



New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____
Preferred Phone: _____ Email: _____ Gender: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____ Patient Marital Status: _____
Occupation: _____ Employer: _____
Primary Care Provider (PCP): _____ PCP Phone: _____
PCP Address: _____
Preferred Pharmacy: _____ Pharm Phone: _____
Preferred Pharmacy Address: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity: Decline Response Hispanic or Latino Not Hispanic or Latino
Race: Decline Response American-Indian or Alaska Native Asian
 Black or African American Native Hawaiian or Pacific Islander White Other
Preferred Language: _____ Decline Response
Patient Signature: _____ Date: _____

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____
Patient or Guarantor Signature: _____ Date: _____

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

Patient Name (Print): _____
Patient Signature: _____ Date: _____

If completed by a patient's personal representative, please print and sign below.

Representative (Print): _____ Relationship: _____
Representative Signature: _____ Date: _____

myColumbiaDoctors Patient Portal Sign Up

Access your personal records securely, 24/7, on a computer, smartphone, or iPad. See brochure for details.

Send me an invitation to join myColumbiaDoctors.

Look for an email invite from noreply@followmyhealth.org and click the Registration link.

Reason for today's visit: _____

General Medical Questionnaire

Have you EVER had any of the following?

- | | | | |
|---|---|---|---|
| Asthma/Breathing Problems..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Disease/Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Arthritis..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Lung Disorder..... | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bleeding/Clotting Disorder..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood Pressure Disorder..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Neurological Disorder/Chronic Headaches.. | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric Disorder/Illness..... | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bowel/Stomach Problems..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Pulmonary Embolism/DVT | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke..... | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cholesterol Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N | Seizure or Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Diabetes..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Thyroid Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Eye Disorder (i.e. Glaucoma, cataract)..... | <input type="checkbox"/> Y <input type="checkbox"/> N | Urinary/Kidney Disorder..... | <input type="checkbox"/> Y <input type="checkbox"/> N |
- Please list any other medical illnesses or problems and provide details for any of the above conditions.

Please list any surgeries you have had and the approximate date.

Procedure	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		<input type="checkbox"/> Y <input type="checkbox"/> N	
Father		<input type="checkbox"/> Y <input type="checkbox"/> N	
Sibling		<input type="checkbox"/> Y <input type="checkbox"/> N	
Other:		<input type="checkbox"/> Y <input type="checkbox"/> N	

Do you currently smoke? Y N If no, previously? Y N Years smoked _____ Packs/day _____

Do you use other tobacco products? Y N Consume alcohol? Y N If yes, drinks/week: _____

Do you have any allergies to medications or other substances? Y N

If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis).



Please list ALL previous physicians who have treated you relevant to your visit (i.e. pulmonologist, oncologist, internist, cardiologist, gastroenterologist, etc...)

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Doctor's Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Specialty: _____

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose

Medication Name	Dose

Provider Signature: _____ Date: _____



ColumbiaDoctors

Review of Systems

Please indicate ALL that you have experienced within the past 6 – 12 months.

General	<input type="checkbox"/> None <input type="checkbox"/> Feeling Tired	<input type="checkbox"/> Fever <input type="checkbox"/> Weight Gain	<input type="checkbox"/> Chills <input type="checkbox"/> Weight Loss	<input type="checkbox"/> Feeling Poorly
Eyes	<input type="checkbox"/> None <input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Eye Pain <input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Vision Changes	<input type="checkbox"/> Eyesight Problems
Ear/Nose/Throat	<input type="checkbox"/> None <input type="checkbox"/> Sinus problems	<input type="checkbox"/> Earache <input type="checkbox"/> Sore throat	<input type="checkbox"/> Loss of hearing <input type="checkbox"/> Hoarseness	<input type="checkbox"/> Nose bleeds
Heart	<input type="checkbox"/> None <input type="checkbox"/> Slow heart rate	<input type="checkbox"/> Chest pain <input type="checkbox"/> Leg swelling	<input type="checkbox"/> Palpitations <input type="checkbox"/> Leg pain, discomfort, fatigue during walking	<input type="checkbox"/> Fast heart rate
Lungs/Breathing	<input type="checkbox"/> None <input type="checkbox"/> Trouble breathing with exertion	<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing <input type="checkbox"/> Trouble breathing when lying flat	<input type="checkbox"/> Shortness of breath
Gastrointestinal	<input type="checkbox"/> None <input type="checkbox"/> Heartburn	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation <input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool
Bladder	<input type="checkbox"/> None <input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Incontinence <input type="checkbox"/> Painful period	<input type="checkbox"/> Discolored urine <input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Painful urination
Skin	<input type="checkbox"/> None <input type="checkbox"/> Skin lesions	<input type="checkbox"/> Acne <input type="checkbox"/> Skin wound	<input type="checkbox"/> Itching <input type="checkbox"/> Breast pain	<input type="checkbox"/> Change in a mole <input type="checkbox"/> Breast lump
Neurological	<input type="checkbox"/> None <input type="checkbox"/> Limb weakness	<input type="checkbox"/> Confused <input type="checkbox"/> Loss of memory	<input type="checkbox"/> Convulsions <input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness <input type="checkbox"/> Difficulty walking
Psychiatric	<input type="checkbox"/> None <input type="checkbox"/> Suicidal	<input type="checkbox"/> Anxiety <input type="checkbox"/> Disturbed sleep	<input type="checkbox"/> Depression <input type="checkbox"/> Emotional problems	<input type="checkbox"/> Change in personality
Endocrine	<input type="checkbox"/> None <input type="checkbox"/> Hair loss	<input type="checkbox"/> Weak muscles <input type="checkbox"/> Hot flashes	<input type="checkbox"/> Feeling weak	<input type="checkbox"/> Deepening of voice
Hem/Lymph	<input type="checkbox"/> None	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Swollen glands

Additional Bariatric Information

Please circle the appropriate answer or fill in the blank for the following questions:

- 1) Do you snore? Yes No Don't know If Yes: Nightly? Loudly?
- 2) Has anyone ever told you that you stop breathing, struggle to breathe or gasp in your sleep? Yes No
- 3) Do you ever wake up short of breath or gasping? No Rarely Occasionally Frequently
- 4) Do you have trouble falling asleep more than once a week? Yes No
- 5) How many times do you usually wake up during the night? 0-1 1-2 2-3 3 or more
- 6) How many times do you usually urinate during the night? 0-1 1-2 2-3 3 or more
- 7) What time do you usually get into bed at night (range is OK)? _____ AM PM (Circle one)
- 8) What time do you usually get out of bed to start your day (range is OK)? _____ AM PM (Circle one)
- 9) How many hours of total sleep do you average each night? _____ Hours
- 10) Are you refreshed (not sleepy or tired) when you first get up for the day? Yes No
- 11) Do you nap on purpose during the day?

Never Rarely (<1/mo) Sometimes (1/wk) Frequently (2 or more/wk) Daily

- 12) Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of the things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate number to describe how likely you are to doze off or fall asleep in each situation:

0= Would never doze 1= Slight chance of dozing 2= Moderate chance of dozing 3=High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in public (i.e. at a meeting or in a theater)	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without any alcohol	
In a car, while stopped for a few minutes in traffic or when you are taking mass transit	

- 13) Please write in any other information about your sleep that you think might be important.

Most insurance companies are requesting a diet history before approving surgery. For each weight loss method, please indicate if you have tried it, the number of times you have tried that method, for how long, and the amount of weight lost.

	<u># of times tried:</u>	<u>From:</u>	<u>To:</u>	<u>Amt. WT. Lost:</u>
<u>Weight Loss Programs:</u>				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<u>Comprehensive Weight Loss Programs:</u>				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<u>Diets:</u>				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<u>Medications:</u>				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<u>Weight Loss Aides:</u>				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
<u>Other Weight Loss Methods:</u>				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MEDICARE PRIVATE CONTRACT

This agreement is entered into this ___ day of _____ by and between _____ (Hereinafter called "physician"), whose principal medical office is located at _____ and _____ (a patient enrolled in Medicare Part B, hereinafter called "patient"), who resides at _____.

Background

A provision in the Social Security Act permits Medicare beneficiaries and physicians to contract privately outside of the Medicare program. Under the law as it existed prior to January 1, 1998, a physician was not permitted to charge a patient more than a certain percentage in excess of the Medicare fee schedule amount. A new provision, which became effective on January 1, 1998, permits physicians and patients to enter into private arrangements through a written contract under which the patient may agree to pay the physician more than that which would be paid under the Medicare program.

A "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has opted out of Medicare for two years for all covered items and services he/she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician/practitioner and to pay the physician/practitioner without regard to any limits that would otherwise apply to what the physician/practitioner could charge.

The purpose of this contract is to permit the patient (who is otherwise a Medicare beneficiary) and the physician to take advantage of this new provision in the Medicare law and sets forth the rights and obligations of each. This agreement is limited to the financial arrangement between Physician and Patient and is not intended to obligate either party to a specific course or duration of treatment.

Patients and physicians who take advantage of this provision are not permitted to submit claims or to expect payment for those services from Medicare.

Exception:

In an emergency or urgent care situation, a physician/practitioner who opts out may treat a Medicare beneficiary with whom he/she does not have a private contract and bill for such treatment. In such a situation, the physician/practitioner may not charge the beneficiary more than what a nonparticipating physician/practitioner would be permitted to charge and must submit a claim to Medicare on the beneficiary's behalf. Payment will be made for Medicare covered items or services furnished in emergency or urgent situations when the beneficiary has not signed a private contract with that physician/practitioner.

A. Obligations of Physician

1. Physician agrees to provide such treatment as may be mutually agreed upon by the parties and at mutually agreed upon fees.
2. Physician agrees not to submit any claims under the Medicare program for any items or services even if such items or services are otherwise covered by Medicare.

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3. Physician acknowledges that (s)he will not execute this contract at a time when the patient is facing an emergency or urgent health care situation.

B: Obligations of Patient

1. Patient or his/her legal authorized representative agrees not to submit a claim (or to request that the physician submit a claim) under the Medicare program for such items or services as physician may provide, even if such items or services are otherwise covered under the Medicare program.
2. Patient or his/her legal authorized representative agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under the Medicare program for such items or services.
3. Patient or his/her legal authorized representative acknowledges that that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner.
4. Patient acknowledges that Medigap plans do not, and other supplemental insurance plans may elect not to, make payments for items and services not paid for by Medicare.
5. Patient acknowledges that (s)he has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that (s)he is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.
6. Patient acknowledges that (s)he or his/her legal representative understands that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

C: Physician's Status

Patient further acknowledges his/her understanding that physician (has/ has not) been excluded from participation under the Medicare program under Section 1128.

D: Term and Termination

This agreement shall commence on the above date and shall continue in effect until _____ (physician should insert date which is two [2] years after [s]he signs the affidavit). Despite the term of the agreement, either party may choose to terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both physician and patient agree that the obligation not to pursue Medicare reimbursement, for items and services provided under this contract, shall survive this contract.

I have read and understand the provisions regarding private contracting.

By signing this contract, I accept full responsibility for payment of the physician's or practitioner's charges for all services furnished to me from the date written above.

Name of Physician (printed)

Name of Patient (printed)

Signature of Physician

Signature of Patient

Date