MADONNA FABIAN

WELLNESS TOGETHER **ADULT INTERNAL MEDICINE**

Patient Information

Last Name: | First Name: | MI:

Address:

City/State/Zip:

Preferred Contact: ○ Home Phone ○ Mobile Phone ○ Work Phone ○ MAIL ONLY

OK to leave a message regarding your medical care on preferred phone? ○ Yes ○ No

Appointment Reminders: ○ Text ○ Voice

Date of Birth:

Gender assigned at birth: ○ Male ○ Female

Home Phone: | Cell Phone: | Work Phone:

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed

Email Address: | Social Security Number:

Occupation: | Employer:

Employment Address:

City/State/Zip:

Emergency Contact: | Emergency Contact Phone: | Relationship to Patient:

Primary Language: ○ English ○ Spanish ○ Other (Please specify):

Hispanic / Latino: ○ Yes ○ No

Race: ○ American Indian or Alaska Native ○ Asian ○ Black or African American ○ Native Hawaiian or Other Pacific Islander ○ White

Pharmacy Name: | Pharmacy Phone:

Pharmacy Address:

Guarantor Information

The guarantor is the responsible party for the patient. The guarantor is responsible for all charges not covered by insurance.

Check here if the patient is the guarantor.

Last Name: | First Name: | MI:

Address:

City/State/Zip: | Relationship to Patient:

Phone: | Date of Birth: | Social Security Number:

Primary Care Physician and Referring Physician Information

Primary Care Physician: | Phone:

Address:

Referring Physician: | Phone:

Address:

Insurance Information

PATIENT REGISTRATION **WELLNESS TOGETHER** **ADULT INTERNAL MEDICINE**

Is this visit work related? ◯Yes ◯No	If yes, authorization Number:		
Primary Health Insurance		**Secondary Health Insurance**	
Insurance Name:		Insurance Name:	
Policy #	Group #	Policy #	Group #
Policy Holder's Name:		Policy Holder's Name:	
Policy Holder's Date of Birth:	Policy Holder's Social Security #:	Policy Holder's Date of Birth:	Policy Holder's Social Security #:
Policy Holder's Employer:	Relationship to Patient:	Policy Holder's Employer:	Relationship to Patient:

If **Medicare is secondary**, please select appropriate reason code:

◯ 12 Working age beneficiary/spouse with employer group health plan
◯ 13 ESRD beneficiary in the 12 month coordination period with an employer group health plan
◯ 42 Disabled beneficiary under age 64 with Large Group Health Plan
◯ 15 Workers Compensation
◯ 41 Black Lung
◯ 42 VA
◯ 47 Any liability insurance

AUTHORIZATION and RELEASE OF INFORMATION

I give Madonna Fabian MD PC permission to ask for third party payor/Medicare payments for my medical care. I understand that third party payor/Medicare needs information about me and my medical condition to decide about these payments. I give permission for that information to go to third party payor/Medicare and the companies that handle third party/payor/Medicare payment requests. I understand that the CENTERS FOR MEDICARE/MEDICAID SERVICES (CMS) is the government Medicare agency. I request that payment of authorized third-party payor/Medicare benefit be made either to me or on my behalf for any services furnished me by Madonna Fabian MD PC, for physician's services. I authorize any holder of medical or other information about me to release to the CMS and its agents any information needed to determine these benefits or benefits for related services.

I understand that Madonna Fabian MD PC and Associates may obtain my prescription history from my pharmacy, other healthcare exchanges as well as querying the state prescription drug monitoring program.

Madonna Fabian MD PC and Associates patient portal is a secure, confidential, HIPPPA compliant communication tool. It is an optional service, and you may enroll at any time. The portal is designed to enhance patient physician communication. Access to this secure patient portal is an optional service which I may suspend or terminate at any time for any reason. I acknowledge and fully understand the risks associated with online communication. I acknowledge that using the portal is voluntary and will not impact the quality of care I receive. I agree to adhere to the policies set forth in this agreement. I understand this consent will expire in 12 months and I will be required to sign and update my form. I will notify the office if there is any change in my email address or if I feel my password has been breached. I agree not to hold Madonna Fabian MD PC liable for infractions beyond its control. By signing below, I give permission to Madonna Fabian MD PC to enroll me in the patient portal.

I have received Madonna Fabian's Notice of Privacy Practices.

PATIENT SGNATURE:	DATE:

Permission to Disclose Medical Information	
I hereby authorize Madonna Fabian MD PC and Associates office to speak to the following people regarding my medical condition:	
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
I understand I may revoke this permission at any time by informing the physician's office in writing.	
Patient Signature (or guarantor if under 18):	**Date:**

FULL NAME: _____ DATE OF BIRTH: _____

REASON FOR YOUR VISIT: _____

_____

LIST ANY CURRENT MEDICAL PROBLEMS OR CHRONIC ILLNESSES

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

LIST ANY PHYSICIANS AND/OR PRACTIONERS YOU CURRENTLY SEE

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER

NAME	STRENGTH	DIRECTION	PRESCRIBED BY

LIST ANY ALLERGIES TO MEDICATION, X-RAY DYES OR FOOD

1. _____ 3. _____

2. _____ 4. _____

LIST ANY PAST SURGERIES OR HOSPITALIZATIONS

1. _____ YEAR: _____
2. _____ YEAR: _____
3. _____ YEAR: _____
4. _____ YEAR: _____
5. _____ YEAR: _____
6. _____ YEAR: _____

LIST ANY CHILDHOOD ILLNESSES

1. _____
2. _____
3. _____
4. _____

LIST HEALTH PROBLEMS AND CAUSES OF DEATH IF APPLICABLE

	LIVING/DECEASED	AGE	MEDICAL PROBLEMS
FATHER:			
MOTHER:			
BROTHER(S):			
SISTER(S):			
MOTHER'S FATHER:			
MOTHER'S MOTHER:			
FATHER'S FATHER:			
FATHER'S MOTHER:			

RECORD THE LAST YEAR YOU HAD THE FOLLOWING. IF YOU DO NOT KNOW, LEAVE BLANK

GLAUCOMA/EYE EXAM: _____
HEPATITIS B SHOT: _____
FLU VACCINE: _____
PNEUMONIA VACCINE: _____
ZOSTAVAX SHOT: _____
BONE DENSITY SCAN: _____
COLONOSCOPY: _____
GLUCOSE: _____
ECHOCARDIOGRAM: _____
HEARING EXAM: _____
HEMOCULT: _____
LIPID PANEL: _____
MAMMOGRAM: _____
PAP SMEAR: _____
PELVIC EXAM: _____
PROSTATE EXAM: _____
PSA TEST: _____
RECTAL EXAM: _____
ABDOMINAL AORTIC ANEURYSM SCREENING: _____
TETANUS DIPHTHERIA VACCINE: _____
DIABETES SELF MANAGEMENT TRAINING: _____
NUTRITIONAL THERAPY: _____
SMOKING CESSATION: _____

SOCIAL HISTORY

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH? _____

ARE OTHERS CONCERNED ABOUT YOUR DRINKING? ☐ YES ☐ NO

DIET: ☐ BALANCED ☐ VEGETARIAN ☐ DIABETIC ☐ LOW SALT ☐ LOW FAT ☐ LOW CARB ☐ OTHER:_____

EDUCATION: ☐ HIGH SCHOOL ☐ COLLEGE ☐ SOME COLLEGE ☐ TRADE SCHOOL ☐ OTHER: _____

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? ☐ YES ☐ NO IF YES, HOW MUCH? _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER: _____

OCCUPATION: _____HOW LONG AT CURRENT EMPLOYER: _____

LIST EVERYONE IN YOUR HOUSEHOLD (INCLUDING PETS):

_____ _____ _____

_____ _____ _____

_____ _____ _____

DO YOU WEAR SEATBELTS? ☐ YES ☐ NO

HAVE YOU EVER SMOKED OR CHEWED TOBACCO? ☐ YES ☐ NO IF YES, HOW MUCH? _____

AUTHORIZED SIGNATURE:_____DATE:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.		Not at all	Several Days	More than half the days	Nearly Everyday
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 or 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 are 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
	(Healthcare professional: For interpretation of TOTAL, please refer to instructions on tear-off pad cover		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 _____

_____ _____

Provider Signature Date

MADONNA FABIAN MD PC

NO-SHOW, LATE, & CANCELLATION POLICY

DESCRIPTION

"**NO SHOW**" shall mean any patient who fails to arrive for a scheduled appointment. "**Same Day Cancellation**" shall mean any patient who cancels an appointment **less than 24 hours** before their scheduled appointment. "**Late Arrival**" shall mean any patient who arrives at the clinic **15 minutes after** the scheduled arrival time for the appointment.

POLICY

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. The clinic's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message **at least 24 hours** before their appointment or a cancellation fee of $55.00 will be charge to you

In the event a patient arrives late as defined by "late arrival" to their appointment, they will have to wait until the Doctor is available to see them or they will be rescheduled for a future appointment.

If a patient has incurred three (3) documented "no-shows" and/or same-day cancellations," the patient may be subject to dismissal from the Practice. The patient's chart is reviewed, and dismissals are determined by the Physician, or Clinical Director after review with the Clinics Physician.

PATIENTS WILL BE NOTIFIED OF THE "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

PATIENT NON-COMPLIANCE POLICY

If a patient does not comply with the prescribed orders from his/her physician, and or keep the appointments required due to their medical conditions and needs on a repetitive basis, they may also be subject to dismissal from the practice. Repetitive meaning, "changing confirmed appointments" more than 6 times in a 12-month period, or not taking medications as directed by the Clinical Physician.

REFILL POLICY

Patients can call and leave messages on our answering machine; we will respond to the messages the next business day. Patients may also call during clinic hours, and we will take your re-fill requests. There will be a two (2) day turnaround for re-fills to be processed.
If you are seeking a new medication, you must be seen in the clinic before one is written for you.
If you have regularly scheduled appointments due to your medical issues, you must also be seen prior to getting your medications refilled.

I have read and understand the Policies presented in this document and understand that I can be dismissed from the practice if I do not adhere to these policies.

SIGNATURE _____ DATE _____

RELEASE OF MEDICAL RECORDS AUTHORIZATION FORM

Your full name _____

Your previous physicians name _____has my permission to release my medical records to:

Madonna Fabian MD PC, 3078 Niles Rd, St Joseph, MI 49085

Phone: (269) 287-3949 – Fax: (269) 408-8631

Medical records will be as follows:

Most recent H&P

Most recent Medications

Most recent Labs

1) I understand that I may inspect or copy the protected health information described in this authorization.
2) I understand that at any time, with written notice this authorization may be revoked and that the revocation would not apply to records already released.
3) I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subjected to Federal or State law protecting its confidentiality.

Signature of Patient or Representative _____

Relationship to Patient if Representative _____

Date_____

MADONNA FABIAN MD PC

Wellness Together

Notice of Privacy Practices
PATIENT ACKNOWLEDGEMENT

Patient Name: _____Date of Birth_____

I have received this practice's Notice of Privacy Practices written in plain language, The Notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of use and disclosures that this practice is permitted to make for each of the following purposes:
- Treatment, payment, and health care operations.
- A description of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual right with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  -The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  -The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction
  -The right to receive confidential communications of protected health information.
  -The right to inspect and copy protected health information
  -The right to receive an accounting of disclosures or protected health information.
  -The right to obtain a copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's Notice of privacy Practices upon request.

Signature_____Date_____

Relationship to patient (if signed by a personal representative of patient) _____

MADONNA MD PC FABIAN

Wellness Together