TWIN LAKES
FAMILY MEDICINE

**ALL INFORMATION REQUESTED HERE IS REQUIRED IN ORDER TO PROPERLY BILL YOUR INSURANCE**

**DATE:**_____ **DATE OF BIRTH:**_____ **AGE:**_____

**NAME:**_____ **SEX: M F**

**STREET ADDRESS:**_____

**CITY:**_____ **STATE:**_____ **ZIP:**_____

**MARITAL STATUS: S M D W SPOUSE NAME:**_____

**SOCIAL SECURITY NUMBER (Last 4 digits acceptable):**_____

**HOME PHONE**: (___)_____ **CELL PHONE:** (___)_____

(In providing my cell phone number I give you permission to contact me at this number.)

**EMAIL ADDRESS:**_____

**EMERGENCY CONTACT:**_____

**OCCUPATION:**_____ **EMPLOYER:**_____

**EMPLOYER PHONE NUMBER:** (___)_____

Insurance Subscriber

**Please list the insurance subscriber (if the subscriber is not patient)**

**SUBSCRIBER NAME:**_____

**SUBSCRIBER'S DATE OF BIRTH:**_____

**RELATIONSHIP TO PATIENT:**_____

**SUBSCRIBER SOCIAL SECURITY NUMBER:**_____

**PATIENT SIGNATURE:**_____

Patient Name: _____

Date of Birth: _____

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# MEDICATION LOG:

**NAME:**_____ **D.O.B.:**_____

**KNOWN ALLERGIES:**_____

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
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**PRIMARY PHARMACY NAME:**

_____

**PRIMARY PHARMACY CITY/STREET:**

_____

**SECONDARY/MAIL-ORDER PHARMACY NAME:**

_____

**SECONDARY PHARMACY CITY/STREET:**

_____

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**For all patients:**

Due to recent healthcare reform laws and meaningful use requirements, we are mandated to request the following information:

1) Ethnicity
2) Race
3) Primary language

Please provide the following information:

Ethnicity:

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black and/or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White and/or Caucasian
- ☐ More than one race
- ☐ Other. Please specify:_____

Primary Language:

_____

The above-collected information is only seen by the practice's registration staff, administrators, and personnel involved in quality control, improvement, and oversight. The confidentiality of information provided herein is protected by law. This information is entered directly into our computer system as anonymous data and your name is not collected anywhere on this form. This form will be destroyed after data entry.

**You have the right to refuse to disclose and/or provide the above-requested information.** This refusal will not affect your status as a patient or the care provided to you. If you so desire, please indicate such refusal below.

☐ I hereby decline to disclose the information requested on this form.

Thank you for your cooperation.

Patient Name: _____ Date of Birth: _____

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# ACKNOWLEDGMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I read and/or took receipt of a copy of the Michigan Healthcare Professionals, P.C. Patient Notice of Privacy Practices (effective September 23, (2013).

**Patient Name:**_____ **Date of Birth:**_____

**Signature:**_____ **Date:**_____

## [OPTIONAL]

**Persons(s) with whom patient's information may be shared:**

**Name:**_____ **Phone Number:**(____)_____

**Relationship to Patient:**_____

**Name:**_____ **Phone Number:**(____)_____

**Relationship to Patient:**_____

**Name:**_____ **Phone Number:**(____)_____

**Relationship to Patient:**_____

Patient Name: _____ Date of Birth: _____

# 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 _____



A2663B 10-04-2005

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Patient Name** _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☐ In three years

**The person named above is or has been a patient of**

Name of Person, Provider, or Facility _____

Address _____

Phone _____

Fax _____

**The person named above hereby authorizes** _____ **to**

Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Discuss health information with
- ☐ Send health information to
- ☐ Discuss health information with

**The person named above authorizes information to be requested or released by representatives of**

Name Of Person, Provider, Or Facility _____

Address _____

Phone _____

Fax _____

**Scope**

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify): _____

**Authorization**

_____

Printed name of Patient or Authorized Representative

_____ Signature of Patient or Authorized Representative

_____ Date

_____ Signature of witness

_____ Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated, the information, if such information exists, cannot be released or discussed.

| Initial | Date | | From | To |
|---|---|---|---|---|
| _____ | _____ | Alcohol or Drug Use/Abuse Treatment | _____ | _____ |
| _____ | _____ | Mental Health Treatment | _____ | _____ |
| _____ | _____ | HIV Status or Treatment | _____ | _____ |

The above named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility for benefits

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge. Please contact a clinic office manager or site administrator for additional information about applicable copying fees.