IMP Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Annual Wellness Health Risk Assessment (65+)

Are you sexually active? ____ Yes ____ No ____ Not Currently

Do you typically have a well-balanced diet, including fruits, vegetables, and whole grains each day? ____ Yes ____ No

How many days per week to you usually exercise? _____ Days per Week

How long do you spend exercising?
____ Minutes per Day ____ Does Not Apply (Skip to next section)

How intense is our exercise?
____ Light (Stretching or Slow Walking)
____ Moderate (Brisk Walking)
____ Heavy (Jogging or Swimming)
____ Very Heavy (Fast Running or Stair Climbing)

Do you have ongoing medical conditions? ____ Yes ____ No

Do you visit your doctors regularly? ____ Yes ____ No

Do you visit the dentist regularly? ___Yes ____ No

Do you visit the eye doctor regularly? ____ Yes ____ No

Do you see any specialty doctors? (Please list all)

_____

Do you always fasten your seatbelt when you are in the car? ____ Yes ____ No

Do you protect yourself form the sun when you are outdoors? ____ Yes ____ No

How often do you get the social and emotional support you need?
____ Always ____ Usually ____ Sometimes ____ Rarely ____ Never

How many hours of sleep do you usually get each night? ____ Hours

Do you Snore ____ Yes ____ No

How often do you feel unusually tired?
____ Always ____ Often ____ Sometimes ____ Rarely ____ Never

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Do you have an Advanced Directive, Living Will, or Power of Attorney (POA) in the event that an injury or illness causes you to be unable to make healthcare decisions? ____ Yes ____ No

Do you find yourself asking people to repeat themselves or having trouble hearing with background noise? ____ Yes ____ No

Do you need help with the telephone? ____ Yes ____ No

Do you need help eating, bathing, getting dressed, or using the toilet?
____ Yes ____ No

Do you need help with shopping or preparing meals? ____ Yes ____ No

Do you need help with managing money or your medications? ____ Yes ____ No

Have you fallen in the past year? ____ Yes ____ No

Do you feel dizzy when you get up from a bed or a chair? ____ Yes ____ No

Does your home have grab bars in the bathroom? ____ Yes ____ No

Is there any clutter in your walking space at home? ____ Yes ____ No

Do you or your family members feel you have more difficulty remembering things?
____ Yes ____ No

Do you have pain that interferes with performing desired activities?
____ Yes ____ No

Please list any additional concerns you would like to address with your provider today. Please be aware that if problems unrelated to health maintenance are covered during this visit there may be an additional problem focused charge.

_____

_____

_____

_____

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Alcohol Use Assessment

1. How often did you have a drink of alcohol in the past year?

   _____ Never (0 points)

   _____ Monthly or less (1 points)

   _____ Two or three times per month (2 points)

   _____ Two or three times per week (3 points)

   _____ Four or more times per week (4 points)

2. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

   _____ 1 or 2 (0 points)

   _____ 3 or 4 (1 points)

   _____ 5 or 6 (2 points)

   _____ 7 or 9 (3 points)

   _____ 10 or more (4 points)

3. How often did you have 6 or more drinks on one occasion in the past year?

   _____ Never (0 points)

   _____ Less than a month (1 points)

   _____ Monthly (2 points)

   _____ Weekly (3 points)

   _____ Daily or almost daily (4 points)

Total Points: _____

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Patient Health Questionnaire (PHQ-9)

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

	Not at all	Several Days	More than half the days	Nearly every day
1. Little Interest of 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	0	1	2	3

add columns _____ + _____ + _____

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

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Male Self Screening Form

Instructions: For each of the seven questions below, please check the one box that best describes your symptoms.

Over the past month:	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
1. How often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. How often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. How often have you found you stopped and started again several times when you urinate?	0	1	2	3	4	5
4. How often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. How often have you had a weak urinary stream?	0	1	2	3	4	5
6. How often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. How many times did you get up to urinate, from the time you went to bed until the time you woke up?	0	1	2	3	4	5

Original Source for information: Barry M.J. Flower FJ Jr., 'Leary MP, er al. The American Urological Association Symptom Index for Benign Prostatic Hyperplasia. J Urol. 1992; 148:1549-1557.

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Equally satisfied and dissatisfied	Mostly dissatisfied	Unhappy	Terrible
If you had to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

For Physician Use ONLY: Calculate the patients total AUA Symptom Score by adding up the numbers for all boxes checked in questions 1 through 7.

AUA_____ Degree of Severity: ☐ Mild (0-7) ☐ Moderate (8-19) ☐ Severe (20-35)

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North Franklin Internal Medicine & Pediatrics
HIPAA Compliance Form

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA), in order for your physician or the staff of **North Franklin Internal Medicine & Pediatrics (NFIMP)** to give copies of and/or discuss your condition, exams, procedures, or 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. We must also 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. 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 NFIMP to communicate with me by any means I provide. I also authorize NFIMP to share my information with the following individuals:
Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

☐ I authorize NFIMP to communicate with only me by any means I provide.

☐ I DO NOT authorize NFIMP to communicate with me by any means other than in person, by phone, or via the portal. I acknowledge by choosing this option it may delay care and thereby adversely affect the quality of my care.

Medication Access Authorization

☐ I authorize NFIMP to obtain/download medication information from my pharmacy via Surescripts.

☐ I DO NOT authorize NFIMP to obtain/download medication information from my pharmacy via Surescripts. I acknowledge by choosing this option it may delay care and thereby adversely affect the quality of my care.

Immunization Access Authorization

☐ I authorize NFIMP to download or update my immunization information to the Tennessee Department of Health Immunization Registry.

☐ I DO NOT authorize NFIMP to download or update my immunization information to the Tennessee Department of Health Immunization Registry.

I acknowledge receipt of the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act about how NFIMP may use and disclose my protected health information. I understand that NFIMP reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____

Signature of Patient/Guardian Date Signed

Reviewed and updated 06/22/2020

IMP Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

North Franklin Internal Medicine & Pediatrics, PLLC
Patient Down Payment Policy

Based on the insurance information you provide Cool Springs Internal Medicine & Pediatrics/North Franklin Internal Medicine & Pediatrics (CSIMP/NFIMP), either a down payment or a co-payment may apply for your visit. Below are details regarding these payment types:

- **Down Payment** -Where a deductible remains, CSIMP/NFIMP collects a $50 down payment per visit towards what will eventually be due once your insurance receives and processes our claims. You will be billed the difference between what you have already paid and what your insurance applies to your responsibility. Down payments are not payments in full for services rendered. **Example**: Mr. Smith has $1500 remaining on his deductible. He paid a $50 down payment for his visit. The claim for the visit is processed and his insurance assigns $150 to the patient's (Mr. Smith) responsibility. CSIMP/NFIMP will bill Mr. Smith for the remaining $100.
- **Self-Pay** – Patients who do not have insurance will be required to make a down payment of $100 per visit towards what will be eventually due once charges have processed through our billing department. New patients who are self-pay will be required to pay $140 at their first visit. Self-Pay down payments are not payments in full for services rendered. **Example**: Mrs. Johnson does not have insurance. She paid a $100 down payment for her self-pay visit. After the provider has completed the visit note and submitted charges, the total charge for the visit is $200. CSIMP/NFIMP will bill Mrs. Johnson for the remaining $100.
- **Co-Payment** – Where a co-pay applies, CSIMP/NFIMP collects a fixed amount per visit. This amount is not always shown on insurance cards and it is the patient's responsibility to let CSIMP/NFIMP know if they have a co-payment. The patient is required by their insurance to pay this fixed amount at each visit. Patients who refuse to pay their co-payment amount will not be seen.
- **None** – Based on verification made, CSIMP/NFIMP will not be collecting on a per visit basis. Patient will not be required to make payment before visit if the patient has met their out of pocket maximum. This can also be the case if the patient has a primary & secondary insurance where no deducible needs to be met. A balance still may be due and will be billed to the patient once the claim has been processed.
- **Wellness Visits** – Most health plans will pay for one wellness or preventative exam per year. Your insurance provider may consider this to be once per calendar year or one year and one day since the date of your last wellness exam. Patients will not be required to pay down payments for wellness visits.
- **CSIMP/NFIMP unable to guarantee benefits details** – Insurance does not mandate that healthcare providers verify and communicate benefits to patients. CSIMP/NFIMP does this as a courtesy. CSIMP/NFIMP is unable to obtain guarantees regarding benefits we verify and therefore cannot pass any guarantees along to our patients. Benefits differ from insurance plan to insurance plan.
- **Independent verification** – We ask that patients contact their insurance company and obtain benefits for services independent of CSIMP/NFIMP.

_____ _____

Signature of Patient or Legal Guardian Date Signed

Reviewed and updated 06/22/2020

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North Franklin Internal Medicine & Pediatrics, PLLC
Telemedicine Patient Consent Form

1. The purpose of this form is to obtain your consent to participate in a telemedicine or electronic consult.
2. During the telemedicine consultation:
    a. Details of your medical history, examination, imaging, and test results will be used.
    b. You will be speaking with a licensed provider through the use of patient portal, telecommunication, and or interactive video.
3. Medical information and records: All existing laws regarding access to your medical information and copies of your medical records apply to this telemedicine consultation. Please note, telecommunications are not recorded or stored.
4. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protection under federal and Tennessee state law apply to information disclosed during the telemedicine consultation.
5. Rights: You may withhold or withdraw consent to the telemedicine consultation at any time.
6. No Shows: A "missed" telemedicine appointment is considered the same as a missed in office visit. We respectfully request our patients cancel or reschedule their appointment a minimum of 24 hours in advance of the appointment time. If a 24-hour notice is not reasonable for the circumstances, any notice prior to the appointment will be accepted.

By signing below, I acknowledge I have been advised of all the potential risks, consequences, and benefits of telemedicine. I had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All questions have been answered and I understand the written information provided above.

_____ _____

Signature of Patient or Guardian Date Signed

Reviewed and updated 06/22/2020