INTERVAL HISTORY QUESTIONNAIRE

Thank you for completing this form. It will help us better serve your health care needs.

Name: ______________________________________ **Date of Birth:** ___________________________

Since your last physical exam:

Has anything in your medical history changed? YES NO
If YES, please explain:
____
____

Has anything in your family history changed (mother, father, and siblings)? YES NO
If YES, please explain:
____
____

Have you been hospitalized or had surgery? YES NO
If YES, please explain:
____
____

Have you seen any other health care providers (including chiropractor, etc)? YES NO
If YES, please explain:
____
____

List all of your medications: Please include dosage, frequency and any supplemental, herbal or prescription medications that you are taking: ____
____
____

Please list prescriptions needed for refills today: ____
____

Do you have an advanced directive (living will or Healthcare Power of Attorney)? YES NO
If YES, where is it on file: ____

Most insurance carriers consider the complete physical exam a preventative medical service. You must verify that your insurance covers this type of service, as well as the frequency of service (i.e. complete physical exam every twelve months). We understand that some carriers might not cover preventative medical services, so it is important that you know your insurance benefits. ***After a claim is submitted we will not be able to change the diagnosis of preventative physical exam. You will be financially responsible for any services denied by your carrier.***

Signature: ____ **Date:** _________________________

Name: ____ Date: _____________________

REVIEW OF SYSTEMS QUESTIONAIRE

Please check (**X**) if any of the following symptoms apply to you.

1.	**CONSTITUTIONAL**	□ FEVER	□ WEIGHT LOSS	□ WEIGHT GAIN	□ FATIGUE
2.	**HEAD & EYES**	□ HEADACHE	□ VISION CHANGE		
3.	**EAR, NOSE & THROAT**	□ SINUSITIS	□ SORE THROAT	□ MOUTH SORES	□ HEARING LOSS
4.	**BREAST**	□ MASSES	□ NIPPLE DISCHARGE	□ PAIN IN BREAST	□ LUMP
5.	**CARDIOVASCULAR**	□ CHEST PAIN	□ PALPITATION	□ SWELLING OF LEGS	
6.	**GASTROINTESTINAL**	□ DIARRHEA	□ CONSTIPATION	□Nausea/vomiting/indigestion	
		□ BLOATING	□ FLATULENCE	□ BLOODY STOOL	□ Abdominal Pain
7.	**MUSCULOSKELETAL**	□ MUSCLE WEAKNESS		□ MUSCLE OR JOINT PAIN	
8.	**RESPIRATORY**	□ COUGH	□ WHEEZING	□ SHORTNESS OF BREATH	
9.	**URINARY**	□ URGENCY	□ INCONTINENCE	□ BLOOD IN URINE	
		□ FREQUENCY	□ PAINFUL	□ INCOMPLETE EMPTYING	
10.	**SKIN**	□ RASH	□ LESION	□ SORES	□ BRUISING
11.	**NEUROLOGIC**	□ DIZZINESS	□ SEIZURES	□ TINGLING/NUMBNESS	
12.	**ENDOCRINE**	□ HEAT/COLD INTOLERANCE		□ EXCESSIVE URINATION	
13.	**HEMATOLOGIC**	□ EASY BRUISING		□ EXCESSIVE BLEEDING	
14.	**LYMPHATIC**	□ ENLARGED LYMPH NODES OR GLANDS			

15.	**PSYCHIATRIC/DEPRESSION QUESTIONAIRE**			
	□ INSOMINA	□ TROUBLE CONCENTRATING		□ FEELING OF HOPELESSNESS/HELPLESSNESS
	□ POOR APPETITE	□ APATHY	□ THOUGHTS OF HURTING YOURSELF OR OTHERS	

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

16.	**ALCOHOL USE QUESTIONAIRE**	
	DO YOU CRAVE ALCOHOL? □ YES If Yes, how many drinks per week (average)?	□ NO

Have you ever felt guilty about the amount you drink or have ever felt a need to control your drinking?
□ YES □ NO

Do you have a family history of alcoholism? □ YES □ NO

PROVIDER REVIEW AND SIGNATURE ___________________________________ DATE_________________________

Patient HIPAA Acknowledgment and Consent Form

Patient Name: ____

Date of Birth: ____________________

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider.

- Each patient is responsible for his or her own bill.
- Payment of all insurance co-payments and deductibles is required at the time medical services are rendered.
- Your insurance policy is a contract between you and your insurance company. We are not party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office immediately. Your bill is your responsibility whether your insurance pays or not. At times you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
- You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any services provided, but not covered by your insurance company will be your responsibility to pay.
- If your insurance company has not paid your full account within 90 days you are responsible to pay the outstanding balance without further delay.
- Monthly payments are required on all accounts with outstanding balances. A minimum of 20% of unpaid balance is expected monthly. A monthly finance charge of 1 ¾% monthly (21% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of $.50 per month. By signing below you agree to pay collection costs up to 40% with or without suit and/or reasonable attorney's fees on any delinquent balance, if referred to any agency or attorney for collection or suit.
- A $25.00 fee will be charged on all returned checks. Cash payments will be required for future payments if you have 2 or more returned checks.
- Patients who fail to appear for their scheduled appointments may be charged a $75.00 unless the patient cancels the appointment at least 24 hours before the scheduled appointment time.

USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance company, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any). I acknowledge that I have been provided access to a copy of the HIPAA Policies and Practices and may request a written copy of said policy any time I wish.

AUTHORIZATION TO PAY BENEFITS

I further authorize and direct said agency, attorney or Insurance Company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

PATIENT Consent to the Use and Disclosure of Personal Health Information (PHI), for Treatment, Payment or Healthcare Operations.

I, ____________________________, understand that as part of my health care, The Care Group originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communicating among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a NOTICE OF PRIVACY POLICIES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent (visit www.thecaregrouppc.com)
- The right to request restrictions as to how my PHI may be used or disclosed to carry out TPO

I understand that The Care Group is not required to agree to the restrictions requested. I further understand that I may revoke this consent in writing, except to the extent of action already taken by the clinic. If I wish to make changes to this consent, I agree to do so in writing. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal regulations.

I wish to have the following restrictions to the use or disclosure of my PHI:

____

____

I wish the following **individuals to have full/limited (*circle one*) access** to my PHI: (please note the extent of information that should be available to this individual, e.g., test results, medications, diagnosis, treatment, appointments, etc.)

____

I further direct The Care Group to contact me regarding labs, appointment reminders, etc as per my preferred method of contact: Phone ____________________ Email: ________________ Message: Yes / No

I fully understand and Accept the terms of this consent.

Signature ___________________________________Date_________________

I fully understand, however I DECLINE the terms of this consent.

Signature ___________________________________ Date __________________