

Squirrel Hill Health Center

CONSENT TO TREATMENT

I request those physicians and other health-care professionals who care for me to perform routine diagnostic procedures, ambulatory care and therapeutic treatments, which in their judgment become necessary while I am a patient with SHHC. Routine diagnostic procedures and medical treatments include but are not limited to ECGs, blood tests and administration of medications. I also consent to medical photography necessary in the judgment of my physician, to document the course of my injury or illness and to provide appropriate medical care.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations. I authorize SHHC to retain, preserve and use for scientific, or education purposes, or dispose of at their convenience, any specimens or tissue taken from my body during my visit. If I undergo any procedure that requires the submission of tissue for pathologic examination, I authorize the use of any excess tissue for educational purposes.

CONSENT TO SHARE MEDICAL INFORMATION

By initialing below I understand that if I am not available by telephone, the practice may leave a message regarding normal results on my home/office/cell telephone. Below I have listed the persons whom the practice may speak with regarding my health care record:

Name: _____ relationship: _____

Name: _____ relationship: _____

Name: _____ relationship: _____

Initial _____

RELEASE OF RESPONSIBILITY

I understand that if I fail to carry out my provider's instructions for follow-up care, I do so at my own responsibility.

RELEASE FROM RESPONSIBIITY FOR VALUABLES

I understand that SHHC is not responsible for loss or damage to any of my personal items.

CONSENT TO APPEAL

In the event that my insurance company denies payment for services rendered during the episode of care, I authorize the SHHC to appeal for payment on my behalf; however, I understand that I have the right to rescind my consent to appeal at any time during the appeal process.

**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER,
PHYSICIANS AND PATIENT**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Administration or its intermediaries or carriers for this or a related medical claim is correct. I authorize the release of all necessary information to agencies just named as well as any Peer Review Organization. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician or nurse practitioner services to SHHC or authorize SHHC to submit a claim to Medicare for payment to me.

**STATEMENT TO PERMIT PAYMENT OF MEDICAID BENEFITS TO PROVIDER AND
PHYSICIAN**

I certify that the information given by me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Department of Public Welfare (D.P.W.) or its intermediaries or carriers any information needed for this or a related Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician or nurse practitioner services to SHHC or authorize SHHC to submit a claim to D.P.W. for payment.

ASSIGNMENT OF INSURANCE OR PAYOR BENEFITS

I recognize that I am primarily liable for payment for services rendered. In the event that I am entitled to medical care benefits or insurance of any type whatsoever, I hereby assign those benefits and my rights to insurance payment to the SHHC and any of its contracted health-care providers. I authorize the SHHC and the appropriate health-care providers to apply for benefits and insurance on my behalf for services rendered to me. I certify that the insurance or other coverage benefit information supplied by me is correct, in accordance with applicable hospital, provider or insurance policies or agreements. If my insurance carrier requires pre-authorization for services I will receive, I understand that it is my responsibility to obtain the required pre-authorization. If I fail to do so, I will be liable for all or part of otherwise covered expenses.

ACKNOWLEDGMENT OF RESPONSIBILITY FOR PAYMENT OF BILL

I guarantee payment of all charges incurred for services rendered by SHHC for the patient named on the bottom of this page. The amount due for non-insurance charges including co-payment and deductibles shall be paid in full at the time when services are rendered. Should my account be referred to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses.

ACCURACY OF INFORMATION

By signing this form, I agree that all information I have submitted in writing to SHHC is accurate and up to date to the best of my knowledge.

BY SIGNING THIS DOCUMENT, I CERTIFY THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND UNDERSTAND ITS CONTENTS

Signature of Patient or Substitute Decision Maker

Witness

If Substitute Decision Maker, state relationship

If Substitute Decision Maker, state reason

Date

Printed Patient Name _____

D.O.B. _____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By initialing below, I acknowledge that I am aware of SHHC's Notice of Privacy Practices and was given a copy upon my request. I understand that information SHHC acquires or creates about me will only be disclosed to others for treatment, payment and healthcare operations as set forth in the notice or as authorized by me in writing.

____ Initial

ORAL CONSENT (ONLY FOR PATIENTS UNABLE TO SIGN)

Relationship to Patient AND Description of authority to act on behalf of patient:

ORAL AUTHORIZATION – NOT APPLICABLE TO HIV RELATED INFORMATION

I witness that the person understood the nature of this release and freely gave his/her oral authorization.
(Two witnesses are required)

Witness #1

Date

Witness #2

Date

- A minor may authorize if for Drug and Alcohol related. If for Behavioral Health, a patient who is 14 or older shall authorize (inpatient records only). A disclosure statement, as required by law, will accompany the records requested.

Office Use Only

Copy provided to patient

Signature: _____

Squirrel Hill Health Center
Patient Demographics and Registration

PATIENT INFORMATION		
Name (Last, First MI) <u>AS LISTED ON INSURANCE CARD</u>		
Social Security number _____ - _____ - _____	Date of Birth _____ (mm/dd/yyyy)	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Life Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Street Address	City, State, Zip	
Home Phone Number	Alternate Phone Number	
Emergency Contact	Emergency Contact Phone Number	
Employer	Employer Phone Number	
Email address		
The following box is for demographic purposes only. These answers will remain strictly confidential.		
1. Ethnicity: Are you of Hispanic/Latino origin? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander, Non-Hawaiian <input type="checkbox"/> White 3. How did you hear about us?: _____ 4. Homeless Status: <input type="checkbox"/> Homeless <input type="checkbox"/> Not Homeless <input type="checkbox"/> Transitional	5. Are you a Migrant Farm Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Are you best served by a language other than English? <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____ 7. Religion: _____ 8. Veteran Status: <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Household income: 10. Number of People in Household: ____ <input type="checkbox"/> \$0-\$10,000 <input type="checkbox"/> \$10,001-\$25,000 <input type="checkbox"/> \$25,001-\$50,000 <input type="checkbox"/> \$50,001-\$100,000 <input type="checkbox"/> \$100,001 and above	
Household member who is responsible for payment (Only one person should be listed per household)		
<input type="checkbox"/> Check here if same as above		
Name (Last, First MI)	Relationship to patient	
Date of Birth	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Street Address	City, State, Zip	
Phone Number		
INSURANCE INFORMATION (Leave blank if no insurance)		
Name of Primary Insurance: _____		
Name of Secondary Insurance: _____		



Attention all new Squirrel Hill Health Center patients:

At SHHC, we recommend routine HIV testing to all patients over age 18. HIV testing is also available at anytime to any patient who requests it.

At SHHC, we offer rapid HIV testing to all new patients:

- It's painless – no needles, no blood – we perform an oral swab with something that looks a Q-tip
- It's confidential
- It's free
- Your results will be available in 20 minutes. You will receive your results today.

Would you like to receive a free, confidential HIV test today? (Please mark with an X)

Yes ____ No ____ I'd like more information ____

SQUIRREL HILL HEALTH CENTER

PATIENT MEDICAL HISTORY - ADULT

DATE: _____

1. SOCIAL HISTORY

Name _____ Birthdate ____/____/____
(Last) (First) (M.I.)
Occupation _____ Education (# of Years Completed) _____
Marital Status/Relationship _____ Partner's Name _____ Religion _____
Who lives with you? (names / relationships / ages): _____

Special cultural beliefs that might affect your healthcare _____

Do you have a Power of Attorney for Healthcare? [] Yes [] No Do you have a living will? [] Yes [] No

Use of home health or other community services? [] Yes [] No

Name of Health Care Provider _____

2. WHAT CONCERNS DO YOU HAVE TODAY?

3. PAST MEDICAL HISTORY Have you ever had (if so, when)

- [] Alcoholism [] Epilepsy / seizures [] Migraines
[] AIDS / related complex [] Gallbladder [] Pleurisy
[] Anemia [] Gonorrhoea [] Pneumonia
[] Anxiety/Depression [] Hemorrhoids [] Rheumatic fever
[] Asthma [] Herpes [] Sexually transmitted disease
[] Bone / joint problems [] High cholesterol / lipid levels [] Stomach disease
[] Cancer; type: [] High / Low blood pressure [] Stroke / paralysis
[] Coronary heart disease [] Jaundice [] Thyroid disease
[] Diabetes [] Kidney disease [] Tuberculosis
[] Diphtheria [] Liver disease / hepatitis [] Other:
[] Emotional problems

4. PERSONAL HISTORY

YES NO

During the past month have you been bothered by:
1) little interest of pleasure in doing things?
2) feeling down, depressed or hopeless?

Have you served in the military?
If yes, type of discharge? For which country?

Do you have any trouble reading?
years of school completed

Do you have any special interests or hobbies?
Please list

Do you have any personal concerns which are troubling you?
If "YES", please check those concerns:

- [] Hospital bills [] Family [] Housing / Rent / Heat
[] Social Security [] Marriage [] Other Money Matters (food, clothing, etc.)
[] Occupation [] Sex [] Community Agencies (welfare, etc.)
[] Transportation [] Loneliness [] Emotional Problems / Nerves
[] Legal [] Death [] Other

SQUIRREL HILL HEALTH CENTER

PATIENT MEDICAL HISTORY - ADULT

PATIENT NAME: _____

5. HOSPITALIZATIONS Have you been hospitalized? YES NO (If so, please list) _____

Have you had: Appendectomy Tonsillectomy (age____) Cholecystectomy (Gallbladder) Hysterectomy
 Other surgeries: _____

6. FAMILY HISTORY

Has any blood relative ever had: (Check all that apply and who)

- | | | |
|---|--|---|
| <input type="checkbox"/> Alcoholism/Substance Abuse _____ | <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Alzheimer's disease _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Senility _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> High cholesterol _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Kidney disease _____ | <input type="checkbox"/> Tuberculosis; when _____ |
| <input type="checkbox"/> Bleeding problem _____ | <input type="checkbox"/> Memory loss _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer; type: _____ | <input type="checkbox"/> Mental illness _____ | |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Thyroid disease _____ | |

7. MEDICINES

Also include any over-the-counter medications such as vitamins, antihistamines, Tylenol, herbal remedies, etc.

8. ALLERGIES Please check items to which you are allergic:

- Drug allergies: (specify) _____
 Food/environmental allergies (specify) _____
 Iodine – Shellfish Bee stings / Insect bites X-ray / Arteriogram or dyes Adhesive tape Latex
 Other allergies: (specify) _____

9. IMMUNIZATIONS Check those that you have had. (Please note the most recent year received.)

- Usual childhood immunizations _____ Flu _____ Pneumonia _____ Tetanus _____
 Chicken pox _____ Hepatitis _____ Others _____

10. HABITS

- Do you exercise regularly? Yes No
How? _____ How long? _____ How often? _____
Do you drink caffeinated beverages? Yes No
How much? _____ Daily / Weekly How long? _____

SQUIRREL HILL HEALTH CENTER

PATIENT MEDICAL HISTORY - ADULT

PATIENT NAME: _____

Do you drink alcoholic beverages? Yes No

How much? _____ Daily / Weekly

Type _____ How long? _____

Do you now, or have you ever used: **Cigarettes** Packs/Day _____ X _____ years **Pipe** X _____ years

Chewing tobacco X _____ years **Cocaine** X _____ years

Marijuana X _____ years If discontinued, when? _____ **Other Drugs:** _____

10. HABITS - continued

Do you regularly use a seat belt? Yes No

Do you keep a gun in your home? Yes No

Do you have smoke detectors in your home? Yes No

Do you limit sun exposure or use sunscreens (# 15 or higher) when tanning? Yes No

11. NUTRITION ASSESSMENT

Have you recently changed the kind and/or amount of food you eat? Yes * No

If yes, was it due to: an illness? Lack of money to buy food? Trying to lose or gain weight?
Other? _____

Are you on a special diet? Yes * No

If yes, what type of diet? _____

Has your weight changed 10 pounds or more in the past 6 months? Yes * No

Amount gained _____ or lost _____

Do you have diabetes? Yes * No

Have you seen a dietician in the past year? Yes No *

Do you take an herbal, vitamin/mineral, nutritional drinks or supplements? Yes * No

If yes, what? _____

Would you like more information about healthy eating? Yes * No

* May indicate referral to dietician

12. GENERAL SCREEN / REVIEW OF SYSTEMS

Last Dental Exam: _____ Last Vision Exam: _____ Last Rectal Exam / Colonoscopy: _____

13. PAIN ASSESSMENT

(Please indicate body site, intensity of pain, things that make your pain better or worse)

Body site: _____ No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Worst Pain Imaginable

What makes this pain better? (i.e. rest, heat, medicine): _____

What makes this pain worse? (i.e. walking, standing, lifting): _____

14. SEXUAL HISTORY (Men & Women)

Are you sexually active? Yes No Lifetime number of partners: _____ with Men Women Both

Current contraception method or protection against STD: _____ Any sexual dysfunction or pain? _____

Any sexual concerns or questions? _____

Have you ever been physically or sexually abused? Yes No

Are you currently at risk for violence? Yes No

15. MEN ONLY

Last rectal exam: _____ Last PSA: _____

SQUIRREL HILL HEALTH CENTER

PATIENT MEDICAL HISTORY - ADULT

PATIENT NAME: _____

- Difficulty getting / keeping an erection? Yes No
- Difficulty with orgasm? Yes No
- Practicing monthly testicular exam? Yes No Need information
- Difficulty urinating? Yes No

16. WOMEN ONLY

- Last menstrual period: _____
- Age at onset: _____ Regular Irregular
- Flow: Heavy Moderate Light
- Length of periods: _____
- Pain / cramps with menses: Yes No
- Days of flow (number): _____
- Length of cycle: _____
- Last Pap smear: _____
- Last mammogram: _____
- Monthly self breast exam Yes No
- Menopause: Yes No Age: _____
- Symptoms of menopause: _____
- _____
- _____
- Reduced sexual interest Yes No
- Difficulty achieving orgasm Yes No
- Pain / bleeding after sex Yes No
- Pregnant Yes No
- Planning pregnancy: Yes No
- Number of pregnancies: _____
- Number of ectopic pregnancies: _____
- Number of live births: _____
- Number of miscarriages: _____ Number of abortions: _____
- Contraception method: _____
- Name of birth control pill, if using: _____
- Any concerns or questions? _____

I reviewed, agree and/or made changes as necessary to form:

Provider Signature: _____

Initial: _____

Date: _____