Please retain
for your records

Atlanta Oncology
ASSOCIATES, P.C.

Notice of Privacy Practices

This notice is to inform you about our company's policy regarding the use and disclosure of your protected health information and how you gain access to your information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) directs healthcare providers, payers and other healthcare entities to develop policies and procedures that assure the privacy, security and authenticity of health information. An employee from the clinic is required by federal law to provide you with a copy of our privacy policy.

Our Commitment to your Privacy

As a provider of healthcare, we may use your confidential information to create records regarding your health information in order to provide quality healthcare. However, we promise to remain in the boundaries of federal and state privacy act laws. Occasionally, we may need to also disclose health information to carry out your treatment, payment or healthcare operations to other clinics or offices within our organization. This notice applies only to records of your care maintained or created in this or an associate's facility. We are required by law to give you a copy of our Privacy Policies and to make sure that your health information is kept private.

How we may use or disclose personal information without authorization

The following describes different circumstances in which we may disclose or use your health information without your authorization.

1. When required by law
2. Organ and tissue donation information
3. To avert serious threat to health and safety to another person or the public
4. To military authorities or if you are a member of the armed forces
5. Workers Compensation
6. By court order for lawsuits or disputes
7. By court order, subpoena, warrant, summons or request by law enforcement officials to identify as suspect, fugitive, witness or missing person
8. Coroners, funeral directors and medical directors
9. Intelligence or National Security
10. If you are an inmate of a correctional institution under the custody of law enforcement officials and it is necessary to carry out proper healthcare
11. In case of emergency, lack of physical or mental awareness

Instances in which we may use and disclose your health information

In efforts to provide care for you, it may be necessary that your health information is available for healthcare providers who are involved in your treatment, care and billing. We will have to communicate with your insurance company about your care in order to obtain prior approval or to determine if your insurance company will pay for your treatment or care.

Your rights regarding your healthcare information

1. You have the right to revoke your consent or authorization to use and disclosure of your personal information by a written notice to the appropriate personnel at the clinic in which you are being treated. Please realize that we will not be responsible for any information that has already been disclosed or obtained by our office. We also are still required to retain any records of the care we provided for you at our clinics.
2. You have the right to copy and inspect your medical or billing records. To do so, you must contact our Privacy Officer. There may be fees for the cost of copying, mailing, or other supplies associated with your request. You also have the right to request that certain information be amended or changed. This must also be done in writing. We may deny your request to inspect or copy your records because of certain circumstances. In this instance, it will be discussed with you and you will also have a right to review the denial with the Privacy Officer.
3. You have the right to request that your information be communicated within the specific guidelines. You may also request with the appropriate form, to restrict or limit our communication with you. For example, not calling your work or leaving messages on your answering machine.

Complaints

If you believe that any of your privacy rights have been violated, you may file a written complaint with our Privacy Officer. The Privacy Officer will then investigate the complaint and follow up with you in an appropriate time frame.

To reach our Privacy Officer, please send all requests and correspondences to:
Atlanta Oncology Associates, Attention: Privacy Officer, 3330 Preston Ridge Road, Suite 300, Alpharetta, GA 30005

New Patient Registration Form

Location-_Hawkinsville_

Patient Name: _____ SS#: _____

Address: _____ Date of Birth: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone Number (with area code): _____ Cell Phone: _____

Email address: _____ Race: _____ Ethnicity: ___Hispanic ___Non-hispanic

Preferred contact: home# cell# work# email mail Preferred language: _____

Employer: _____ Phone Number (with area code): _____

May we contact you at work? ___ Yes ___ No

Spouse/Significant Other: _____ Date of birth: _____

Work Number: _____ Cell phone number: _____

Emergency Contact (other than spouse): _____ Relationship: _____

Home Phone Number: _____ Cell phone number: _____

Referring Doctor: _____ Phone Number (with area code): _____

Primary Care Physician: _____ Phone Number (with area code): _____

Other Doctor: _____ Phone Number (with area code): _____

Primary Insurance Company: _____ Policy holder: _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____ Policy holder: _____

Policy Number: _____ Group Number: _____

Do you have a Cancer Policy? Yes ____ No ____ I Do you have an FSA or HSA? Yes ____ No ____

Are you a resident at a: Skilled Nursing Facility: _____ Hospice? _____ Assisted Living Facility? _____

Address: _____ Phone Number (with area code): _____

Other than your physician, how did you hear about us? (please select all that apply)

Former Patient _____ Radio_____ TV _____ Billboard _____ Website/Online Search _____

Magazine/Newspaper _____ Event/Seminar _____ Other: _____

All information given above is true and factual to the best of my knowledge.

_____ _____

Patient/Representative Signature Date

New Patient Intake Form – page 2

Patient Name: _____ Date: _____

CONSENT FOR MEDICATION HISTORY RETRIEVAL

I hereby authorize the Atlanta Oncology Associates and its affiliates to download my medication history electronically.

_____
Patient Initials

CONSENT TO OBTAIN/RELEASE MEDICAL RECORDS

I hereby authorize the AOA and its affiliates to obtain medical records from any other Physician or medical facility necessary in the course of my treatment. Additionally, I authorize the AOA and its affiliates to release any information acquired in the course of my treatment to other Physicians and medical facilities as needed. I authorize that this acquisition/release may occur by regular mail, fax or e-mail, as necessary. I also authorize the release of any information to a government agency (DEA, GBI, etc.) if requested by said agency.

_____
Patient Initials

CONSENT FOR TREATMENT

I hereby authorize any medical/surgical, x-rays, drug or laboratory tests, medications or exam as deemed necessary by the Physician, Physician Assistant or Nurse Practitioner. I understand that I may have the right to see a Physician if I chose and have the right to see the Physician prior to any prescription drug or devise order being carried out by a Physician Assistant. In case of an unemancipated minor, the consent below is given by his/her parent/guardian.

_____
Patient Initials

CONSENT TO EMAIL COMMUNCATION VIA PATIENT PORTAL

I hereby authorize AOA and its affiliates to use my email address given, to set up an account with MedFusion's Patient Portal on my behalf. I certify the email address provided is accurate, and that I, accept full responsibility for messages sent to or from this address. I understand I may receive my health record information via the patient portal. I agree to hold harmless the Provider, his/her medical practice, AOA and its affiliates and individuals associated with it harmless from any and all claims and liabilities arising from or related to communicating via email.

_____
Patient Initials

CONSENT TO RELEASE MEDICAL INFORMATION/RECORDS/ACCOUNT INFORMATION TO A *SPOUSE or FAMILY MEMBER/FRIEND*

I hereby authorize AOA and its affiliates to release any information contained in my medical records to the person or person indicated below:

YES _____, release to: _____ (please indicate relationship)

NO _____, release to only me.

By initialing the above items, I am stating that I have read the information contained therein. My signature below shows my acceptance of all items defined above.

_____ _____
Signature of patient or responsible party Date

Atlanta Oncology
ASSOCIATES, P.C.

Assignment of Benefits

Atlanta Oncology Associates (FACILITY)

Patient Name: _____

Patient Address: _____

_____

I hereby assign to FACILITY all healthcare and medical benefits payable for care provided to the Patient named above under coverage existing at the time FACILITY provides treatment, which benefits are provided to me by any Payer whatsoever (including, but not limited to, commercial insurance coverage, ERISA-governed benefit plans, governmental health benefits plans, Medicare, Medicaid, and any other source of welfare coverage or insurance) and related rights existing under such coverage. This assignment applies to both past and future medical services provided by FACILITY to the Patient named above. I understand that this assignment is irrevocable. I hereby certify that the Payer information I have supplied FACILITY is true and accurate as of the date of service. I am fully aware that having healthcare coverage does not absolve me of my responsibility to ensure that my medical bill is paid in full. I understand different Payers have different requirements for payment including, but not limited to, pre-certifications, authorizations or that the services be medically necessary. I understand that it is my obligation to know my Payer's requirements and ensure that they have been fulfilled. I also understand that my Payer may not pay 100% of the amount of the medical claim and that I may be responsible for any and all amounts not paid by the identified Payer. I agree to notify FACILITY if any of the information I have supplied changes at any time during my treatment.

I hereby authorize FACILITY to submit claims on my behalf to the Payer listed on the copy of the current benefits card I have supplied FACILITY. I hereby instruct and direct my Payer to pay FACILITY directly. If my current coverage prohibits direct payment or assignment to FACILITY for services, I hereby instruct and direct my Payer to make the check payable to me, but to mail it directly to FACILITY for the professional or medical expense benefits allowable that are payable to me under my current coverage under Payer's policy for payment towards the total charges for medical services rendered. Upon receipt of any such check, I authorize FACILITY to deposit to FACILITY's account such check received if such check is made payable to me.

I am hereby making a direct and express assignment of all my rights and benefits (including, but not limited to, payment) under existing coverage to the fullest extent of the law. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of medical service charges over and above this payment (certain regulations and exceptions apply for Medicare and Medicaid Beneficiaries). I hereby acknowledge and give my express permission for FACILITY or its legal representative to release any of my patient health information, including privileged information (*i.e.*, mental health, alcohol/drug abuse or HIV/AIDS) for payment purposes. Furthermore, I authorize FACILITY or its legal representative to obtain information concerning my medical benefits directly from Payer (including, but not limited to, the policy or plan governing my benefits).

In the event that my coverage prohibits assignment of certain rights (such as right to file appeals or to file suit in state or federal court) I expressly authorize FACILITY, in its sole discretion, to be my personal representative such that FACILITY may: (1) submit any and all appeals if my Payer denies benefits in whole or part to which I may be entitled; (2) submit any and all requests for benefit information from my Payer; and (3) initiate formal or informal complaints to any State or Federal agency that has jurisdiction over my benefits; this includes express permission for the FACILITY or its legal representative to file suit against Payer for healthcare and medical benefits to which I may be entitled. I also agree that any fines, interest, attorney's fees, or other awarded damages that may be levied against my Payer will be paid to FACILITY for acting as my personal representative.

A photocopy of this Assignment shall be considered effective and valid as the original.

_____ _____

Signature of Patient/Policy Holder Date

_____ _____

Signature of Policy Holder if not Patient Date

_____ _____

Witness Date

Authorization for Release of Information

Please sign only! We will fill in the information if needed at a later time.

1. I hereby authorize _____ to release information including, if any psychiatric or psychological information, infectious or contagious disease information (including AIDS confidential information, and/or information about drug or alcohol abuse or treatment of the same) for the health records of:

Covering the periods from: _____ to: _____

Date of Birth: _____ SSN#: _____

2. Information to be released:
   - ☐ Copy of Radiation Oncology Records
   - ☐ Pathology
   - ☐ History & Physical
   - ☐ Diagnostic Reports
   - ☐ Port Films
   - ☐ Other _____

3. Information to be released to: (Please include name and address):

_____

_____

4. Purpose or disclosure _____

5. I have read and understand the Consent for Release of Radiation Oncology Records, and have voluntarily and knowingly signed such consent.

_____ _____

Signature of Patient or Representative Date

Atlanta Oncology
ASSOCIATES, P.C.

Consent for use and disclosure of Protected Health Information

I hereby give my consent to Atlanta Oncology Associates, and its affiliates (AOA) to use and disclose protected health insurance information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). (AOA Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Atlanta Oncology Associates, and its affiliates (AOA) reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Atlanta Oncology Associates, Privacy Officer at: 3330 Preston Ridge Road, Suite 300, Alpharetta, GA 30005.

With this consent, AOA may mail to my home or other alternative locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, AOA may mail to my home or alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that AOA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to AOA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, AOA may decline treatment to me.

_____ _____

Signature or Patient or Legal Guardian Date

_____ _____

Patient Name Print name of legal guardian (if applicable)

Atlanta Oncology
ASSOCIATES, P.C.

Patient Financial Policy

Thank you for entrusting us with your care. We at **Atlanta Oncology Associates** (AOA) realize this may be a stressful period of your life and we want to make your experience with us as pleasant as possible. We are committed to the success of your treatment. Part of that success is making sure you have a clear understanding of our financial policy and payment guidelines.

1) CO-PAYMENTS, DEDUCTIBLES, AND FEES – All co-payments, insurance deductibles, and fees for services not covered by your insurance policy are due at the time service is rendered. We accept cash, check, or credit cards (VISA, MasterCard, and American Express). **Deposits will be required prior to the start of treatment.**

2) Medicare Patients: The physicians of **Atlanta Oncology Associates** are proud to be "Participating Providers" of medical services under the Medicare Part B program. As Participating Providers, we agree to accept an amount of payment equal to the Medicare "allowable" for covered services. Medicare pays 80% of the allowable, and the patient, or the patient's secondary insurance, is responsible for paying the remaining 20% of the allowable amount and any deductibles.

3) Insurance is a contract between you and **your insurance** company. We will file claims with your insurance company as a courtesy to you. In order to properly bill your carrier we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to, those charges above the usual and customary allowance. If we are out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

4) **Prior to you beginning treatment**, you will be scheduled for an appointment to meet with one of our financial counselors. At this time we will discuss insurance coverage, authorization information, and provide you with an estimate of the cost you will be expected to pay towards your care. If monies are due from you, **you will be required to make a deposit prior to the start of treatment. The amount of the deposit will be based on the amount that is determined to be your responsibility.** Keep in mind, the benefits and estimated amount due are quoted to you are based on the information that AOA received from your insurance carrier at the time of insurance verification. AOA is not to be held responsible for inaccurate information received. This estimate is provided to you as a courtesy and is not a guarantee of benefits or payment to us by your insurance carrier. We will also take the opportunity to provide you with a statement of your current charges to ensure you do not have any questions and are comfortable on how to interpret the statement. During this appointment, feel free to discuss any concerns you may have with your financial counselor. It is our expectation that your total out of pocket cost be paid in full by the end of your course of treatment. If paying the entire balance will be a hardship, we will make every effort to accommodate you by offering reasonable payment arrangements. We also offer a Charity and Indigent program for those patients who may qualify.

5) **If you are unable to pay the required deposit we must have a completed financial assistance application prior to the start of treatment.**

6) AOA files claims with your insurance carrier on a daily basis. Keep in mind the balance on your statements may change; this is due to subsequent payments being made by your carrier and additional monies being transferred to patient responsibility. Remember, although you may not receive a statement initially you are considered to be liable for the bill at the time service is rendered.

7) **Cancer Policies-** AOA will provide information necessary for you to file any cancer policy claims. This information will be made available to you at the completion of your course of therapy and once your AOA account has been paid in full, unless otherwise approved by our management team.

8) If you have questions about your insurance or your statement feel, free to contact our centralized billing department at (770) 350 – 0126. They are available Monday through Friday 8:00am to 5:00pm.

Patient Financial Agreement

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for services rendered. I have read the above Patient Financial Policy and have provided the practice with true and correct insurance information. I will notify the practice of any changes in my health insurance coverage.

A copy of this agreement may be used in place of the original.

_____	_____	_____
Signature of Patient/Responsible Party	**Print Name**	**Date**

PATIENT PHOTOGRAPH AND INFORMATION RELEASE FORM

Patient's Name_____ Date:_____

I hereby acknowledge that I have been advised that photographs will be taken of me before and after medical services are provided to me at _____ (the "Practice"). The photographs will be taken by one of the members of the Practice staff. I hereby give my consent for the Practice to take photographs of me and use the photographs as well as the fact that I have received medical services (including the type of medical services I have received) at the Practice in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, the Practice's internet site and television, in order to inform the public about our Practice's medical services.

Federal and state laws protect the personal health information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a healthcare provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected. I release and discharge the Practice and its employees, officers and agents acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication.

This authorization will expire upon the expiration of twelve (12) months following the date below. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to you. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility benefits. I understand that if this authorization is sought by a covered entity I will be given a copy of this Authorization form, after signing it.

Signature of Patient/Authorized Representative (include relationship or nature of authority)

_____(LS)
Signature

_____
Print Name

Date_____

Witness_____

Patient or Guardian Signature_____

Patient Pharmacy Information

Patient Name: _____ Acct #: _____

Date of Birth: _____ SS #: _____

Insurance: _____ ID #: _____

Pharmacy Name: _____

Address/Location: _____

Pharmacy #: _____ Alt #: _____

Drug Allergies:

_____

_____

_____

For Office Use Only

Vital Signs: Temp_____ B/P_____ Resp. _____ O2 Sat _____ % HR _____ Weight_____ Date _____ Height _____

PERSONAL INFORMATION

Name: _____ Date of Birth____/____/____ Age: ___

Home Ph: (___)_____-_____ Work Ph: (___)____-_____ Cell Ph: (___)_____ - _____

Emergency Contact: _____ Relationship:_____ Phone: (___)___ - _____

PHYSICIAN INFORMATION

Referring Physician: _____ City/State: _____ Phone: (___) ____ - _____

Medical Oncologist: _____ City/State: _____ Phone: (___) ____ - _____

Surgeon: _____ City/State: _____ Phone: (___) ____ - _____

Primary Care Physician: _____ City/State: _____ Phone: (___) ____ - _____

Other: _____ City/State: _____ Phone: (___) ____ - _____

HISTORY OF PRESENT ILLNESS

What were your initial symptoms? _____

When did they begin? _____

Who did you initially see to address the problem? _____

Which of the following test have been done to investigate the problem?

TEST	DATE	TEST	DATE
CT SCAN		PET SCAN	
MRI		BONE SCAN	
MAMMOGRAM		COLONOSCOPY	
BIOPSY		BRONCHOSCOPY	
SURGERY		OTHER (please list)	

Have you ever had chemotherapy? ☐ Yes ☐ No

If so, list the type of chemotherapy give: _____

What were the dates of treatment? _____

Have you ever had radiation therapy? ☐ Yes ☐ No

If so, what area was treated? _____

What were the dates of treatment? _____

CURRENT MEDICATIONS: Please bring list of medications, if you need additional space

Medications	Dose	Frequency	Prescribed By

HERBS/SUPPLEMENTS

ALLERGIES

☐ None ☐ Contrast Dye ☐ Surgical Tape ☐ Seasonal Allergies ☐ Shellfish

☐ Other: (please list) _____

Medication Allergy	Type of Reaction

_____

MD Initials

MEDICAL HISTORY **(please check any of these you have been diagnosed with and indicate the year diagnosed)**

√		*Year*		√		*Year*
	Cataracts				History of Colon Polyps	
	Glaucoma				Kidney Failure	
	Difficulty Hearing				Kidney Stones	
	Thyroid Disease or Goiter				Cystitis or Bladder Infections	
	Chronic Bronchitis/Emphysema/COPD				Urinary Tract Infections	
	Asthma				Arthritis	
	Tuberculosis				Multiple Sclerosis	
	Irregular Heart Beat				Parkinson's disease	
	Heart Murmur				Other Neurologic Problems	
	High Blood Pressure				Lupus	
	High Cholesterol				Scleroderma	
	Congestive Heart Failure				Skin Condition	
	Heart Attack				Other Collagen Disease	
	Angina				Blood Clots or Clotting Disorder	
	Stroke or paralysis				Anemia	
	Pacemaker/Defibulator				Seizures or Epilepsy	
	Hernia				Depression	
	Ulcerative Colitis				Severe Anxiety	
	Ulcers of Stomach or Duodenum				Psychiatric Treatment	
	Crohns Disease				Diabetes or Sugar	
	Irritable Bowel Syndrome				History of falls	
	Diverticular disease				HIV/AIDS	
	Hepatitis or Liver Disease				Other:	
	Pancreatitis				Other:	

PAST SURGICAL HISTORY

Type of Surgery	Date of Surgery	Surgeon	Hospital	Complications

FAMILY HISTORY

Relation to You		Diseases	Cause of Death
Mother	☐Alive ☐ Deceased		
Father	☐Alive ☐ Deceased		
Sister	☐Alive ☐ Deceased		
Brother	☐Alive ☐ Deceased		
Maternal Grandmother	☐Alive ☐ Deceased		
Paternal Grandmother	☐Alive ☐ Deceased		
Maternal Grandfather	☐Alive ☐ Deceased		
Paternal Grandfather	☐Alive ☐ Deceased		
Aunt/Uncle	☐Alive ☐ Deceased		
Other:	☐Alive ☐ Deceased		

Other medical problems that run in the family:

MD Initials

GYNECOLOGIC HISTORY (female only)

Age at first menstrual cycle: _____ Last menstrual period: _____ Age at menopause: _____
Age at first pregnancy: _____ # of pregnancies: _____ # of live births: _____
Did you breast feed? ☐ Yes ☐ No Did you/do you use birth control? ☐ Yes ☐ No
Duration of birth control pill use: _____ Duration of hormone replacement therapy: _____
Bra Size: _____ Age at first mammogram: _____Date of last mammogram_____
GYN Problems/Infections: _____
Date of last PAP Smear? _____ Where was it performed? _____
Are you sexually active? ☐ Yes ☐ No If yes, age when you became sexually active: _____

PROSTATE HISTORY (male only)

Age at first PSA: _____ Is your PSA checked regularly? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No
If yes, do have impotence or difficulty with erection? ☐ Yes ☐ No
Have you had a TURP (Roto-rooter)? ☐ Yes ☐ No
If yes, what was the date of the surgery? _____
How many times do you urinate during the night? _____
Have you had prostate infections? ☐ Yes ☐ No
If yes, what are the dates of the infection? _____

SOCIAL HISTORY

Personal Situation: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated
Children's ages: Boys_____ Girls _____

Living Situation: ☐Home ☐Apartment ☐Mobile Home ☐Nursing Home ☐Assisted Living
Name/address: _____

How many people live with you?_____ Any pets? ☐ Yes ☐ No, Type: _____

Highest Education: ☐High School ☐Trade School ☐College ☐Graduate School

Current Work Situation: ☐Full-time ☐ Part-time ☐Medical leave ☐Retired
Occupation: _____

Tobacco use: ☐None ☐Cigarettes ☐Cigars ☐Snuff/Chew ☐Pipe
How old were you when you started smoking? _____ How many years have you smoked?_____
Are you still smoking? ☐ Yes ☐No If no, when did you quit? _____
If yes, how many packs per day do you smoke? _____ Are you interested in quitting ☐Yes ☐ No

Alcohol Use: ☐None ☐Beer ☐Wine ☐Liquor
How old were your when you started drinking? _____ Do you have a history of alcohol abuse ☐Yes ☐No
Are you still using alcohol? ☐Yes ☐No If no, when did you quit? _____
If yes, how many drinks do you have per week? _____ Are you interested in quitting? ☐Yes ☐No

Drug Use: ☐None ☐Marijuana ☐Cocaine ☐Heroin ☐Amphetamines
How old were you when you started using drugs? _____Do you have a history of drug abuse? ☐Yes☐No
Are you still using drugs? ☐Yes ☐No If no, when did you quit?_____
If yes, how often do you use drugs? _____ Are you interested in quitting? ☐Yes ☐No

Exercise/Activities: _____Frequency of exercise/activities: _____

Please describe any emotional/spiritual/cultural practices that may influence your medical care:

_____

Would you like to discuss advanced care planning? ☐Yes ☐No

Do you have a living will? ☐Yes ☐No

_____
MD Initials

REVIEW OF SYSTEMS (circle all that apply)

EYES		**GASTROINTESTINAL**		**NEUROLOGIC**	
Corrective lenses	Vision loss	Nausea	Constipation	Headaches	Tingling
Cataracts	Black spots	Vomiting	Abdominal pain	Weakness	Tremors
Blurred vision	Other	Black Stool	Bloody stool	Numbness	Imbalance/falls
Double vision		Hemorrhoids	Gas	Dizziness	Difficulty walking
Tunnel vision		Jaundice	Other	Seizures	Other
		Diarrhea		Decreased coordination	
EARS/NOSE		**URINARY**		**LYMPHATIC/HEMATOLOGIC**	
Hearing loss	Decreased smell	Pain	Night-time urination	Swollen glands	
Earache	Sinus trouble	Burning	Weak stream	Decreased blood counts	
Vertigo	Nose bleeds	Frequency	Blood in urine	Easy bruising	
Ear pain/ringing	Other	Incontinence	Other	Other	
CARDIOVASCULAR		**MUSCULOSKELETAL**		**SKIN/HAIR**	
Chest pain/pressure	Murmur	Back/neck pain	Stiffness	Hair Loss	Rash
Leg/arm swelling	Irregular heart beat	Bone pain	Other	Itching	Other
Palpitations	Other	Joint pain		Ulcers	
Difficulty lying flat		Decreased range of motion		Change in skin color	
LUNG		**THROAT**		**MOUTH**	
Dry cough	Other	Hoarseness		Mouth pain	
Productive cough		Change in voice		Dental problems	
Coughing up blood		Difficulty swallowing		TMJ	
Shortness of breath		Painful swallowing		Oral ulcers	
Pain with inspiration		Other		Other	
BREAST		**GYNECOLOGIC**		**GENERAL**	
Swelling	Lumpy breast	Vaginal discharge	Pelvic pain	Fever	Weight gain
Pain	Breast mass	Bleeding	Other	Chills	Weight loss
Nipple discharge	Other	Itching		Fatigue	Night sweats
Skin changes		Painful intercourse		Loss of appetite	Other
PSYCHIATRIC		**OTHER ISSUES/COMPLAINTS:**			
Depression	Irritability				
Anxiety	Other				
Claustrophobia					
Trouble Sleeping					

_____
MD Initials

Fall Risk Assessment Tool for Age 65+	
Core Elements Assess one point for each core element	**Points**
Diagnosis (3 or more co-existing)	
Prior history of falls within 3 months	
Urinary Incontinence (urgency, frequency, and/or nocturia)	
Visual Impairment (includes any eye disease)	
Impaired Functional Mobility (arthritis, impaired sensation, unsteady gait, etc.)	
Environmental Hazards (poor lighting, inappropriate foot wear, clutter, etc.)	
Poly Pharmacy (4 or more prescriptions- any type)	
Pain affecting the level of function	
Cognitive Impairment	
TOTAL: A score of 4 or more is considered at risk for falling	

Depression Screening Tool

Over the last two weeks, how often have you been bothered by any of the following problems?
(Circle the number to indicate your answer)

Questions	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 fidgety 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		+	+	
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 at all difficult _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____			

***If there are at least 4 numbers circled in the shaded section, consider depression. May add columns for severity

Vaccine History

Type of Vaccine	Date
Influenza	
Pneumococcal	

Pain Assessment

Are you experiencing pain?	☐ Yes ☐ No
Location of pain?	
How does the pain feel? Sharp, dull, burning, etc.	
Severity? Circle one	1 2 3 4 5 6 7 8 9 10
How long ago did it start?	
When does it bother you?	
What happens to cause the pain?	
What makes it better?	
What makes it worse?	
Any other signs and symptoms associated with pain?	

Patient Signature _____ Date _____ Nurse Signature _____ Date _____ MD Initials _____

Patient Name: _____ **Date:** _____

Pharmacy Name/Location: _____

Patient Medication List

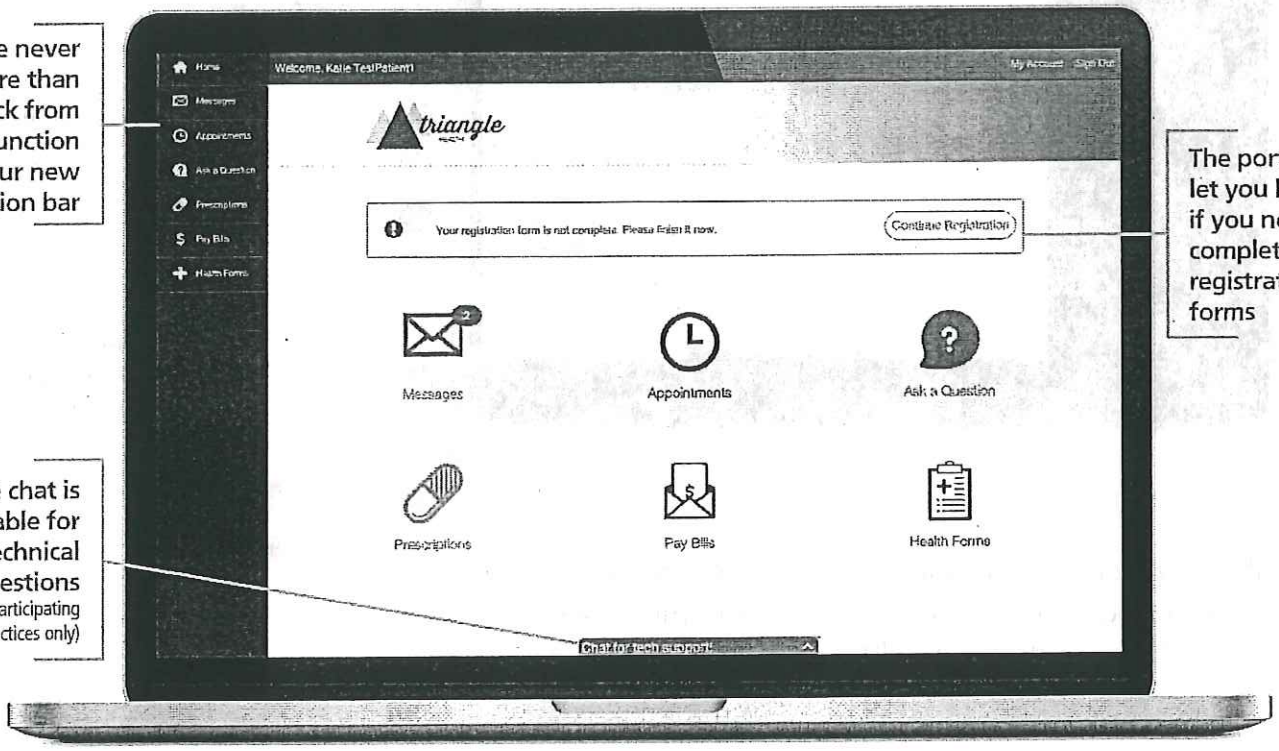
Please list all medications you are presently taking, including all prescriptions, vitamins, herbs, supplements, and over the counter medications.

Name of Medication	Dose

The Medfusion Patient Portal:
Intuitive. Indispensable. In Your Pocket.

The Medfusion Patient Portal is a convenient online connection to your provider that puts you in control of your healthcare.

You're never more than one click from any function with our new navigation bar



The portal will let you know if you need to complete any registration forms

Live chat is available for your technical questions (for participating practices only)

Messages
Connect With Your Provider: secure messaging allows you to recap your appointments, obtain lab results and get answers to your medical questions.

Appointments
Manage Your Appointments: Request, reschedule and cancel appointments at your convenience.

Ask a Question
Questions?: Eliminate phone tag by submitting questions to your provider online.

Prescriptions
Request Prescription Refills: Request a refill for your prescription medications.

Pay Bills
Pay your provider bills online at your convenience.

Health Forms
Complete paperwork before your appointments and maintain updated records.

medfusion
WWW.MEDFUSION.COM

Note: Your provider's practice may not offer all patient portal functions shown.