Patient Information Form

Please print clearly and fill in all fields.

Name ________________________________ Date of Birth ____ / ____ / ____

Social Security Number____ / ____/ ____ Primary Care Physician________________

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Mailing Address:

Street ____________________City__________ State ______ Zip Code______

Billing Address: (If different from Mailing Address)

Street ____________________City__________ State ______ Zip Code______

E-Mail ____________________Home Phone__________Cell Phone__________

Ethnic Group: ☐ American Indian ☐ Asian or Pacific Islander ☐ Black ☐ Hispanic ☐ White ☐ Unknown

Primary Language(s) spoken at home______________ Do you need an interpreter? ____

Employer ____________________ Address ____________________

Work Phone______________ ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student

Emergency Contact Information

Contact Name______________Relationship __________Phone__________

Contact Name______________Relationship __________Phone__________

Insurance Information

Primary Insurance ____________________ ID Number____________________

Name of Subscriber______________ Relationship __________ Date of Birth ______

Secondary Insurance ____________________ ID Number____________________

Name of Subscriber______________ Relationship __________ Date of Birth ______

Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other insurance Company benefits be made on my behalf for any services furnished to me by its physicians or employees. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me, to release to my insurance company, the Social Security Administration and Health Care Company claim, as applicable. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.)

Signature Date

New Patient Questionnaire

Name ______________________ Date of Birth ____________ Date ____________

Do you have any current concerns you would like addressed?

____

MEDICATIONS: (Include prescription medications, over the counter medications, vitamins, herbs and supplements)

Drug Name	Dose & Frequency	Drug Name	Dose & Frequency

ALLERGIES: (List all allergies to medications, x-ray dye, or other substances)

______________________ Reaction: ____________

______________________ Reaction: ____________

______________________ Reaction: ____________

______________________ Reaction: ____________

______________________ Reaction: ____________

MEDICAL HISTORY

Please check next to any problems with or are presently experiencing any of the following:

	High Blood Pressure		Weight gain/loss		Blood Clots
	High Cholesterol		Hemorrhoids		Anemia
	Diabetes		Gallbladder Disease		Skin Diseases
	Cancer		Liver Disease		Kidney Disease
	Heart Attack		Thyroid Disease		Kidney Stones
	Heart Failure		Headaches		Anxiety
	Chest pain/angina		Seizures		Depression
	Asthma		Stroke		Hearing Problems
	Pneumonia		Fractures/broken bones		Vision Problems
	Tuberculosis		Arthritis		Other
	Seasonal Allergies		Gout		

Use this space if you wish to explain in detail:

____

____

OPERATIONS/HOSPITALIZATIONS: (Females: If you have had a hysterectomy please include information here)

Reason	Date

HEALTH MAINTENANCE

Please check if you have had any of the following tests and write the date it was done:

	Pap Smear	Date:		Cholesterol Check	Date:
	Mammogram	Date:		Stool Check for Blood (FOBT)	Date:
	Breast Exam	Date:		Colonoscopy	Date:
	Bone Density	Date:		Prostate Exam	Date:
	Diabetic A1C	Date:		Flu Shot	Date:
	Diabetic Urine Micro Albumin	Date:		Pneumonia Shot	Date:
	Diabetic Eye Exam	Date:		Tdap Vaccine	Date:
	Glaucoma Screening	Date:		Shingles Vaccine	Date:

FAMILY HISTORY

Please check if your family (parents, grandparents, siblings, or children) has ever had one of the following:

	Cancer		Mental Disease (Depression/Anxiety)
	Heart Disease		Memory Problems/Alzheimer's Disease
	Hypertension		Osteoporosis/Broken Bones
	Diabetes		Other
	Stroke		

LIST FAMILY MEMBERS, PARENTS, SIBLINGS, AND CHILDREN

Father:	L or D Age:	Illness:
Mother:	L or D Age:	Illness:
Siblings: Male or Female:	L or D Age:	Illness:
	L or D Age:	Illness:
	L or D Age:	Illness:
	L or D Age:	Illness:
	L or D Age:	Illness:
	L or D Age:	Illness:
Number of Children:		

SOCIAL HISTORY

Marital Status Please Check: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Highest Grade Level Completed:____________________Occupation: ____________________

Do you currently live alone? Y or N Do you have any concerns about your living situation?__________

Do you smoke or have you ever smoked cigarettes or cigars? (including chewing tobacco) Y or N

#packs/day__________ #of years__________ Quit-When?______________

Do you currently or have you ever used Alcohol? Y or N

#per day __________ #per week __________ When did you stop?__________

Do you currently or have you ever used recreational or street drugs? "i.e. marijuana or cocaine" Y or N

When did you stop?__________

Patient Signature ____________________________________ Date ________________

PHQ9-Patient Health Questionnaire

(NPV, CPE an H/O Depression)

Patient Name ______________________ Date of Birth ____________ Date ___________

Over the last 2 weeks how often have you been bothered by any of the following problems?
Circle the number to the right for your answer.

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure 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 slowly that other people 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 each line:	+	+	+	

= Total Score __________

If you have 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?

☐ Not At All ☐ Somewhat ☐ Very ☐ Extremely

Personal Primary Care & Weight Management

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

(To be filed in Patient's Medical Record)

This acknowledges receipt of Personal Primary Care & Weight Management's Notice of Privacy Practices, including my rights under the privacy regulations, 45C.F.R., Parts 160 and 164, issued pursuant to the Health Insurance Portability and Accountability Act.

______________________________ ______________

Signature Date

____

Please Print Name

Internal Use only

If patient/patient's representative refuses to sign acknowledgement, document date and time notice was presented and sign below.

Presented on______________________________

By ______________________________

Personal Primary Care & Weight Management

Payment Policy

Thank you for choosing us as your primary care/specialty provider. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with, but don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles: All co-payments, deductibles and any balance due must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services: Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days the balance will automatically be billed to you.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to provide the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of responsible party ______________________________ Date ________________

Personal Primary Care & Weight Management

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(To be filed in Patient's Medical Record)

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______________________________ ______________

Signature Date

____

Please Print Name

Internal Use only

If patient/patient's representative refuses to sign acknowledgement, document date and time notice was presented and sign below.

Presented on______________________________

By ______________________________

299 Carew Street, Suite 234
Springfield, MA 01104
Tel. (413) 787-2575
Fax (855) 569-3033

Late, Cancellation and No Show Appointment Patient Letter

Dear Patient:

We sincerely appreciate that you have chosen a provider with Personal Primary Care & Weight Management to participate in providing you with comprehensive and quality healthcare. We ask for your help in accomplishing this goal for all of our patients by following the practice guidelines below:

1. **Cancellation for Provider Appointment**
   Personal Primary Care & Weight Management providers require a minimum of 24 hours in advance to cancel an appointment.

2. **Late Arrival for Provider Appointments**
   We understand that delays can happen, arriving late may prevent you from being seen by the physician, when you arrive it may be determined by the physician if he/she can fit you into the schedule at that time, or you may be requested to reschedule.

3. **No Show for Provider Appointments**
   A "no show" for appointments is when you do not call to cancel or reschedule your appointment a minimum of 24 hours prior to your appointment and/or if you just do not show for the scheduled appointment.

Patients that arrive late and do not call to cancel or do not show up for their appointments cause disruption in patient care and satisfaction for all patients. If you are habitually late to your appointments or "no show" for your appointment 2 times in a 12 month period causing a disruption in all patients care, you may be terminated from this practice. There will be a $25.00 charge for "no show" to your appointment which has to be paid in full before future appointments.

Sincerely,
Personal Primary Care & Weight Management

By signing this letter I understand and agree to the terms stated herein:

Patient Signature: ______________________________ Date: ______________

299 Carew Street, Suite 234
Springfield, MA 01104
Tel. (413) 787-2575
Fax (855) 569-3033

Consent Form

I, ______________________________ give permission to Personal Primary Care & Weight Management to allow the undersigned to speak with my Primary Care Provider/Medical Staff in regards to my medical history, care, and treatment. This consent is valid until I request in writing that it be voided. This is in compliance with the HIPAA (Health Insurance Portability and Accountability Act) to protect patient's confidentially of medical information.

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

I, ______________________________ give permission to Personal Primary Care & Weight Management to allow the undersigned to pick up prescriptions and other paperwork from the office if the need arises. Photo ID will be required for prescription pick up.

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

______________________ ______________ ______________
Patient Signature Date of Birth Date

______________________ ______________
Witness Date

ADVANCE BENEFICIARY NOTICE (ABN)

Patient Name:______________________ Date of Birth:___________

It is a possibility that your health insurance may not cover the service provided for you today. All insurance companies have different guidelines that need to be met to cover charges.

The purpose of this form is to help you make an informed decision about whether you want to receive these services, knowing that you may be responsible for any charges not covered by your insurance.

SERVICES THAT MAY NOT BE COVERED:

(a) Body Composition Analyzer — $50/scan.

(b) Supplements — Prices Vary

(c) Vitamin B12 — $25/month

Date_____________ Signature_________________________________

Mediation and Dispute Resolution Agreement

Your care is important to us, and we feel it is vital to your treatment that we communicate openly and honestly. As such, we request that you: Ask questions and participate in your care, be honest about your history, symptoms, and other important health information, prepare for and keep scheduled visits, and be respectful to our office staff and healthcare providers. In exchange, we agree that we will: Explain diagnosis, treatment recommendations, and outcomes in an easy-to-understand way, listen to your questions and help you make decisions about your care, keep discussions and records private, and determine when a referral or termination of care is appropriate.

MEDIATION

As a part of our emphasis on open communication, we ask our patients to sign this mediation agreement. While we do not anticipate any issues or concerns during the course of your treatment, if any arise, you (and/or your legal counsel) and your healthcare provider (and/or their legal counsel) agree to meet with a neutral mediator and work toward a solution. Whether or not a solution is found, mediation may postpone but does not remove or block your legal rights. Importantly, you agree that any usage or inference to a "claim" will be understood and read as "potential claim" until the mediation is complete. This designation allows us to begin in a less formal manner that has been shown to expedite the resolution process. Your signature on this page confirms that should a concern arise in any aspect of the care provided by this office, staff, and affiliated healthcare professionals, you agree to mediate first before pursuing legal action.

EXPERT WITNESSES

Further, if after mediation, you still wish to pursue a court action relating to your care, your signature on this page confirms that you will use, as your expert witness(es) in your legal action, American Board of Medical Specialties board-certified medical witness(es) in the same specialty as Physician. Furthermore, you agree that the physicians who you select will be in good standing and adhere to all of the rules and guidelines of professional conduct of the American Board of Medical Specialties. As consideration for this agreement, we agree that we will adhere to these same guidelines in selecting our expert witness(es) for any court action relating to your care.

____
PRINT PATIENT NAME

____
PATIENT SIGNATURE

____
WITNESS SIGNATURE

____
DATE

299 Carew St Suite 234
Springfield, MA 01104
413-787-2575

294 North Main St Suite 101
East Longmeadow, MA 01028
413-798-0301