Plotsky Medical Associates

NEW PATIENT REGISTRATION

PATIENT	DATE OF BIRTH	DATE

CONTACT INFORMATION

Street Address			Unit #		
City	State	Zip			
SS#	Marital Status	Sex	[ ] Male	[ ] Female	[ ] Transgender
Preferred Language	Race	Ethnicity			

Please choose your preferred method(s) of contact for appointments as well as CONFIDETIAL MEDICAL INFORMATION:

[ ] Cell	[ ] Home	[ ] Work

[ ] PATIENT PORTAL

HIPAA laws prevent us from sending your medical information via email, but you can access your records through our Patient Portal. You can also request or cancel appointments, check your balance and pay your bill. Please provide your email and we'll send you an invite to join.

Email

Emergency Contact	Relationship	Phone
Employer	Address	

INSURANCE

PRIMARY	Policy Number	PolicyHolder
Zip Code (found on back of card)	Group Number	Policy Holder's Date of Birth
SECONDARY	Policy Numer	Policy Holder
Zip Code (found on back of card)	Group Number	Policy Holder's Date of Birth

PATIENT

_____

MEDICAL QUESTIONAIRE

Current Conditions *(please check all that apply)*		**Specialists you see:**
[ ] High Blood Pressure	[ ] Gynecological Disorders	
[ ] Diabetes	[ ] Blood Disorder	
[ ] Heart Attack	[ ] Asthma	
[ ] Stroke	[ ] Intestinal Disorders	
[ ] Arthritis	[ ] High Cholesterol	
	[ ] Migraines	
[ ] Cancer/Specify Type:	[ ] Other (Specify):	

Current Medications

Medication	**Dosage/Frequency**	**Reason for Taking**

Medication/Food Allergies (Please list reaction)

Surgical History

Procedure	**Date**

Family History (Check all that apply)

	Living		**Heart Disease**	**Diabetes**	**Stroke**	**Cancer**	**Type of Cancer**	**Other**
Mother	**Y**	**N**						
Father	**Y**	**N**						
Siblings	**Y**	**N**						
Other	**Y**	**N**						

Health Maintenence/Screenings

[ ] Mammogram Approximate Date:	[ ] Prostate Exam Approximate Date:
[ ] Pap / Pelvic Approximate Date:	[ ] Colonoscopy Approximate Date:
[ ] Bone Density Approximate Date:	[ ] Other

Social History

Occupation	Tobacco use? Y N How much?
[ ] Single [ ] Married [ ] Divorced [ ] Widowed	Alcohol use? Y N How much?
Children? How many?	Exercise? Y N How often?

PREFERRED PHARMACY INFORMATION

Please fill preferred pharmacy contact information so medication refills can be sent electronically. It is the patient's responsibility to inform the office of any changes.

LOCAL PHARMACY	Address	Phone
MAIL ORDER PHARMACY	Address	Phone

Please review, sign and initial where indicated. Let us know if you have any questions.

_____ When running low on medication, contact the office directly for refills. We DO NOT honor refill requests from pharmacies.

_____ Refill requests can take up to 72 hours to complete.

_____ If your insurance requires a prior-authorization for medication, an administrative fee of $35.00 PER PRIOR-AUTH will be charged.

WORKMAN'S COMP

If the purpose of today's visit is to address an injury sustained at work, and you've filed a claim with your employer, please provide the following information:

Employer		Phone
Date of Accident	Location	
WC Insurance	Claim Number	

AUTO ACCIDENT

If the purpose of today's visit is to address an injury sustained at because of a car accident, and you've filed a claim, please provide the following information:

YOUR Auto Insurance (not the third party)

Date of Accident	Location	Claim Number
Claim Adjuster/Representative		Phone

PLOTSKY MEDICAL ASSOCIATES | **Authorization to Release Medical Records**

PATIENT | **DOB** | **DATE**

I hereby authorize the following practice to release my medical records:

PRACTICE | **PROVIDER** | **LOCATION**

PHONE | **FAX**

Please provide the following records to:

Plotsky Medical Associates
15225 Shady Grove Road, Suite 102
Rockville, MD 20850
Phone: 301-330-0661
Fax: 301-977-6940

Labs, EKG, Imaging __ 2 Years __ 1 Year __ Most recent

Office/Progress notes __ 2 Years __ 1 Year __ Most recent

___ Vaccine History

Other:

PATIENT SIGNATURE | **DATE**

PLOTSKY MEDICAL ASSOCIATES | **Office Policy Agreement**

Please review, sign and initial where indicated. Let us know if you have any questions.

INSURANCE: Plotsky Medical Associates (PMA) will bill your insurance carrier for you. Co-payments/co-insurance are due at the time of service. PMA does **not take assignment on auto-related claims** or insurance carriers that we do not accept. In the event your health plan determines a service to be "not covered" or it has been over sixty (60) days with no payment from your insurance; then you will be responsible for the complete charge. In that event, we will bill you, and **payment is due upon receipt of that statement.**

_____ I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Plotsky Medical Associates PC will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

_____ INSURANCE AUTHORIZATION: I request that payment of authorized insurance benefits be made directly to PMA for any services provided. I authorize PMA, and its employees and agents to release all information, reports and records if necessary, to secure the payment of my account, including a discussion of my medical condition, to the insurance plan, hospitals, and/or other health care providers. If "other health insurance: is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In insurance assigned cases, PMA agrees to accept the charge determination of the insurance carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, co-pay, and for non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

CANCELATIONS: We require a 24-hour notice for cancellations. There will be a **$25.00 charge for all routine office visits and a $50.00 charge for all annual physical appointments**.

RETURNED CHECKS: It is our office policy to charge a fee of **$35.00 for any returned checks.**

COMPLETION OF FORMS: PMA can complete primary care physician statements for insurance, disability, or other forms for our patients. An office visit may be required. **Please allow 7 business days for completion of forms.**

DELIQUINT ACCOUNTS: We reserve the right to add reasonable collection charges to any account over 60 days past due.

Patient/Responsible Party Signature	*Printed Name*	*Date*
Signature of Co-Responsible Party	*Printed Name*	*Date*

PLOTSKY MEDICAL ASSOCIATES | **Notice of Privacy Policy & Practices**

Plotsky Medical Associates PC is required by law to protect the privacy of your personal health information (PHI) and to inform you of our policies to do so. In order to comply with HIPAA regulations, Federal and State laws, we adhere to this Privacy Policy. We reserve the right to change this policy and if we do so, we will post written notification of the policy changes and effective dates. The following is a guideline of our PHI compliance:

- We do not fax patient PHI other than to other physician offices, hospital, health care facilities, or insurance carriers. Only at the patient's request will send PHI to the patient's home or place of employment.
- We do not discuss patient information with anyone either over the phone or in person without the written authorization of the patient (this includes family members of minors).
- We will not give out patient demographic information without the patient's written consent unless for ongoing health care for the patient. When requested by other health care providers, we will confirm that provider's identity and relationship with the patient.
- We will speak in soft or low tones in the office to minimize the possibility of being overheard.
- We will not release patient information such as referrals, test results, prescriptions, or orders to anyone other than the patient unless written authorization is given from the patient. Below, please provide those individuals who are authorized to receive your PHI.

I, _____, date of birth _____ hereby authorize Plotsky Medical Associates PC to speak to the following individuals on my behalf, pick up lab orders, referrals, prescriptions and/or copies of any lab or imaging results that I request:

NAME/RELATIONSHIP	**TELEPHONE**

Plotsky Medical Associates PC also has my permission to include information that may pertain to AIDS, ARC, HIV-related disease, blood alcohol content, and alcohol/substance abuse in the course of your health care operations. This authorization does not expire. I understand that I have the right to withdraw this authorization at any time except to the extent that action has been taken based on this authorization

Patient/Responsible Party Signature	*Printed Name*	*Date*
Witness	*Printed Name*	*Date*

PLOTSKY MEDICAL ASSOCIATES |

Patient Consent for use and Disclosure of Protected Health Information

I, _____, hereby give my consent for Plotsky Medical Associates PC to use and disclose my protected health information (PHI) in order to carry out treatment, payment, and health care operations (HCO). I too have the right to review the notice of Privacy Practices prior to signing this consent. (The enclosed Notice of Privacy Policy and Practices provided by Plotsky Medical Associates PC describes such uses and disclosures more completely).

With this consent, Plotsky Medical Associates PC may contact me through my preferred contact method or, if necessary, other methods of communication, such as leaving a voice mail, secure patient portal message, or in person pertaining to any items that assist the carrying out of HCO, such as appointment reminders, insurance items and/or any correspondence pertaining to my clinical care.

With this consent, Plotsky Medical Associates PC, may send mail to my home or other alternative locations items that assist the practice in carrying out my HCO, such as appointment reminders and patient statements. I have the right to request that Plotsky Medical Associates PC restrict how it uses or disclose to carry out HCO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Plotsky Medical Associates PC to use and disclose my PHI to carry out HCO.

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, Plotsky Medical Associates PC may decline to provide treatment to me.

_____	_____	_____
Patient's/Responsible Party Signature	*Printed Name*	*Date*

_____

PATIENT

PHQ-9 Checklist

INSTRUCTIONS: **Over the last 2 weeks**, how often have you been bothered by any of the following problems? (Circle what most applies)

	Not at all	Several days	More than half of 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

If you circled on any problems above, how difficult have they 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 ☐

	Total Score	**Degree of Depression**
Add up your score and record it here:____, and use the key below to interpret your score.	1 – 4	Minimal depression
	5 – 9	Mild depression
	10-14	Moderate depression
	15-19	Moderately severe depression
	20-27	Severe depression

Wellness Questionnaire |

PATIENT

| Generalized Anxiety Disorder (GAD-7) Scale

INSTRUCTIONS: The following is a list of symptoms of anxiety that most people sometimes have. Circle the number in the space to the right of the symptom that best describes how much that symptom or problem has bothered you **DURING THE LAST TWO WEEKS.**	Not at all sure	Several days	Over half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid, as if something awful might happen	0	1	2	3
ADD THE SCORE FOR EACH COLUM	+	+	+	+
TOTAL SCORE (add your column scores)	=			

If you checked off any of these symptoms, how difficult have they 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 ☐

_____

PATIENT

| Audit-C

Questions	**Scoring System**					**Your Score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 to 4 times per month	3 or 4 times per week	4 or more times per week	
How many drinks did you have on a typical day when you were drinking in the last year?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
How often did you have 6 or more drinks on one occasion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL SCORE	

Score	**Risk Level**	**Counsel**
4 – 7	Moderate risk	Reduce use or stop
8 or higher	High risk	Consider substance abuse evaluation

PATIENT

| STOP-BANG Sleep Apnea Questionnaire

INSTRUCTIONS: Please answer the following questions to see if you could be at risk for Obstructive Sleep Apnea (OSA)**.**

Height:
Weight:
BMI:
Age:
Gender:

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)	YES	NO
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	YES	NO
Has anyone **O**BSERVED you stop breathing during your sleep?	YES	NO
Do you have or are you being treated for high blood **P**RESSURE?	YES	NO
BANG		
BMI more than 35kg/m2?	YES	NO
AGE over 50 years old?	YES	NO
NECK circumference > 16 inches (40cm)?	YES	NO
GENDER: Male	YES	NO
TOTAL SCORE		

LOW RISK:	Answered YES to 0-2 questions
MODERATE RISK:	Answered YES to 3-4 questions
HIGH RISK:	Answered YES to 5-8 questions