

Patient Information

First Name	Last Name	MI	Date of Birth
Address	City	State	Zip
Please check Primary Phone #	Home Phone <input type="checkbox"/>	Work Phone <input type="checkbox"/>	Cell Phone <input type="checkbox"/>
Occupation	Employer	Email Address	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	SSN	Preferred language	Driver's License #

Marital Status	Preferred Contact	Ethnicity	Race
<input type="checkbox"/> Married	<input type="checkbox"/> Mail	<input type="checkbox"/> Cambodian	<input type="checkbox"/> American Indian or Alaskan Native
<input type="checkbox"/> Single	<input type="checkbox"/> Home Phone	<input type="checkbox"/> Filipino	<input type="checkbox"/> Asian
<input type="checkbox"/> Divorced	<input type="checkbox"/> Day Phone	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Separated	<input type="checkbox"/> Cell Phone	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Native Hawaiian/Other Pacific Isl.
<input type="checkbox"/> Widowed	<input type="checkbox"/> Patient Portal		<input type="checkbox"/> White
<input type="checkbox"/> Life Partner			<input type="checkbox"/> Other

Responsible Party (Guarantor, if different from patient)

First Name	MI	Last Name	Date of Birth	Relationship
Address		City	State	Zip
Please check Primary Phone #	Home Phone <input type="checkbox"/>	Work Phone <input type="checkbox"/>	Cell Phone <input type="checkbox"/>	
SSN	Relationship to Patient	Preferred Language	Driver's License #	

Emergency Contact (for Minor child, this section may be used for other parent)

First Name	MI	Last Name	Date of Birth	Relationship
Address		City	State	Zip
Please check Primary Phone #	Home Phone <input type="checkbox"/>	Work Phone <input type="checkbox"/>	Cell Phone <input type="checkbox"/>	

I/We do hereby consent to and authorize the performance of all treatments and medical services deemed advisable by the physicians, Thomas E. Sulkowski, MD to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I also hereby authorize Sulkowski Family Medicine PLLC to release information requested by the insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (Please Print)

Relationship to Patient

Assignment of Insurance Benefits/Eligibility Certification IRS# 47-1538606

Primary Insurance Plan

Patient Name		Date of Birth
Insurance Plan Name	Policy #	Group #
Insurance Company Address, City, State, Zip		Phone #
Subscriber's Name		Relationship to Patient
Subscriber's SSN		Subscriber's Date of Birth
Subscriber's Employer		Employer's Phone
Employer's Address, City, State, Zip		

For Medicare Patients Only

Medicare ID number	Part A Effective Date	Part B Effective Date
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Other Insurance Coverage for Patient

Insurance Plan Name		Policy #	Group #
Insurance Company Address, City, State, Zip		Phone #	
Subscriber's Name		Relationship to Patient	
Subscriber's SSN		Subscriber's Date of Birth	
Subscriber's Employer		Employer's Phone	
Employer's Address, City, State, Zip			

I hereby authorized and request that payment of authorized Medicare/other insurance company benefits, be paid directly to Sulkowski Family Medicine PLLC for any medical services and treatments to me or a member of my family. I authorized any holder of medical or other information about me to release to the social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable to related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

I understand that I am eligible for benefits through my insurance carrier. I understand that my assigned PCP for my benefits is Thomas E. Sulkowski MD. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me), will pay full all such charges.

Signature of Patient/Responsible Party	Date
Name of Patient/Responsible Party (please print)	Relationship to patient

Agreement for Financial Responsibility

Thank you for choosing Sulkowski Family Medicine as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, credit cards and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) and/or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 15-21 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- We do not render any services for Worker's Compensation medical situations, as your employer should have an assigned provider for your company to provide these services.
- We do not file auto insurance if you are seen in the office for services pertaining to a motor vehicle accident. You will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- We charge a fee for no show appointments and same day cancellations. That fee is \$40 and will be the responsibility of the patient and/or responsible party to pay.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If your received services are part of an Out-of-Network benefits, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient

Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message your left for your physician's office.

We may communicate with you through mail, secure email and telephone, including leaving messages on your answering machine/voicemail.

Please check all the boxes that you give the SFM staff permission to use for communications:

<input type="checkbox"/> You may contact me by telephone	Phone number: _____
<input type="checkbox"/> You may leave a message/voice mail	Phone number: _____
<input type="checkbox"/> You may contact me by mail	
<input type="checkbox"/> You may contact me through email (Patient Portal)	

If your give permission for us to communicate with any else, please complete the list below:

Name/Phone Number	Relationship	Options(check all that applies)
1.		<input type="checkbox"/> Billing Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Medical/Health Information
2.		<input type="checkbox"/> Billing Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Medical/Health Information
3.		<input type="checkbox"/> Billing Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Medical/Health Information
4.		<input type="checkbox"/> Billing Information <input type="checkbox"/> Appointment Information <input type="checkbox"/> Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

Signature of Patient/Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient

**ACKNOWLEDGEMENT OF RECEIPT
Notice of Privacy Practices**

Your Name and signature on this forms indicates that you have reviewed and/or received a copy of Sulkowski Family Medicine PLLC Notice of Privacy Practices on the date and time indicated below.

If you have any questions regarding the information contained in Sulkowski Family Medicine PLLC Notice of Privacy Practices, please contact, Danna Duncan, our privacy compliance office at 615-900-1381.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____

FOR FACILITY USE ONLY

We attempted to obtain written acknowledgement of patient's receipt of Notice of Privacy Practices, but acknowledgment could not be obtained from the patient for the following reasons:

- Individual refused to sign
- Emergency situation prevented signature
- Patient requested above individual sign on his/her behalf
- Other (please specify) _____

Registration Representative Signature: _____ Date: _____

Patient Name _____

Date _____

Pharmacy Information

Preferred Pharmacy

Secondary Pharmacy

Name

Name

Address

Address

Medications-List all medications you take, prescription and non-prescription, and the dosage

I do not take any medications

Medication and Food Allergies-List all known allergies (drugs, food, animals, etc.)

No known allergies

Medical History-Check if you have ever experienced the following conditions and the year and month of onset.

Condition	Month/Year	Condition	Month/Year
<input type="checkbox"/> None		<input type="checkbox"/> Gallbladder Disease	
<input type="checkbox"/> Allergies		<input type="checkbox"/> GERD (Reflux)	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Hepatitis C	
<input type="checkbox"/> Angina		<input type="checkbox"/> Hyperlipidemia	
<input type="checkbox"/> Anxiety		<input type="checkbox"/> Hypertension	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Irritable Bowel Disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Benign Prostatic Hypertrophy		<input type="checkbox"/> Myocardial Infarction	
<input type="checkbox"/> Blood Clots		<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> Cancer-Type		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Cerebrovascular Accident		<input type="checkbox"/> Peptic Ulcer Disease	
<input type="checkbox"/> Coronary Artery Disease		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> COPD (Emphysema)		<input type="checkbox"/> Seizure Disorder	
<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Depression		<input type="checkbox"/> Chicken Pox (history of)	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Other	
<input type="checkbox"/> Other		<input type="checkbox"/> Other	

Social History – Please choose the options that apply to you, the patient.

Occupation <input type="checkbox"/> Employed <input type="checkbox"/> Student	Employer and/or School
What year of education did you complete? <input type="checkbox"/> through 12 th grade <input type="checkbox"/> College <input type="checkbox"/> Beyond 4 years of college _____	Who do you Reside with: <input type="checkbox"/> Parents <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Other _____
Is your Mother still alive: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your father still alive: <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many?	Female(s)	Male(s)
Tobacco Use <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less <input type="checkbox"/> Former/Year quit:	<input type="checkbox"/> Chewing <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Cigarette <input type="checkbox"/> Smokeless Brand:	
Are you?: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed		Drug Use: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol Use <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Less <input type="checkbox"/> Former/Year quit:	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor <input type="checkbox"/> Other:	

Health Maintenance – Check if you have received the following and the date of most recent exam.

Exam	Month/Year	Exam	Month/Year
<input type="checkbox"/> None		<input type="checkbox"/> GYN Exam	
<input type="checkbox"/> Breast Exam		<input type="checkbox"/> Influenza Vaccine	
<input type="checkbox"/> Cardiac Stress Test		<input type="checkbox"/> Lipid Panel	
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Mammogram	
<input type="checkbox"/> DEXA Scan		<input type="checkbox"/> PAP Test	
<input type="checkbox"/> Echocardiogram		<input type="checkbox"/> Physical Exam	
<input type="checkbox"/> EKG		<input type="checkbox"/> Pneumococcal Vaccine	
<input type="checkbox"/> Eye Exam		<input type="checkbox"/> Pulmonary Function Test	
<input type="checkbox"/> FOBT (stool card for hidden blood)		<input type="checkbox"/> Sigmoidoscopy	
<input type="checkbox"/> Foot Exam		<input type="checkbox"/> Tetanus Vaccine	

Advanced Directives

None Do Not Resuscitate Durable Power of Attorney Living Will HC Proxy Date Reviewed:

THE PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	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 asleep, 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’re 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

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those 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