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Full Name:			Primary Care Physician:		
Address:			Referring Provider:		
			Date of Birth:	Sex	Marital Status
City			Social Security Number		
State	Zip Code		Emergency Contact		
Primary Phone	Alternate Phone		Relationship to the patient	Phone Number	
Work Phone		Ext	Emergency Contact Address		
E-mail Address			Preferred Pharmacy		

Patient Information

Responsible Party Information

Full Name			
Address			
Primary Phone	Alternate Phone		
Employer Name	Employer Address	City, State, Zip	
Social Security Number	Relationship to the patient	Sex	Date of birth
Email Address	Marital Status		

Insurance Information

Insurance Name	Policy Holder Name		Self-Pay	
Policy / ID Number	Group Number			
Insurance Address	City	State	Zip	
Policy Holder Social Security Number	Date of Birth	Policy Holder Employer		
Policy Holder Address if different than above	City	State	Zip Code	

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Reason for your Visit Today:

_____

New Patient Medical History

Name _____

Current Medications: Please list all medication you are taking, including over the counter (or provide a copy):

Name:	**Dosage:**	**How Often:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications tried and failed for any behavioral health or sleep concerns:

Name:	**Dosage:**	**How Often:**	**Date Started & Date Ended:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Weight _____ **Current Height** _____

Past Psychiatric History:

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Psychosis (hallucinations, delusions, paranoia)
- ☐ Suicide Attempt
- ☐ Psychiatric Hospitalization
- ☐ History of Abuse (circle: Sexual abuse / Physical abuse / Emotional Abuse / Neglect)
- ☐ ADHD

Past Medical History: Has a doctor or other health care provider ever told you that you have any of the following?

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Coronary Artery Disease
- ☐ Asthma
- ☐ HIV or AIDs
- ☐ Cancer _____
- ☐ Other _____

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Allergies: please list all drug and food allergies and the type of reaction

_____ _____
_____ _____
_____ _____

Past Surgical History: Do you have a surgical history of the following?

	Date:		Date:		Date:
☐ Appendectomy	_____	☐ C-Section	_____	☐ Tubal Ligation	_____
☐ Bypass	_____	☐ Hip Replacement	_____	☐ Hysterectomy	_____
☐ Cardiac Stent	_____	☐ Hernia Replacement	_____	☐ Tonsillectomy	_____
☐ Cholecystectomy	_____	☐ Knee Replacement	_____	☐ Other	_____
☐ Colonoscopy	_____	☐ Pacemaker	_____		

Past Hospitalization History: Psychiatric and medical hospitalization history? (If applicable)

_____ _____
_____ _____
_____ _____

Family Psychiatric History:

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Suicide Attempt
- ☐ Psychiatric Hospitalization
- ☐ ADHD

Social History:

- ☐ Non-smoker
- ☐ Current smoker _____ packs per day
- ☐ Former smoker _____ quit date
- ☐ Chewing Tobacco
- ☐ Dip
- ☐ Vape
- ☐ Number of children
- ☐ Married / Widow / Single / Divorce (Circle)
- ☐ Legal problems
- ☐ Illicit Drug use (current / past); which substance _____

Occupational History:

- ☐ Working (where are you employed: _____)
- ☐ Unemployed
- ☐ Student (Grade Level:_____ School: _____)
- ☐ Disabled
- ☐ Retired
- ☐ Military
- ☐ First Responder

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CONSENT, ASSIGNMENT, AND RELEASE FORM

CONSENT FOR MEDICAL TREATMENT

I voluntarily present to Family Medicine Center/Carexpress and consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiological evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

____(**Initial**)

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to Family Medicine Center/Carexpress any and all rights, which I have against insurance companies or third party payers, for payment of charges for services provided by Family Medicine Center/Carexpress to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third-party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with Family Medicine Center/Carexpress. It is our policy that any insurance co-pays and deductibles or any balance of a bill owed by those without insurance is due at the time of service.

_____(**Initial**)

Patient's Consent to Obtain External Prescription History

I grant permission to the healthcare providers at Family Medicine Centers/CareXpress to view my prescription history from other external sources (other pharmacies and/or providers). I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff, and it may include prescriptions back several years.

____(**Initial**)

Completion of Disability/FMLA Paperwork

Effective November 21st, 2023, any patient who requests Disability/FMLA paperwork to be completed will be charged a $50 fee upfront and a $20 fee for any additional paperwork required.

____(**Initial**)

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Patient Portal Authorization on the Web

Family Medicine Centers/ CareXpress clinics offer the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables patients to communicate with our staff easily, safely, and securely *via* the internet.

Patients are sent, via email, a secure User IDs and password, enabling them to access our secure Patient Portal to view their health records, including lab and diagnostic test results, educational information, billing statements, and other health information. You can also send a message to the office through the Portal. In order to provide you access to the Patient Portal, please provide us your email address

Email Address: _____

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. TREATING PHYSICIANS on staff at Family Medicine Center/Carexpress and their staff, agents of another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow up care.
2. AN EMPLOYER who requests services. This may include your personal medical history, physical, laboratory and diagnostic tests, and drug screenings (including the presence of drugs, alcohol, or marijuana).
3. INSURANCE COMPANY or other third-party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided, and insuring government compliance.
4. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS, authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.

I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected and that I could be held liable for the full cost of services provided by Family Medicine Center/Carexpress. I understand this information may contain my personal medical history, physical, and treatments (if necessary), radiographic and laboratory results, and more specifically results in reference to alcohol/drug abuse, mental health, or infectious disease (including human immune-deficiency virus, hepatitis, or other infectious diseases). I understand that I have the right to revoke this authorization.

____(**Initial**)

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER INDIVIDUALS

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, in order for your physician or the staff of Family Medicine Center/Carexpress to give copies of and/or discuss your condition/exams/procedures/x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. I authorize Family Medicine Center/Carexpress to release all information (including verbal information, copies of x-rays and medical paperwork) concerning my medical care to the following individuals listed below.

Name: _____Relationship: _____ Phone Number: _____

Name: _____Relationship: _____ Phone Number: _____

AUTHORIZATION TO DISCUSS FINANCIAL INFORMATION

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966, we must obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents. I authorize Family Medicine Center/Carexpress to verbally discuss financial information with the following individual listed below.

Name: _____Relationship: _____ Phone Number: _____

Name: _____Relationship: _____ Phone Number: _____

_____ I DO NOT authorize Family Medicine Center/Carexpress to release any information concerning my care to any individual.

____(**Initial**)

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Family Medicine Center/Carexpress may use and disclose my protected health information. I understand that Family Medicine Center/Carexpress reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me upon request.

Signature of Patient or Parent/Guardian: _____ Date: _____

These policies are subject to change without notice. I acknowledge that I have received, signed a copy and agree to this Financial Policy.

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APPOINTMENT CANCELATION/NO SHOW POLICY

Thank you for trusting your medical care to FMC/Carexpress. When you schedule an appointment with FMC/Carexpress we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective August 16th 2022, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least a 24 hour notice** will be considered a No Show and charged **$50.00 fee.**
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.
- If you arrive to your appointment more than 10 min later than your appointment time, you may be asked to reschedule your appointment.
- Effective, November 21st, 2023, any patient who no shows, reschedules, or cancels a scheduled appointment more than 3 times in a row, will not be rescheduled.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) **Relationship to Patient**

_____ _____

Printed Name **Date**

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CONSENT TO TREATMENT & CONTROLLED SUBSTANCES AGREEMENT FORM

The purpose of this agreement is to prevent any misunderstandings regarding controlled substances that you may be prescribed by the providers at this clinic. The goal is to treat you safely with these potent medications and also to prevent abuse of or addiction to these medications. This agreement is also set forth to assist you and your provider to comply with the law regarding controlled pharmaceuticals.

Because these medications have the potential for abuse or diversion, strict accountability is necessary for both medical safety and legal reasons. Therefore, the following polices are agreed to by you, the patient, to help maintain safety and provide quality, effective care.

I agree to the following:
• I am responsible for my medications. I will not share, sell or trade my medication. I will not take anyone else's medication.
• I will not increase my medication until I speak with my provider. If I do so on my own, the provider may taper and d/c medication. Use of medication at a greater rate than prescribed may result in my being without medication for a period of time.
• My medication may not be replaced if it is lost, stolen or consumed earlier than prescribed. My prescription for a controlled substance may not be replaced if lost/stolen.
• Renewals are contingent on keeping scheduled appointments. I will not phone/text for prescriptions after hours or on weekends. Early refills will not be given.
• I agree to voluntary urine drug testing for controlled substances before initiation of therapy and that random urine follow-up testing may be done even if not covered by my insurance. If there is a presence of unauthorized substances, illicit substances or absence of prescribed medications, I may be referred for assessment for addictive disorder and possibly tapered and discontinued from the controlled substance immediately or in the future.
• I will exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to drive or operate heavy machinery.
• I will not obtain any controlled medications, including benzodiazepines, nonbenzodiazepine hypnotics, controlled stimulants or anti-anxiety medications to treat the same symptoms from any other doctor.
• If I am pregnant or intend to get pregnant, I am required to notify BSA Behavioral Health immediately to discuss tapering off stimulants that could potentially harm the fetus. I understand that failure to do so may result in discharge from the clinic. I will not hold the clinic responsible for any harm that may occur to me and/or my unborn.
• I must obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, our office must be informed.

Patient's Withdrawal
The patient understands that he/she can decline and withdraw his/her consent and participation at any time, provided that such withdrawal shall be made in writing and signed by the withdrawing party.

Patient's Dismissal
The patient may be discharged from the clinic due to abusive behavior or language, threatening behavior, noncompliance with treatment regimen or noncompliance with appointments. The patient understands the expectations and dismissal criteria of BSA Behavioral Clinic.

I, _____, I have read this document. I understand that if I break this Agreement, my provider may stop prescribing me certain medications and /or release me from the practice. I agree to follow these guidelines that have been fully explained to me. I consent to the use of stimulants, benzodiazepines, nonbenzodiazepine hypnotics and other prescribed medications. All my questions and concerns regarding this agreement have been adequately answered.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Witness Signature: _____

(PHQ-9 and GAD-7)

Date_____ Patient Name: _____ Date of Birth: _____

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

PHQ-9	**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 in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020