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

Patient Name: _____

Date of Birth: _____

Today's Date: _____

## Questions for Male Patients age 40-64

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 have regular seatbelt use in the car? __ Yes __ No

Do you have satisfactory school and/or work experience and performance? __ Yes __ No

Do you have normal sleep patterns (6-8 hours)? __ Yes __ No Comment: _____

Do you have a history of sleep apnea and/or use of CPAP machine? __ Yes __ No

Are you currently dealing with abnormal amounts of stress? __ Yes __ No Comment: _____

Have you been a victim of abuse, violence, or rape? __ Yes __ No Comment: _____

Do you have a satisfactory marriage/partner relationship? __ Yes __ No Comment: _____

Do you have a regular diet with balanced nutrition? __ Yes __ No Comment: _____

Exercise includes: ____ days a week ____ minutes each ___ NO EXERCISE

Type of exercise: _____

Have you had a: Pneumonia vaccine ___, Tetanus-diphtheria booster ___, Flu Vaccine ___

Are you sexually active? __ Yes __ No Concerns: _____

Do you wish to discuss STD testing or concerns? __ Yes __ No Comment: _____

Current form of birth control or protection: _____

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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# 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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# Cool Springs 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 **Cool Springs Internal Medicine & Pediatrics (CSIMP)** 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 CSIMP to communicate with me by any means I provide. I also authorize CSIMP to share my information with the following individuals:
Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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

☐ I DO NOT authorize CSIMP 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 CSIMP to obtain/download medication information from my pharmacy via Surescripts.

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

☐ I DO NOT authorize CSIMP 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 CSIMP may use and disclose my protected health information. I understand that CSIMP 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

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

Patient Name: _____

Date of Birth: _____

Today's Date: _____

## Cool Springs 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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## Cool Springs 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