Hooked On Health

Date:_____

Patient Name: (Last)_____ (First)_____ (M)_____

Birthdate:_____ Social Security #_____

- o Male
- o Female

Race:

- o Amer. Indian/Alaska Native
- o Asian
- o Black/African American
- o Declined
- o Nat Hawaiian/Pacific Islander
- o Other Race
- o Unknown
- o White

Pharmacy:_____

Martial Status:_____ Primary Language:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone # Home:_____ Work:_____ Cell:_____

Email:_____

Insured Name (IF NO INSURANCE, RESPONSIBLE PARTY)

Name:_____ Relationship:_____

Social Security #:_____ Date of Birth:_____

Address:_____ City/State/Zip:_____

Phone #:_____ Cell:_____

Notify In Case of Emergency

1. Name:_____ Relationship:_____
   Phone:_____

Insurance Information -- Copies of Insurance Card and Drivers License are Required

Insurance 1:_____

SS#_____ Policy #:_____ Group#:_____

Insurance 2:_____

SS#:_____ Policy #:_____ Group:_____

Signature:_____ Date:_____

PATIENT INFORMATION SHEET

NAME: _____ Gender:_____ DOB:_____ AGE:_____ DATE:_____
ALLERGIES:_____

List ALL MEDCATIONS you take, including over-the-counter medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

Name of current/past health care provider: _____ Date last seen:_____

Specialist (Cardiologist, Gastroenterologist, etc.) : _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heart beat)
Arthritis
Asthma
Bipolar
Bladder Problems/Incontinence
Bleeding Problems
Cancer: _____
Headaches
Crohn's Disease
COPD/Emphysema
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease
High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Macular Degeneration
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Polycystic Ovarian Syndrome
Psoriasis
Pulmonary Embolism (PE)
Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis

Last labs done (bloodwork)	Date:	
Last Menstrual Period	Date:	Normal Abnormal
Colonoscopy	Date:	Normal Abnormal
Mammogram	Date:	Normal Abnormal
Dexa Scan (Bone Density)	Date:	Normal Abnormal
Pap (wellwoman)	Date:	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

FAMILY HISTORY:

MOTHER: Living: Age ____ Deceased: Age _____

Alcoholism
Anemia
Asthma
Arthritis
Bipolar Disorder
Cancer: _____
COPD/Emphysema
Dementia
Depression
Diabetes 1 or 2
DVT (Blood Clot)
Heart Disease
High Cholesterol
High Blood Pressure
Kidney Disease
Migraines
Osteoporosis
Stroke
Thyroid Disorder

Other: _____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Cancer: _____	DVT (Blood Clot)	Migraines
Anemia	COPD/Emphysema	Heart Disease	Osteoporosis
Asthma	Dementia	High Cholesterol	Stroke
Arthritis	Depression	High Blood Pressure	Thyroid Disorder
Bipolar Disorder	Diabetes 1 or 2	Kidney Disease	

Other: _____

SIBLINGS:

_____

_____

SOCIAL HISTORY (please be honest, yes... this is all important):

Smoking/Tobacco Use: __Current __Past __ Never Type: _____ Amount/Day: _____ Number of years:____

Alcohol: __Current __ Past __ Never Drinks/week: _____

Recreational Drug Use___ Current __Past __Never Type:_____

Cardiovascular: __ Eat healthy meals __ Regular Exercise __Take daily Aspirin

Education Level: __ Elementary __ High School __ Vocational __College __ Graduate/Professional

Are there any vision or hearing problems that may affect your communication? Hearing (Y/N) Vision (Y/N)

Are there any limitations to understanding or following instructions (either written or verbal)? __ Yes __ No

Current Living Situation (Check all that apply):
__Single Family Household __ Multi-generational Household __ Homeless __Shelter __Skilled Nursing Facility __Other

Safety (check if applicable): __ I have household smoke detectors __ I keep firearms in my home __ I wear seatbelts

Sexual History: I am sexually active (Y/N) I practice safe sex (Y/N) Exposure to STD(Y/N) Homosexual or Bisexual (Y/N)
I currently have multiple sexual partners(Y/N)

Other issues/concerns not covered elsewhere:

_____

_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name_____ ("Patient") DOB_____

Phone Number _____

1. Entity who is authorized to release Patient's information:

Name _____ Fax _____Phone _____

2. Entity(ies) to whom the Patient's information may be disclosed:

Name _____

Address_____

Phone _____ Fax _____

3. The specific information that should be disclosed:

_____ LAST 24 MONTHS OFFICE NOTES/LABS/X-RAYS _____ LAST 12 MONTHS OFFICE NOTES/LABS/X-RAYS

OTHER (BE SPECIFIC):

_____

4. The purpose for the disclosure is:

_____

5. This authorization will expire on the following date or event:

_____

If no expiration date or event is listed, the authorization will expire one year after the date of the authorization.

Signed:

_____

Date: _____

Patient:

_____

Personal Representative

_____

Authority of Personal Representative (e.g., parent, guardian, etc.)

Hooked On Health Permission To Treat Form

1. I _____ (patient name) give permission for **Hooked On Health Family Practice** to give me medical treatment.

2. I allow **Hooked On Health Family Practice** to file for insurance benefits to pay for the care I receive.

   I understand that:

   - **Hooked On Health Family Practice** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:

   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____

Patients Signature Date

_____ _____

Parent or Guardian Signature Date

(for children under 18)

_____

Print name

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you 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 difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Financial Policy

A **No Show fee of $25** will be charged to the patients account for the **first no show appointment**, after that any other **no-show visits will be charged for the full amount of the visit to the patients account**.

Patients are responsible for these fees and they must be paid in full to be seen in the future.

Please give the office a 24-hour notice if you will not be able to make it to any appointments. This will help us schedule other potential patients in your place and help you avoid a fee.

Patient Signature_____

Date:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. Uses And Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information to a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your email address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist.

6. Complaints. You may complain to us if you believe your privacy rights have been violated. All complaints must be in writing. We will not retaliate against you for filing a complaint.