liquor or 5 oz. of wine*	Never 0	Less than monthly 1	Monthly 2	Weekly 3	Daily or almost daily 4
4. In the <u>past 3 months</u>, how often have you used marijuana, other drugs, or nonmedical use of prescription drugs?	Never 0	Less than monthly 2	Monthly 3	Weekly 4	Daily or almost daily 6
5. In the <u>past 3 months</u>, how often have you had a strong desire or urge to use alcohol or drugs?	Never 0	Less than monthly 3	Monthly 4	Weekly 5	Daily or almost daily 6
6. In the <u>past 3 months</u>, has your use of alcohol or drugs led to health, social, legal, or financial problems?	Never 0	Less than monthly 4	Monthly 5	Weekly 6	Daily or almost daily 7
7. In the <u>past 3 months</u>, how often have you failed to do what was normally expected of you because of your use of alcohol or drugs?	Never 0	Less than monthly 5	Monthly 6	Weekly 7	Daily or almost daily 8

Are you currently receiving services from a psychologist, a substance abuse program or counselor, and/or a mental health program or counselor? (Circle your answer)

YES	NO

The comprehensive screening tools were developed as a way to provide a quick measure of mental health and substance abuse issues in the primary care setting. Areas covered: substance abuse, depression, anxiety and familial relations. The backside of the forms allow for fast documentation for the medical record. The scoring instructions below correspond with the appropriate sections on each of the tools.

Adult Behavioral Health Screener

PHQ – Patient Health Questionnaire 2+1 (initial Depression and Anxiety Screen)

1. Sum items 1 & 2. If total is ≥3 then result is a positive screen. Recommend completing PHQ-9, which is provided in the toolkit to further assess depressive symptoms.*
2. If item 3 is endorsed ≥ 1 then result is a positive screen and warrants further assessment.

AUDIT – Alcohol Use Disorder Identification Test (Alcohol Screen)

3. Sum items 1, 2 & 3. If total ≥5 then result is a positive screen and warrants further assessment.

NM-ASSIST – National Institute Drug Abuse Modified Alcohol, Smoking and Substance Involvement Screening Test

4. Drug Use – If Item 4 is endorsed as "Daily or Almost Daily" then result is a positive screen and warrants further assessment.
5. Alcohol and Drug Functional Impairment – Sum items 5, 6 & 7. If total is ≥ 15 then result is a positive screen and warrants further assessment.

Conversation Starter Questions

6. The last question was included to assist with making appropriate referrals for further behavioral health and/or substance use assessment.

Screening Instructions

1. Client (or guardian for children) completes the screening tool as part of their regular visit paperwork.
2. PCP and/or office staff calculates the score.
3. If screen is positive, PCP will discuss results with member and refer for a full assessment if needed.
4. PCP completes documentation side of the tool to place in the medical record.
5. PCP's office bills procedure code – 96160 – in addition to their E & M code.

**Optional: PHQ-9 (follow-up depression screen located in toolkit provided)*
Sum items 1-9 to determine severity of depressive symptoms
1-4 Minimal symptoms
5-9 Mild symptoms
10-14 Moderate symptoms
15-19 Moderately severe symptoms
20-27 Severe symptoms
If item 9 is endorsed ≥ 1 then result is a positive screen and warrants further assessment.
Item 10 provides estimate of functional impairment.

Patient's Name:

_____

Screening Date: _____

Screening Results

PHQ-2 for depression was

- ☐ Negative
- ☐ Positive
- ☐ Positive for suicidal ideation

AUDIT for alcohol use was

- ☐ Negative
- ☐ Positive

Drug use screen was

- ☐ Negative
- ☐ Positive

Symptoms endorsed on patient's drug and alcohol screen _____ in functional impairment.

- ☐ Do not result
- ☐ Result

Patient currently followed by a mental health provider

- ☐ No
- ☐ Yes – Provider is

  _____

Screening Summary

Patient's overall screen was:

- ☐ Negative.
- ☐ Positive, but patient is already followed by a mental health provider.
- ☐ Positive and warrants further monitoring.
- ☐ Positive and warrants further assessment.

Intervention

- ☐ Reviewed screening results with patient/family.
- ☐ Discussed with patient/family impact of screening results on patient's health & need for:
  - ☐ Continued monitoring of patient's symptoms.
  - ☐ Further assessment by a behavioral health provider.
  - ☐ Patient to follow up with patient's current mental health provider.
- ☐ Patient/family given copy of screening results.

Referral

- ☐ No referral made at this time.
- ☐ Referred patient to in-house Behavioral Health/Pediatric Psychology service for further assessment and treatment recommendations.
- ☐ Referred patient to

  _____
- ☐ Patient/family has appointment

  _____

  _____
- ☐ Patient/family given contact number 1-800-652-2010 to call for assistance with locating a behavioral health provider to conduct further assessment.

Comments

_____

_____

_____

_____

Medical Home Agreement

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ***ongoing, quality*** and ***safe*** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your ***PCP,*** to meet ***all*** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report ***any*** changes related to your health, treatments, medications, etc.
   This includes use of ***all medications*** - prescription, over-the-counter, herbal and street drugs.
   This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us ***before*** going to the Emergency Room, unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.

_____ _____

Patient or Guardian Signature Date

_____ _____

Provider Signature Date

Updated 1/13/2015