FAMILY PRACTICE BY THE Lake

PATIENT INFORMATION

Name: Last:__________________First:___________________MI:_____Preferred:_______________

Date of Birth:________________ SSN:____________________

Marital Status:_____________

Address:______________________________ City:______________State:____ Zip:____________

Phone:________________________ May we leave a message at this number?_______________

Email:____

EMERGENCY CONTACT

Name:_______________________________ Phone:________________ Relationship:__________

PHARMACY INFORMATION

Preferred Pharmacy:____

INSURANCE INFORMATION

Insurance Name:____

Insurance ID:_________________________________ Group Number:____________________

Policy Holder Name:____________________________ DOB:___________________

Policy Employer:____

I hereby authorize direct payment of medical benefits of Family Practice By the Lake for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company. I also authorize a release of my medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I certify that the information given by me in applying for payment is correct. I authorize release or reports on request. I request that payment of authorized benefit be made on my behalf. A photocopy of the assignment shall be valid as original.

Sign:___________________________________ Date:___________________

Family Practice by the Lake

EMPLOYER INFORMATION

Name of Company:______________________________________

Employer Name: __________________________________

Address:________________________________ City:_______________State:____ Zip:_____________

Phone:_____________________________

Family Practice by the Lake

PATIENT MEDICAL HISTORY

Prescription Medication (include dose and frequency):

1.____

2.____

3.____

4.____

5.____

6.____

Medical Problems:

____
____
____
____
____
____

Allergies: (including reaction and severity):

____
____
____

Tobacco user ______ Since________ Amount____________
Alcohol _______________ How often/Much______________
Recreational Drugs _______________ Type/Frequency____

Last Colonoscopy____________ Bone Density____________ Dental Exam____________
Eye Exam______________________

Females:
LMP_________ Number of Pregnancies:_____ Live Births_____ Last Pap_______ Mammogram______

Latest Vaccination: **Flu** **Pneumonia** **Shingles** **Tetanus**
Other____

Surgeries:

____

____

____

____

____

____

FAMILY MEDICAL HISTORY

	Alive/Deceased	Medical Problems
Father		
Mother		
Paternal Grandparents		
Maternal Grandparents		
Siblings		
Others		

Notice of HIPPA Privacy Practices:

Acknowledgement of Receipt of HIPPA Privacy Practice • I understand I have a right to review Family Practice by the Lakes's Notice of Privacy Practices prior to signing this document • Family Practice by the Lakes's Notice of Privacy Practices has been provided to me • The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Family Practice by the Lake • The Notice of Privacy Practices for the providers at Family Practice by the Lake is also provided at the front desk of Family Practice by the Lake • This Notice of Privacy Practices also provided at the front desk of Family Practice by the Lake • This Notice of Privacy Practices also describes my rights and the duties of the providers at Family Practice by the Lake with respect to my protected health information • Family Practice by the Lake reserves the right to change the privacy practices that are described in the Notice of Privacy Practices • I may obtain a revised notice of privacy practices by calling the office and requesting revised copy be sent in the mail or asking for one at the time of my next appointment • By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices and have had an opportunity to discuss any questions I may have.

Signature of Patient: ______________________________ Date: ________________

FAMILY PRACTICE BY THE LAKE

Notice of Missed Appointment Policy

All appointments are scheduled time between you and your provider; therefore, when an appointment is missed, someone else could have had that scheduled time with the provider.

Twenty-four (24) hours advance notice is required for an appointment cancellation.

If this notice is not given, Family Practice by the Lake reserves the right to charge you for a full visit ($125).

Please keep your appointments.

Thank you!

I have read and agreed to the information provided above.

Printed Name: ______________________________ Date: ________________________

Family Practice by the Lake

Consent for Purposes of Treatment, Payment & Health Care Operations

I consent to the use or disclosure of my protected health information by Family Practice by the Lake for the purpose of diagnosing or providing treatment to me, obtaining payment or my healthcare bills or to conduct health care operations of Family Practice by the Lake.

I understand that diagnosis or treatment of me by providers at Family Practice by the Lake may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Family Practice the Lake is not required to agree to the restrictions I request. However, if Family Practice by the Lake agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent in writing at any time, except to the extent that Family Practice by the Lake has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me, and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

Your provider at Family Practice by the Lake will keep a record of the healthcare services provided to you. You may ask to see a copy of that record. Your provider will not disclose your record to others unless you direct them to do so or unless the law authorizes or compels them to do so. You may also ask to correct your record. You may also get more information about this by contracting your provider at Family Practice by the Lake.

Signature: ______________________________ Date: ______________

(Patient or Guardian)

PATIENT RESPONSIBILITY FORM

Family Practice by the Lake serves all patients regardless of inability to pay. Discounts for essential services are offered based on family size and income. For more information, ask at the front desk or visit our website.

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

   - I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service. o Co-payments are due at time of service.
   - If my plan requires a referral, I must obtain it prior to my visit.
   - In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
   - If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

   I hereby authorize and direct payment of my medical benefits to Family Practice by the Lake on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

   I hereby authorize Family Practice by the Lake to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

4. MEDICARE REQUEST FOR PAYMENT

   I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Family Practice by the Lake. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

____ Date__________

Signature of Patient, Authorised Representative or Responsible Party

____ ______________________

Print name of Patient, Authorised Representative or Responsible Party Relationship to Patient

RELEASE OF INFORMATION

PATIENT NAME		DATE OF BIRTH
I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW;		
☐ THE MOST RECENT 2 YEARS OF MEDICAL RECORDS		
☐ ALL HEALTH CARE INFORMATION IN THE MEDICAL RECORD (COMPLETE COPY)		
OTHER INFORMATION (PLEASE SPECIFY BELOW)		
I GIVE SPECIAL PERMISSION TO RELEASE ANY INFORMATION REGARDING:		
☐ SUBSTANCE ABUSE	☐ PSYCHIATRIC (MENTAL HEALTH)	☐ HIV INFORMATION

I AUTHORIZE Family Practice by the Lake TO RECEIVE THIS INFORMATION:

1875 N Lakewood Dr, Suite 205, Coeur D'Alene, Idaho 83814
Ph 208 966 4087 Fx 208 966 4031

ENTITY OR ENTITIES TO WHO MAY DISCLOSE INFORMATION,

CLINIC OR PROVIDER	ADDRESS	PHONE

For the purpose of ☐ Transfer of Care ☐ Referral to Specialist ☐ Legal ☐ Other ____________________

This authorization will expire on the following date or event:

ONE YEAR FROM THE DATE OF THE AUTHORIZATION (MAXIMUM ALLOWED) ☐
OTHER: UNTIL REQUESTED BY PATIENT TO END AUTHORIZATION ☐

I UNDERSTAND THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE RE-DISCLOSED BY THE RECIPIENT AND NO LONGER BE PROTECTED BY APPLICABLE LAW. HOWEVER, THE RECIPIENT MAY BE PROHIBITED FROM DISCLOSING SUBSTANCE ABUSE INFORMATION UNDER THE FEDERAL SUBSTANCE ABUSE CONFIDENTIALITY REQUIREMENTS, I UNDERSTAND THAT FAMILY p MAY NOT CONDITION MY TREATMENT ON PROVISION OF THE AUTHORIZATION UNLESS THE AUTHORIZATION IS FOR THE USE OR DISCLOSURE OF INFORMATION FOR RESEARCH-RELATED TREATMENT, OR UNLESS THE TREATMENT IS SOLELY FOR THE PURPOSE OF DISCLOSING INFORMATION TO A THIRD PARTY (E.G., AN EMPLOYMENT PHYSICAL). I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANYTIME UNLESS FAMILY PRACTICE BY THE LAKE HAS TAKEN ACTION IN RELIANCE ON THE AUTHORIZATION.

Sign ______________________________ Date ________________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name:________________________________ Date:________________

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answers)

	Not at all	**Several Days**	**More than half the days**	**Nearly everyday**
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 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

Total Number added up:__________

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

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

CHECKLIST: Review of Systems

General:

- ☐ Fever/ chills
- ☐ Fatigue
- ☐ Trouble Sleeping
- ☐ Weakness
- ☐ Weight lose or gain

Teeth:

- ☐ Pain with chewing
- ☐ Dentures
- ☐ Hx of tooth abscess

Skin:

- ☐ Rashes
- ☐ Itching
- ☐ Changes in skin and nails
- ☐ Lumps
- ☐ Dryness

Head:

- ☐ Head injury
- ☐ Headaches

Eyes:

- ☐ Change in vision
- ☐ Eye pain
- ☐ Flashing lights
- ☐ Glaucoma/Cataracts
- ☐ Specks
- ☐ Redness

Ears:

- ☐ Change in hearing
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Ringing
- ☐ Dizziness

Nose/Sinuses:

- ☐ Nosebleeds
- ☐ Nasal stuffiness
- ☐ Frequent colds
- ☐ Sinus pain
- ☐ Itching

Allergies:

- ☐ Hives
- ☐ Swelling of lips and tongue
- ☐ Asthma

Mouth/Throat:

- ☐ Bleeding gums
- ☐ Sore tongue
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Dry mouth

Neck:

- ☐ Lumps
- ☐ Swollen glands
- ☐ Goiter
- ☐ Stiffness
- ☐ Pain

Respiratory/Cardiac

- ☐ SOB
- ☐ Cough
- ☐ Production of phlegm
- ☐ Wheezing
- ☐ CP Night sweats
- ☐ Swelling in hands/feet
- ☐ Hypertension
- ☐ heart disease
- ☐ Heart murmur
- ☐ Skipping heart beats:
- ☐ Painful breathing

- ☐ **Are you on cholesterol medication?** Yes or No

- ☐ **Are you sexually active?** Yes or No

Gastrointestinal:

- ☐ Problems swallowing
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Yellow color of skin
- ☐ Nausea
- ☐ Constipation
- ☐ Excessive belching
- ☐ Heartburn
- ☐ Diarrhea
- ☐ hepatitis/jaundice

Urinary:

- ☐ Difficulty in urination
- ☐ Blood in urine
- ☐ Frequency/Urgency
- ☐ Dysuria
- ☐ Incontinence of urine
- ☐ Burning or pain

Genital:

Males only-

- ☐ Prostate pain
- ☐ Erectile Dysfunction
- ☐ Increased nighttime trips to the bathroom.
- ☐ Dribbling
- ☐ Decreased urine stream
- ☐ Hernia
- ☐ Family history of prostate cancer
- ☐ Pain with sex
- ☐ STIs (aka STDs)

Females only-

- ☐ Does self breast exam
- ☐ Family history of breast cancer.
- ☐ Breast pain
- ☐ Breast lump
- ☐ Pain with sex
- ☐ STIs (aka STDs)

Peripheral Vascular:

- ☐ Leg cramps
- ☐ Varicose veins
- ☐ Clots in veins

Musculoskeletal:

- ☐ Muscle or joint pain
- ☐ Arthritis
- ☐ Swelling of muscle or joint
- ☐ Gout
- ☐ Decreased joint motion
- ☐ Back pain

Neurologic:

- ☐ Seizures
- ☐ Weakness
- ☐ Tremor
- ☐ Numbness
- ☐ LOC/fainting
- ☐ Loss of muscle size
- ☐ Involuntary movement
- ☐ Feeling of pins and needles
- ☐ Paralysis
- ☐ Muscle spasm
- ☐ Incoordination

Hematologic:

- ☐ Anemia
- ☐ Easy bruising/bleeding
- ☐ Past Transfusions

- ☐ **Are you currently taking blood thinners?** Yes or no

Endocrine:

- ☐ Abnormal growth
- ☐ Polyuria
- ☐ Excessive sweating
- ☐ Increased appetite
- ☐ Thyroid trouble
- ☐ Changes with hair
- ☐ Increased thirst
- ☐ Heat/Cold intolerance
- ☐ Skin or Nails

Psychiatric:

- ☐ Tension/stress
- ☐ Memory problems
- ☐ Other unusual problems
- ☐ Anxiety/Depression
- ☐ Family history of suicide
- ☐ Suicide ideation
- ☐ Sleep problems.