ST. JOHN NP
IN FAMILY HEALTH PLLC

Adult New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Legal Sex*: ____ Home Phone: _____ Mobile Phone: _____

Preferred Phone: Home or Mobile (circle one) Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ Employer: _____

Primary Care Provider (PCP): _____ PCP Phone: _____

Referring Provider: _____ Referring Phone: _____

Preferred Pharmacy: _____ Pharm Phone: _____

Preferred Pharmacy Address: _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc…)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

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 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 St. John NP for services rendered. I authorize representatives of St. John NP to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

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

□ Received □ N/A (only if you received the notice from ColumbiaDoctors previously)

Information Disclosure and Consent

St.John NP will provide you with the health plans that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____ Date: _____

Please refer to our website: www.stjohnnp.com for a list of insurances accepted by your provider.

***Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.**

Name: DOB:

Reason for today's visit:

Please be aware that the name and sex you have listed on your insurance

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems	□ Y	□ N	Heart Disease/Disorder	□ Y	□ N
Arthritis	□ Y	□ N	Lung Disorder	□ Y	□ N
Bleeding/Clotting Disorder	□ Y	□ N	Liver Disease	□ Y	□ N
Blood Pressure Disorder	□ Y	□ N	Neurological Disorder/Chronic Headaches	□ Y	□ N
Blood Transfusion	□ Y	□ N	Psychiatric Disorder/Illness	□ Y	□ N
Bowel/Stomach Problems	□ Y	□ N	Pulmonary Embolism/DVT	□ Y	□ N
Cancer	□ Y	□ N	Stroke	□ Y	□ N
Cholesterol Disorder	□ Y	□ N	Seizure or Epilepsy	□ Y	□ N
Diabetes	□ Y	□ N	Thyroid Disorder	□ Y	□ N
Eye Disorder (i.e. Glaucoma, cataract)	□ Y	□ N	Urinary/Kidney Disorder	□ Y	□ N

If Relevant: Gynecological Issues..... □ Y □ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	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		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ 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: _____

If Relevant: Any past pregnancies? □ Y □ N How many? ___ How many deliveries? ____

Name: DOB:

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N

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

Allergy	Reaction	Allergy	Reaction

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

Medication Name	Dose	Medication Name	Dose

Review of Systems

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

Constitutional

□Y□N Fever
□Y□N Chills
□Y□N Fatigue
□Y□N Feeling Poorly
□Y□N Sweats
□Y□N Weight Gain (___ Lbs)
□Y□N Weight Loss (___ Lbs)
□Y□N Unexp. Weight Change
□Y□N Sleep Disturbances
□ Other:

Head, Eyes, Ears, Nose, and Throat

□Y□N Vision Problem
□Y□N Decreased Hearing
□Y□N Double Vision
□Y□N Light Sensitivity
□Y□N Itchy Eyes
□Y□N Red Eyes
□Y□N Eye Pain
□Y□N Runny Nose
□Y□N Neck Stiffness
□Y□N Nosebleed
□Y□N Congestion
□Y□N Snoring
□Y□N Dry Mouth
□Y□N Flu-Like Symptoms
□Y□N Sore Throat
□Y□N Hoarseness
□Y□N Ringing in Ears
□Y□N Vertigo
□Y□N Earache
□Y□N Other:

Cardiovascular

□Y□N Chest Pain
□Y□N Palpitations
□Y□N Leg Swelling
□Y□N Cold Extremities
□Y□N Cold Hands or Feet
□Y□N Leg Pain w/ Walking
□Y□N Irregular Heart Rhythm
□Y□N Other:

Respiratory

□Y□N Shortness of Breath
□Y□N Cough
□Y□N Rapid Breathing
□Y□N Wheezing
□Y□N Shortness of Breath
□Y□N Chest Congestion
□Y□N Coughing Up Blood
□Y□N Coughing Up Sputum
□ Other:
□

Gastrointestinal

□Y□N Abdominal Pain
□Y□N Blood in Stool
□Y□N Vomiting
□Y□N Nausea
□Y□N Constipation
□Y□N Diarrhea
□Y□N Black/Tarry Stools
□Y□N Decreased Appetite
□Y□N Yellow Skin
□Y□N Trouble Swallowing
□Y□N Change in Bowels
□Y□N Vomiting Blood
□Y□N Bowel Incontinence
□Y□N Rectal Pain
□Y□N Heartburn
□Y□N Painful Swallowing
□ Other:

Name: DOB:

Neurological

□Y□N Headache	□Y□N Unsteady	□Y□N Numbness	□Y□N Tremor
□Y□N Dizziness	□Y□N Disorientation	□Y□N Tingling	□Y□N Memory Lapses/Loss
□Y□N Decreased Strength	□Y□N Confusion	□Y□N Seizures	□ Other:
□Y□N Poor Coordination	□Y□N Burning Sensation	□Y□N Fainting (Syncope)	

Musculoskeletal

□Y□N Joint Pain	□Y□N Limb Pain	□Y□N Muscle Pain	□ Other:
□Y□N Neck Pain	□Y□N Joint Swelling	□Y□N Muscle Weakness	
□Y□N Back Pain	□Y□N Muscle Cramps	□Y□N Leg Swelling	

Genitourinary

□Y□N Frequent Urination	□Y□N Pelvic Pain	□Y□N Painful Intercourse	□Y□N Heavy Period Bleeding
□Y□N Incontinence	□Y□N Nocturia	□Y□N Discharge- Vaginal	□ Other:
□Y□N Urinary Urgency	□Y□N Itching- Genital	□Y□N Vaginal Bleeding	
□Y□N Painful Urination	□Y□N Change in Libido	□Y□N Irreg. Monthly Cycles	

Integumentary

□Y□N Rash	□Y□N Skin Wound	□Y□N Unusual Growth	□Y□N Skin Cancer
□Y□N Dry Skin	□Y□N Change in A Mole	□Y□N Itching	□ Other:

Psychiatric

□Y□N Depression	□Y□N Anxiety	□Other:

Hematologic/Lymphatic

□Y□N Easy Bruising	□Y□N Easy Bleeding	□Y□N Swollen Lymph Nodes	□ Other:

Endocrine

□Y□N Excessive Thirst	□Y□N Heat Intolerance	□Y□N Changes- Skin
□Y□N Cold Intolerance	□Y□N Changes- Hair	□ Other:

OFFICE USE ONLY: Provider Signature: _____ Date: _____

ST. JOHN NP
IN FAMILY HEALTH PLLC

Substance Use History

How many drinks containing alcohol do you have, on average, per week?

_____

Have you ever been concerned about your drinking? Yes No Not Sure

Has anyone, including a family member, friend, or healthcare worker been concerned about your drinking or suggest you cut down?

Yes No I'm not sure

How many cigarettes do you smoke per day? _____

How old were you when you first started smoking? ____

Have you ever tried to quit smoking? Yes No NA

Are you interested in quitting smoking? Yes No NA

If you are a former smoker, how long ago did you quit?

_____

Please check any of the substances listed below that you have used, even if it was only once:

___ Marijuana

When was the last time you used it? _____

How frequently do you/did you use it? _____

___Cocaine

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie, smoke, inject, sniff)? _____

___Crystal Meth

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie, smoke, inject, etc)? _____

___Heroin

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie, smoke, inject, etc)? _____

___Other Opiates (oxycontin, vicodin, percodan, etc)

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie, orally, smoke, inject, etc)? _____

___Ecstasy/Mushrooms/LSD

When was the last time you used it? _____

How frequently do you/did you use it? _____

Other Substance(s):

_____

When was the last time you used it? _____

How frequently do you/did you use it? _____

How do/did you use it (ie smoke, inject, etc)? _____

Have you *ever* injected any type of substance? Yes No

Did you ever share your needle, cooker, cotton, rinse water, or any other part of your set?

Yes No I'm not sure

What types of problems has drug use caused for you (ie, relationships with others, problems at work, depression, anxiety, physical health, etc)?

_____

_____

_____

_____

What concerns, if any, do you have about either your past or current drug use?

_____
_____
_____
_____

Thank you for answering this comprehensive health history form. Your answers are confidential and will help us provide more complete and knowledgeable care of you.

ST. JOHN NP
IN FAMILY HEALTH PLLC

Patient Health Questionnaire

Name: _____Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use a check mark to indicate your answer)

	Not at all	Several Days	More than 1/2 the day	Nearly 1/2 the day
1.Little interest or pleasure in doing things.				
2. Feeling down, depressed or hopeless.				
3. Trouble falling or staying asleep, or sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
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.				
9. Thoughts that you would be better off dead, or of hurting yourself.				
	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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CAGE Questionnaire

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

Scoring:

Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

……..

Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Cahpel Hill, CAGE is an internationally used assessment instrument for identifying alcoholics. It is particularly popular with primary care givers. CAGE has been translated into several languages.

The CAGE questions can be used in the clinical setting using informal phrasing. It has been demonstrated that they are most effective when used as part of a general health history and should NOT be preceded by questions about how much or how frequently the patient drinks (see "Alcoholism: The Keys to the CAGE" by DL Steinweg and H Worth; American Journal of Medicine 94: 520-523, May 1993.

The exact wording that can be used in research studies can be found in: JA Ewing "Detecting Alcoholism: The CAGE Questionaire" JAMA 252: 1905-1907, 1984. Researchers and clinicians who are publishing studies using the CAGE Questionaire should cite the above reference. No other permission is necessary unless it is used in any profit-making endeavor in which case this Center would require to negotiate a payment.

……..

Source: *Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Chapel Hill*

Smoking Assessment Questionnaire

Name: _____

Today's Date: _____

Address: _____ Date of Birth: _____

_____

Smoking History

1. At what age did you begin to smoke? _____

2. How many cigarettes do you smoke **before** starting the work day? _____

3. How many cigarettes do you smoke **during** the work day? _____

4. How many cigarettes do you smoke **after** the work day? _____

5. What is the **total** number of cigarettes smoked **per day**? _____

6. What is the **total** number of cigarettes smoked per **day during the weekend**? _____

7. How many cigarettes have you smoked per day during your **heaviest** smoking period? _____

8. How many times have you tried to stop smoking? *(Please check one.)*

_____Never
_____One
_____Two
_____Three
_____Four
_____Five
_____Six or more

9. What is the longest period of time you have gone without smoking since you first started smoking regularly? *(Please check one.)*

_____1 week or less
_____1 week - 1 month
_____>1 month - 6 months
_____>6 months - 1 year
_____longer than 1 year

10. Have you ever tried to stop smoking before using the following methods? *(Check all that apply.)*

_____Clinic or group
_____Written materials
_____Cold Turkey
_____Gradual reduction
_____Special filters
_____Stop with a friend (buddy system)
_____Hypnosis
_____Self-help program
_____Medications
_____List: _____

Current Plan to Stop Smoking

1. How interested are you in stopping smoking? *(Please check one.)*
_____strongly
_____very
_____somewhat
_____a little
_____not at all

2. If you decide to quit smoking completely, during the next two weeks, how confident are you that you will succeed? *(Please check one.)*
_____strongly
_____very
_____somewhat
_____a little
_____not at all

3. Do the following people smoke?

_____Family (those living with you)
_____Friends
_____Coworkers

4. Are family members (encouraging / discouraging) you from trying to stop smoking?
(Please circle one.)

ST. JOHN NP
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Chronic Pain Assessment Questionnaire

Pain is a patient-specific experience that requires ongoing assessment and evaluation, both by patients and their providers. This questionnaire will help assess the two parts of chronic pain that often change over time, persistent baseline and breakthrough pain. Please take a moment to complete this questionnaire.

Part 1: Assessment of Persistent Baseline Pain

1 During the past week, have you had any pain or would you have had pain if not for the treatment you are receiving?

- ❑ If **Yes**, please proceed to the next question.
- ❑ If **No**, your pain profile may not include persistent baseline pain; please return this form to your physician.

2 Is this pain present continuously (most of the day) on most days or would the pain persist if not for the treatment you are receiving?

- ❑ If **Yes**, please proceed to the next question. This is known as persistent baseline pain.
- ❑ If **No**, your pain profile may not include persistent baseline pain; please return this form to your physician.

3 During the past week, on average, how would you rate your baseline pain on a scale of 0 to 10? (Refer to ***Figure 1A***)

- ❑ If **Severe**, your baseline pain may be uncontrolled; please return this form to your physician who may adjust your baseline treatment as needed.
- ❑ If **Mild** or **Moderate**, your baseline pain is controlled. Please proceed to the next question.

4 Assess the nature of your baseline pain

- Where do you feel this pain? (Refer to ***Figure 1B***)
- What does the pain feel like? (Refer to ***Figure 1C***)
- How long have you experienced this pain? **(in weeks)** _____
- Does anything that you do reduce your pain? ❑ Yes ❑ No
  If **Yes**, please describe what reduces your pain: _____
  _____
- Does anything that you do make your pain worse? ❑ Yes ❑ No
  If **Yes**, please describe what makes your pain worse: _____
  _____

5 Are you taking opioid medications **daily**?

- ❑ If **Yes**, which opioid are you taking? _____
  _____
  How often are you taking it? _____
  _____
  Please proceed to the next question.
- ❑ If **No**, please proceed to the next question.

6 **Evaluate for breakthrough pain** *(see reverse)*

Patient Information

❑ First visit ❑ Follow-up visit

Age ❑ 20-29 ❑ 30-39 ❑ 40-49 ❑ 50-59 ❑ 60-69 ❑ 70+

Height _____ Weight _____

Sex ❑ Male ❑ Female

Race ❑ Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other

Pain Diagnosis _____

FIGURE 1A

Please rate your **baseline pain** by circling the one number that best describes your pain on the average during the past week.

0-10 Numeric Pain Intensity Scale

FIGURE 1B

Where do you feel this pain?

(In the diagram below shade in the areas where you experience this pain)

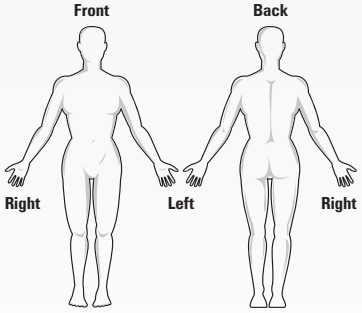

FIGURE 1C

What does the pain feel like?

(Check all that apply)

❑ Aching	❑ Hurting	❑ Shocking
❑ Agonizing	❑ Intense	❑ Shooting
❑ Annoying	❑ Itchy	❑ Sickening
❑ Beating	❑ Miserable	❑ Sore
❑ Burning	❑ Nauseating	❑ Spreading
❑ Cold	❑ Numb	❑ Squeezing
❑ Cramping	❑ Piercing	❑ Stabbing
❑ Crushing	❑ Pinching	❑ Stinging
❑ Cutting	❑ Pounding	❑ Suffocating
❑ Dreadful	❑ Pressure	❑ Tearing
❑ Dull	❑ Prickling	❑ Throbbing
❑ Exhausting	❑ Pulling	❑ Tight
❑ Flashing	❑ Pulsing	❑ Tingling
❑ Flickering	❑ Radiating	❑ Troublesome
❑ Freezing	❑ Scalding	❑ Tugging
❑ Hot	❑ Sharp	❑ Unbearable

Part 2: **Assessment of Breakthrough Pain**

1 Do you have periods during the day when you have temporary episodes of uncontrolled pain (also known as breakthrough pain)?

- ❑ If **Yes**, how often? _____
- What time of day do these episodes occur? _____
- ❑ If **No**, please return this form to your physician.

2 How long does it take from the time you first notice the pain until it is at its worst?

_____

- How long do the episodes last? _____
- How long does it usually take from the time you take medicine until the pain goes away? _____

3 How would you rate your breakthrough pain at its worst on a scale of 0 to 10? (Refer to ***Figure 2A***)

4 Where do you feel this pain? (Refer to ***Figure 2B***)

5 What does the pain feel like? (Refer to ***Figure 2C***)

6 Do you know what causes these breakthrough pain episodes? ❑ Yes ❑ No

- Are the episodes associated with certain activities (for example, gardening, walking)? ❑ Yes ❑ No
  If **Yes**, what are these activities? _____
- Does the onset occur with certain bodily functions (for example, coughing, sneezing)? ❑ Yes ❑ No
  If **Yes**, what are these bodily functions? _____
- Does the onset usually occur right before a scheduled dose of your pain medication? ❑ Yes ❑ No

7 Are these episodes of breakthrough pain the same type of pain as your usual pain? ❑ Yes ❑ No

If **No**, how do they differ? _____

Function

8 Do the episodes of breakthrough pain affect your ability to handle daily responsibilities at home or work? ❑ Yes ❑ No

If yes, how often? _____

9 To what extent does avoiding activities due to fear of an episode of breakthrough pain compromise your quality of life?

❑ A little ❑ A fair amount ❑ A lot ❑ An extreme amount

Medications

10 Does anything help lessen the severity of these episodes of breakthrough pain? ❑ Yes ❑ No

- What helps? _____
- What doesn't help? _____

11 Do you take any breakthrough pain medication(s)? ❑ Yes ❑ No

If yes, complete questions 12 and 13. If no, please return this form to your physician.

12 In the past 24 hours, how long has it taken for your breakthrough pain medication to begin to take effect? _____minutes

13 In the past 24 hours, how satisfied or dissatisfied have you been with how fast your breakthrough pain medication began to reduce your breakthrough pain?

❑ Very satisfied ❑ Satisfied ❑ Neutral ❑ Dissatisfied ❑ Very dissatisfied

Additional Patient Information

Marital Status _____

Occupation _____

FIGURE 2A

Please rate your **breakthrough pain** by circling the one number that best describes your pain on the average during the past week.

0-10 Numeric Pain Intensity Scale

FIGURE 2B

Where do you feel this pain?

(In the diagram below shade in the areas where you experience this pain)

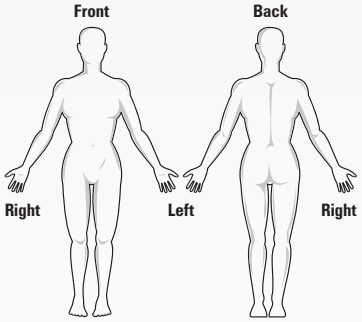

FIGURE 2C

What does the pain feel like?

(Check all that apply)

❑ Aching	❑ Hurting	❑ Shocking
❑ Agonizing	❑ Intense	❑ Shooting
❑ Annoying	❑ Itchy	❑ Sickening
❑ Beating	❑ Miserable	❑ Sore
❑ Burning	❑ Nauseating	❑ Spreading
❑ Cold	❑ Numb	❑ Squeezing
❑ Cramping	❑ Piercing	❑ Stabbing
❑ Crushing	❑ Pinching	❑ Stinging
❑ Cutting	❑ Pounding	❑ Suffocating
❑ Dreadful	❑ Pressure	❑ Tearing
❑ Dull	❑ Prickling	❑ Throbbing
❑ Exhausting	❑ Pulling	❑ Tight
❑ Flashing	❑ Pulsing	❑ Tingling
❑ Flickering	❑ Radiating	❑ Troublesome
❑ Freezing	❑ Scalding	❑ Tugging
❑ Hot	❑ Sharp	❑ Unbearable

Adapted from Portenoy RK, et al. *J Pain*. 2006;7:583-591; Hagen NA, et al. *J Pain Symptom Manage*. 2008;35:136-152; and the clinical practice of Michael J. Brennan, MD.

Random Tox Screen Policy

Effective immediately ALL patients who are required to take a urine drug screen may need to do so under observation from a staff member. This includes during regular appointments and random urine drug screens/ medication count. If you have any questions please ask one of the staff members.

I understand I have 24 hours from the time I am called to present to the office.
I will have provided accurate phone numbers and my voice mailbox will not be full.

If I do not comply with this office policy or my mailbox is full, this is considered a "no show" whereby I will be charged the no show fee and may result in a reduction of my medication or discharge from the practice.

I have read and understand this policy. All of my questions were answered to my satisfaction. I agree to comply with all aspects of this policy.

Staff Signature: _____Date: _____

Patient Signature: _____ Date: _____

Travel Office Policy

Please be advised you must discuss your travel plans with the provider prior to requesting an early refill or an extended refill. of your medication. You must bring in your itinerary such as an airline ticket or hotel receipt the date you intend on traveling.

If you do not supply the requested documentation, you will not receive your medication early or for an extended time.

In addition, you will need to bring in a receipt dated the day you travel and the day that you return. *(gasoline receipts, magazines , gum; any receipt that has a date and location is acceptable)*

Please note: a 2 -3 hour drive is not considered traveling or “out of town”.

Travel Date _____ Where _____ Return Date._____

I have read the above policy and will abide by the terms of the policy. Thank you.

Staff Signature: _____Date: _____

Patient Signature: _____ Date: _____

ST. JOHN NP
IN FAMILY HEALTH PLLC

Patient Covenant

No controlled substances are refilled after hours, when the office is closed, on the weekend or holidays. If your next visit would fall on a holiday, it is your responsibility as the patient to make sure your provider knows you may need additional medication until your follow up appointment. Failure to do so will result in a reduction on your medication.

All patients are responsible to check with their pharmacy the day they have been seen to ensure they have the following:

1. Their script is at the pharmacy.
2. The pharmacy has enough of your medication.
3. There are no problems with how the prescription is written.

Prior authorizations may take up to 3-4 business days. The office has no control over how quickly prior authorizations are made.

As the patient it is your responsibility to make sure your medication is covered by your insurance.

You are responsible for all office visits not covered by your insurance. You alone are responsible to ensure you have enough medication until your next follow up appointment.

If you need a prescription refill on a non controlled medication, you must call to request at least 5 days before the medication is due otherwise, this may cause a delay in your medication management.

At check in it is your responsibility to make sure you have the correct pharmacy listed.

Frequent changes in pharmacy requests will not be honored. You must select a pharmacy only is cases where you have permanently moved will the pharmacy be adjusted. Should your pharmacy not have your full prescription, you have will need to check back with your pharmacy for the remaining doses. No exceptions will be made.

If your mailbox is full, this is against strict office policy. As the patient it is your responsibility to ensure we are able to reach you, and that all of your patient information is true and accurate. If we cannot reach you for a random drug screen, you ill be charged a no show fee of $50 and may have a dose reduction in your medication and or/ you may be discharged from the practice for non compliance and office protocols/ policies. The above agreement is non-negotiable and is in place for your compliance and safety

Patient Signature: _____ Date: _____

Patient Financial Agreement

You are financially responsible for the medical services you receive at St John NP in Family Health PLLC. Please carefully review this Financial Policy, initial each section and sign the Agreement to indicate your acceptance of its terms.

Appointments

1. CO PAYMENTS AND DEDUCTIBLES: Co payments and deductibles for office visits are due at the time of service, in accordance with your insurance carrier's plan. If you are unable to make your Co payment at the time of service, the Practice reserves the right to reschedule your appointment until such time that you are able to make your co payment. **Initial: _____**

2. SELF-PAY: I f you do not have health insurance, or if your health insurance will not pay for services rendered by the Practice or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service. **Initial: _____**

3. MISSED APPOINTMENTS AND LATE ARRIVALS: You will be charged $30 for a same day cancellation or reschedule of appointment. You will be charged $50 for a no show fee, this includes calling to reschedule the day of your missed appointment. These charges are your personal responsibility and will not be billed to any insurance carrier. **Initial: _____**

Insurance Payments

4. FINANCIAL RESPONSIBILITY: Your insurance policy is a contract between you and your insurance Carrier. You are ultimately responsible for payment-in-full for all medical services provided to You. Any charges not paid by your insurance carrier will be your responsibility. It is your responsibility to make sure your insurance is accepted by St. John NP in Family Health, NOT the office.

5.COVERAGE CHANGES: I t is your responsibility to inform us of any change to your billing or insurance information. Your insurance carrier places a time limit within which the Practice can submit a claim on your behalf. If the Practice is unable to process your claim within this period due to your providing incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges. **Initial: _____**

Benefits & Authorization

6. INSURANCE PLAN PARTICIPATION: The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and co payments, which you will be responsible for. **Initial: _____**

7. REFERRALS: Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by the Practice, it is your responsibility to obtain this referral prior to your appointment. Although, your referring health care provider, and the Practice, are expressly permitted to disclose your Protected Health Information (PHI) for your treatment, under HIPAA, you have the right to request restrictions on the disclosure of your PHI. Under HIPAA, the Practice is not required to agree with you. As a matter of course, the practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission machine or by an employee of the Practice
Initial: _____

Patient Financial Agreement

8. PRIOR AUTHORIZATION AND NON-COVERED SERVICES: The Practice may provide services that your insurance carrier's plan excludes or require prior authorization. The Practice, as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier. **Initial: _____**

9. OUT-OF-NETWORK PAYMENTS AND DIRECT INSURER PAYMENTS: You are personally responsible for all charges. If we are not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly, you are obligated to forward the payment or payment proceeds to the Practice immediately. **Initial: _____**

Account Balance Payments

10. REASSIGNMENT OF BALANCES: If your insurance carrier does not pay for services, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving an initial statement. Any unpaid balance will result in a FEE of $5.00 applied to your account for nonpayment and further processing fees. **Initial: _____**

11. COLLECTION OF UNPAID ACCOUNTS: I f you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in reporting it to the credit bureau and additional legal action.

The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device.

12. WE DO NOT ACCEPT CHECKS

Additional Fees

13. MEDICATION RE-FILLS REQUESTS: All medication refill requests are to be approved by your provider, only during office hours. No narcotic medication will be prescribed without having an appointment, no refills after hours.

Patient Financial Agreement

14. FORMS: The Practice will respond (at the provider's discretion) to requests for the completion of certain medical forms (FMLA, Short Term Disability & Temporary Disability Parking Permit) assuming the patient is in good standing and has been active with the. Other forms not listed may be considered for completion by the Practice. In these cases, the fee for forms completion is $50. If the form requires a physician signature and additional $50 will be added. Initial: _____

We are pleased to serve you and glad that you chose St. John NP In Family Health PLLC as your provider. We will always strive to provide exceptional care for you. Reasons that St. John NP Family Health PLLC may ask you to seek health care services elsewhere might include:

Rude or violent behavior to staff via in-person or telephone - this also applies to your family members and/or friends.

Repeated no shows, cancellations, or continual late arrivals for office visits or procedures Refusal to adhere to the plan of care as outlined by your Provider or to follow health insurance or government guidelines.

Unwarranted requests for disability paperwork, parking permits or other paperwork

Our goal is to help you. Therefore, we ask that you schedule and keep all follow up appointments, participate in all treatments and diagnostic testing. **Initial: _____**

I have read and understand the Financial Policy of St. John NP In Family Health PLLC, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to St. John NP in Family Health PLLC. I understand that I am financially responsible for all services I receive from the Practice.

This financial policy is binding upon me and my estate, executors and/or administrators, if applicable.
We reserve the right to accept only cash, credit or debit, and FSA Card.
Any forms that need to be completed by the provider will incur a $50.00 fee due at the time of the paperwork completion. Sometimes patients require a Physician signature this will incur an additional $50.00.

Printed Name: _____Date: _____

Provider Signature: _____ Date: _____

ST. JOHN NP
IN FAMILY HEALTH PLLC

Current Pain Questionnaire:

Limitations of Activities: The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

Vigorous Activities, such as running, lifting heavy objects, participating in strenuous sports:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

Lifting of/carrying groceries:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

Climbing several flights of stairs:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

Climbing one flight of stairs:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

Bending, kneeling or stooping:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

Walking more than a mile:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

Walking several blocks:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

Walking one block:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

Bathing or Undressing self:

[ ] Yes, limited a lot **[ ]** Yes, limited a little **[ ]** No, not limited at all

ST. JOHN NP
IN FAMILY HEALTH PLLC

Current Injury Pain Disability Index:

A score of 0 means no disability at all and a score of 10 signifies that all of the activities which would normally be involved have been totally disrupted or prevented by your pain.
No Disability 0 1 2 3 4 5 6 7 8 9 10 **Worst Disability**

Family/Home responsibilities: [ ]

Refers to activities of the home and family. It includes chores or duties performed around the house (i.e. yard work) and errands or favors for other family members.

Recreation: [ ]

This disability includes hobbies, sports, and other similar leisure time activities.

Social Activity: [ ]

This category refers to activities. Which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

Occupation: [ ]

This category refers to activities that are a part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

Sexual Behavior: [ ]

This category refers to the frequency and quality of one's sex life.

Self Care: [ ]

This category includes activities, which involve personal maintenance and independent daily living (i.e. taking a shower, driving, and getting dressed.)

Life Support Activities: [ ]

This category refers to basic life supporting behaviors such as eating, sleeping and breathing.

SOAPP® Version 1.0

Name: _____ **Date:** _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids to treat their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the following questions using the scale below:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	0	1	2	3	4
2.	How often do you smoke a cigarette within an hour of waking up?	0	1	2	3	4
3.	How often have you taken medication other than the way it is prescribed?	0	1	2	3	4
4.	How often have you used illegal drugs? (i.e. cocaine, methamphetamine, heroin, etc) in the past five years?	0	1	2	3	4
5.	How often, in your lifetime, have you had legal issues or been arrested?	0	1	2	3	4

Please include any additional information you wish about the above answers. Thank you.

Signature: _____

ST. JOHN NP
IN FAMILY HEALTH PLLC

24 Hour Cancellation Policy

Marianne St John FNP-B-C requests a 24-hour notice upon canceling an appointment. If prior notice is not given, YOU WILL BE CHARGED A $50 NO SHOW FEE.

Each appointment is customized and catered to each patient. We are committed to you 100% and expect your commitment in return.

Signing this agreement means you consent to these terms.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

ST. JOHN NP
IN FAMILY HEALTH PLLC

Opioid Risk Assessment

Name: _____

		Mark Each Box as it Applies to You	
		Male(s)	**Female(s)**
Factors			
1. Family History of Substance Abuse:	Alcohol	☐	☐
	Illegal Drugs	☐	☐
	Prescription Drugs	☐	☐
2. Personal History of Substance Abuse:	Alcohol	☐	☐
	Illegal Drugs	☐	☐
	Prescription Drugs	☐	☐
3. Age between 16-45 years of age?		☐	☐
4. History of Preadolescent Sexual Abuse:		☐	☐
5. Psychological Disease:	ADD, OCD, Bipolar, or Schizophrenia	☐	☐
	Depression	☐	☐
	TOTAL SCORE		

*** Scores 3 or below indicate low risk

*** Scores between 4 - 7 indicate moderate risk

*** Scores 8 and above indicates high risk

Name:

DOB:

Date:

1. **Marital Status**
2. **Who do you live with?**
3. **Any Children?**
4. **What is your occupation?**
5. **Work Status**
6. **Do you write with your Left or Right hand?**
7. **Any Pets?**
8. **Any guns in the home?**
9. **If yes, are they locked up in a safe place?**
10. **What are your hobbies?**
11. **Do you have a CO & smoke detector in your home?**
12. **What is your highest level of education?**
13. **What is your spiritual orientation?**

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name:	Date of Birth:	SSN:
Patient Address:		

I or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the PrivacyRule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This Authorization may incluse disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except physchotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in item 8.

2. If I am authorizing the release of HIV-related, alcohol or drug treament, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law.

3. I have the right to revoke this authorization at any tiem by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that actuion has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure mayb longer be protected by federal or state law.

6. THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENT AGENCY SPECIFIED IN ITEM 9(b).

7. Name and address of health provider or entity to release this information:

8. Name and adress of person(s) or category of person to whim this information will be sent:

St John NP in Family Health PLLC 2809 Wehrle Dr Ste 1, Williamsville, NY 14221 Fax: (716)-245-4432

9(a). Specific information to be released:

____ Medical Record from (insert date) _____ to (insert date) _____

____ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, biling records, insurance records, amd records sent to you by other health care providers.

____ Other: _____

_____

_____

Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

Authorization to Discuss Health Information

(b) By Initialing here _____ I authorize ST JOHN NP IN FAMILY HEALTH to discuss my health information with my attorneym or a governmental agency listed here:

_____

10. Reason for release of information:	**11. Date or event on which this authorization will expire:**
___ At request of individual ___ Other:	_____
12. If not the patient, name of person signing form:	**13. Authority to sign on behalf of patient:**
_____	_____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient of representive authorized by law

** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.*

ST. JOHN NP
IN FAMILY HEALTH PLLC

Pain Treatment with Opioid Medications: Patient Agreement

This Agreement is essential to the trust and confidence necessary in a prescriber/patient relationship. My prescriber has discussed my treatment plan with me. I understand that there is a risk of psychological and/or physical dependence and addiction associated with the chronic use of controlled substances for pain. I have been told about the side effects that I may experience. My prescriber is undertaking to treat me with controlled substances for pain because:

I, _____ , understand and voluntarily agree to the following (initial each statement after reviewing):

☐ I have told my prescriber about other medication I am taking and my medical history, including my prior experience with pain medications or other drugs. Throughout my treatment, I will communicate fully with my prescriber about the character and intensity of my pain, the effect of my pain on my daily life, and how well the medication is helping relieve my pain.

☐ I will take my medication, _____ , as instructed and not change the way I take it without first talking to my prescriber or other members of the treatment team. I understand that my prescriber may change this medication during my course of treatment.

☐ I will not attempt to obtain pain medications from any other prescribers and understand that my prescriptions will only be issued ONLY during scheduled office visits with the treatment team. If I require surgery or emergency treatment, and I am able to communicate, I will tell the health care professional taking care of me about the medications I am taking and, at or before my next refill, I will tell my prescriber about my use of medications in these circumstances.

☐ I agree not to use illegal drugs or alcohol while on these medications.

☐ I understand that I should not drive a motor vehicle or operate machinery if the medication causes dizziness, drowsiness, or sedation.

☐ I will only use one pharmacy to get all of my medications: _____
(Pharmacy Name & Phone Number)

☐ I understand that I may be referred to other health care professionals for other modes of treatment, such as physical therapy, exercise, relaxation techniques or psychological counseling, or for certain diagnostic tests and that my prescriber my speak with other health care professionals about my treatment plan.

☐ I will keep the medicine safe, secure, ad out of reach of others, and will dispose of unused medications by bringing them into my providers office to be destroyed.

☐ I will not sell this medicine or share it with others. If my medicine of prescription is lost or stolen, I understand that it may not be replaced.

☐ I understand that I will need to submit to a urine drug screening every visit and random pill counts if requested by my prescriber and that my prescriber will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program website.

☐ I understand that if I do not follow all of the terms of this agreement, omy prescriber may stop prescribing pain medications, and/or that I could be required to find another prescriber or health care professional for my future medical treatment.

_____	_____	_____
(Patient Signature)	(Patient Name Printed)	(Date)
_____	_____	_____
(Prescriber Signature)	(Prescriber Name Printed)	(Date)