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

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

Pediatric Behavioral Health Screen (Ages 5-16)

Person Completing Form: ______________________________ | **Relation to Child:** ______________________________

INFORMATION FOR YOUR CHILD'S DOCTOR

Emotional and physical health go together in children. Parents are often the first to notice a problem with their child's behavior and/or emotions. You can help your child get the best care possible by answering these questions. Please circle the box that best describes your child. If you do not wish to answer a question, you can leave it blank.

Please circle the answer that best describes your child:

PSC	**NEVER**	**SOME TIMES**	**OFTEN**	Office Use I	A	E
1. Fidgety, unable to sit still	0	1	2			
2. Feels sad, unhappy	0	1	2			
3. Daydreams too much	0	1	2			
4. Refuses to share	0	1	2			
5. Does not understand other people's feelings	0	1	2			
6. Feels hopeless	0	1	2			
7. Has trouble paying attention	0	1	2			
8. Fights with other children	0	1	2			
9. Is down on himself or herself	0	1	2			
10. Blames others for his or her troubles	0	1	2			
11. Seems to be having less fun	0	1	2			
12. Doesn't listen to rules	0	1	2			
13. Acts as if driven by a motor	0	1	2			
14. Teases others	0	1	2			
15. Worries a lot	0	1	2			
16. Takes things that don't belong to him or her	0	1	2			
17. Distracted easily.	0	1	2			

HOW MUCH DO THE PROBLEMS OR DIFFICULTIES YOU CIRCLED ABOVE INTERFERE WITH YOUR CHILD'S EVERYDAY LIFE?

	Not at all	**Only a little**	**A lot**	**A great deal**
18. Do the difficulties you checked above upset or distress your child?	0	1	2	3
19. Do the difficulties you checked above place a burden on you and your family?	0	1	2	3
20. Do the difficulties you checked above interfere with your child's home life?	0	1	2	3
21. Do the difficulties you checked above interfere with your child's friendships?	0	1	2	3
22. Do the difficulties you checked above interfere with your child's activities?	0	1	2	3
23. Do the difficulties you checked above interfere with school or learning?	0	1	2	3
24. Do you think your child might have a problem with alcohol or drugs?			YES	NO
25. Is your child in in counseling or seeing a mental health professional?			YES	NO
26. Does your child have an IEP (Individualized Educational Plan) at school?			YES	NO
27. Are there problems or concerns about your child, yourself or your family that you would like to talk about privately with your doctor?			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.

Pediatric Behavioral Health Screener

PSC – Pediatric Symptom Checklist

Transfer parents responses to the white boxes in scoring grid on right side of the page. Sum the columns to create scores for scale scores. Sum these scores to create total score.

I (Internalizing symptoms – anxiety and depression)	≥ 5 positive
A (Attention – ADHD)	≥ 7 positive
E (Externalizing symptoms – disruptive behavior)	≥ 7 positive
Total Score	≥ 15 positive

Functional Impairment

For items 18-23, any item ≥ 2 represents functional impairment and warrants further assessment.

Conversation Starter Questions

Items 24-26 are open-ended questions, included as conversation starters between the physician and the patient regarding any mental health and/or substance abuse concerns.

Item 27 is included in the event that there are issues the patient may be concerned with, which have not been covered by other questions.

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.

SoonerCare
Oklahoma Health Care Authority

Pediatric Behavioral Health Screen (Ages 5-16)

Child's Name: ________________________________

Screening Date: ________________________

Screening Results

Patient's Pediatric Symptom Checklist was

- ☐ Negative
- ☐ Positive for
  - ☐ Internalizing symptoms
  - ☐ Externalizing symptoms
  - ☐ Attention symptoms
  - ☐ Overall symptoms

Symptoms endorsed on patient's Pediatric Symptom Checklist

- ☐ Do not result in functional impairment
- ☐ Result in functional impairment for:
  - ☐ Child
  - ☐ Family
  - ☐ Child activities
  - ☐ Child's home life
  - ☐ Child's friendships
  - ☐ Child's school or learning
- ☐ Caregiver has concern for patient's use of alcohol or drugs:
  - ☐ No
  - ☐ Yes
- ☐ Caregiver had other concerns:
  - ☐ No
  - ☐ Yes – Concern was _____________________________

Patient currently followed by a mental health provider:

- ☐ No
- ☐ Yes – Provider is _____________________________

Patient currently on an Individualized Education Plan at school

- ☐ No
- ☐ Yes – Reason for IEP: _____________________________________

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
  - ☐ Family to follow up with patient's current mental health provider
  - ☐ Family to follow up with patient's school personnel
- ☐ If ADHD is considered, then will further assess for ADHD with Vanderbilt Assessment Protocol
- ☐ 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 patients 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:____________________________
____

PEDIATRICS NEW PATIENT QUESTIONNAIRE

Patient Name ______________________________________ Age_____ Sex_____ Patient Date of Birth____________________

Mother's Name___________________________________ Age_____ Father's Name___________________________________ Age_____

Siblings' Names____

Family History

Are the child's parents both in good health? Yes ☐ No ☐

Check any diseases that the child's parents, grandparents, brothers, sisters, aunts, or uncles have had:

☐ Asthma ☐ Allergies ☐ Diabetes

☐ High Blood Pressure ☐ Heart disease before age 50 ☐ High Cholesterol

☐ Seizures ☐ Cancer ☐ Tuberculosis

☐ Kidney Stones ☐ Sudden unexplained death ☐ Mental Illness

List any other significant chronic illnesses in the family: ____

Is there a smoker in the household? Yes ☐ No ☐

Do both parents live at home? Yes ☐ No ☐ If "No", with whom does the patient live? ______________________________

Pregnancy and Birth

Mother's age at child's birth ____________

Did mother have an illness during pregnancy? Yes ☐ No ☐ List illness: ___________________________________

Did mother take medications other than vitamins? Yes ☐ No ☐ List: ____

Was the baby premature? Yes ☐ No ☐ If "Yes", the baby was born at _______ weeks.

Child's birth weight ____________ What type of delivery? Vaginal ☐ C-section ☐

Did the baby have trouble while in the hospital? Yes ☐ No ☐

If " Yes", what kind of trouble?____

Past Medical History (these questions refer to the child)

Any allergic reactions to medications, foods, insect bites or stings? Yes ☐ No ☐
If "Yes", which ones?____

Reactions to immunizations? Yes ☐ No ☐ Which ones?____

Hospitalizations? Yes ☐ No ☐ Why, what age?____

Surgeries? Yes ☐ No ☐ What kind, at what age?____

Serious Injuries Yes ☐ No ☐ What kind, what age?____

Medications taken regularly? Yes ☐ No ☐ Which ones?____

Check any medical problems your child has had:

☐ Asthma ☐ Frequent Ear Infections ☐ Frequent Strep Throat ☐ Constipation

☐ Pneumonia ☐ Vision/Hearing problems ☐ Urinary Tract Infections ☐ Heart Problems

☐ Seizures ☐ Allergies ☐ Anemia

List any other medical problem your child has that is not listed: ____