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TROY INTERNAL MEDICINE
A Division of Arcturus Healthcare, PLC

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Dear _____

We are writing to remind you that your annual complete physical exam is scheduled for _____ at _____. Please bring all your medications with you for this visit. **Please do not eat the morning of your appointment unless there is a medical reason that prevents you from fasting.** (You may have water, black coffee and/or tea the morning of your appointment).

You are responsible for knowing whether or not your insurance provides coverage for preventative or diagnostic physicals and you must notify your physician at the start of your physical.

Medicare patients: The Annual Medicare Wellness Visit is not the same as what many people often refer to as their yearly physical exam. The Wellness Visit does not include a hands-on exam or any testing that your Doctor may recommend, or medication. At your yearly physical exam, you can discuss with your Doctor when to schedule your Annual Wellness visit.

We are including a registration form we would like you to fill out and bring with you.

Thank you for your participation and we look forward to addressing your health care needs in the future.

Sincerely,

Troy Internal Medicine

We kindly ask that you arrive fifteen minutes prior to your appointment. Please bring your identification and insurance card(s) with you.

If you have NOT YET confirmed your appointment, please call and confirm at (248) 267-5000.

Thank You.

REGISTRATION

TROY INTERNAL MEDICINE, P.C.
4600 Investment Dr., Suite 300
Troy, Michigan 48098

Date _____

Home Phone _____ Cell Phone _____

Patient _____
Last Name First Name Middle Initial

Street Address _____

City _____ State _____ Zip Code _____

Email Address _____

Sex __M __F Age_____ Birth Date _____

Patient Employed By _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Do you have Medical Insurance? __No __Yes

Name of Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber # _____

In case of emergency, who should be notified? _____ Phone # _____

How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance

And assign directly to Troy Internal Medicine, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured /Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Troy Internal Medicine, P.C. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full chare, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Insured /Guardian Date

Arcturus Health Care, PLC

Name_____ **DOB**_____ **Doctor**_____

Drug Allergies

Current Medications **Current Medications**

Please indicate any changes in medical history (i.e. medical problems, surgeries, etc.)

_____
_____
_____
_____
_____
_____

Other Physicians seen (Specialty and Phone Number Please)

_____
_____
_____
_____
_____
_____

Do you smoke? **Yes** **No** **Packs per day**_____ **Years**_____

Do you drink alcohol? **Yes** **No** **Drinks per week** _____

PATIENT CONSENT FOR USE, TREATMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Arcturus Healthcare, PLC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to Arcturus Healthcare PLC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy prior to signing this consent. Arcturus Healthcare, PLC reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by written request.

I request the following person (s) to receive information regarding my protected health information: (Please mark N/A if you choose not to list anyone)

Name: _____ Relation: _____ Date of Birth: _____

Name: _____ Relation: _____ Date of Birth: _____

I request the following person to pick up prescriptions on my behalf:
(Please mark N/A if you choose not to list anyone)

Name: _____ Relation: _____ Date of Birth: _____

Name: _____ Relation: _____ Date of Birth: _____

For lab results, and other issues, I wish to be contacted in the following manner (check all that apply)

Preferred Daytime Phone number: _____

- o OK to leave a message with call-back number only
- o OK to leave message with detailed information
- o OK to leave detailed message with the following person(s):

_____ _____

By signing below I acknowledge that I have access to a copy of this office's Notice of Privacy Practice Form.

Patient Name: _____ **Signature:** _____

Signature of Representative: _____ **Relationship to Patient:** _____

Patient's DOB: _____ **Date:** _____

Office Use Only

I attempted to obtain a written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign
__ Communication barriers prohibited obtaining acknowledgement
__ Emergency situation prevented signature
__ Other: _____

Employee Name: _____ Date: _____

The **Patient-Centered Medical Home (PCMH)** is an approach to providing comprehensive care for our patients, in a health care setting that facilitates partnerships between patients and their primary care physicians. Our goal is to provide quality care that is respectful and responsive to your preferences, values, and needs.

As a part of a PCMH, your doctor will:

- Reserve space in our schedule for you to accommodate a same-day appointment
- Work with you to improve your health
- Review your medications at every visit and discuss with you any interactions or contraindications
- Electronically prescribe your medications to ensure they are accurate and available to you promptly
- Develop a personal action plan with you to address your chronic conditions
- Set goals with you and monitor your progress
- Use computer technology to monitor your progress and determine if your health is improving
- Inform you of all test results
- Help you take control of your health by providing you educational material, hosting group visits, and linking you to other community programs and resources
- Provide you 24 hour access to a clinical decision-maker by phone
- Have arrangements with after-hours care to be informed of your visit or emergent treatment within 24 hours or next business day

By participating in a PCMH, you agree to:

- Make sure your doctor knows your entire medical history
- Tell your doctor all of the medications you are taking
- Actively participate with your doctor in planning your care
- Adhere to the action plan designed by your doctors
- Consult your doctor before making your own appointment with a Specialist
- Request that any other doctor you see send your doctor a report, copies of lab work, test results, and x-rays
- Know your insurance and what it covers
- Provide the office with feedback on how they can improve
- Keep your appointments as scheduled

I acknowledge that I have read and understand PCMH (Patient Centered Medical Home) requirements for Troy Internal Medicine.

_____ _____

PRINT NAME SIGNATURE

DATE: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling 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
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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