

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 charge, 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 _____

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: _____

- OK to leave a message with call-back number only
- OK to leave message with detailed information
- 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: _____

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 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

UHS Rev 4/2020



Hearing Handicap Inventory for the Elderly Screening Version (HHIE-S)

Instructions: Please check "yes," "no," or "sometimes" in response to each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

	Item	Yes (4 pts)	Sometimes (2 pts)	No (0 pts)
E	Does a hearing problem cause you to feel embarrassed when meeting new people?	_____	_____	_____
E	Does a hearing problem cause you to feel frustrated when talking to members of your family?	_____	_____	_____
S	Do you have difficulty hearing when someone speaks in a whisper?	_____	_____	_____
E	Do you feel handicapped by a hearing problem?	_____	_____	_____
S	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	_____	_____	_____
S	Does a hearing problem cause you to attend religious services less often than you would like?	_____	_____	_____
E	Does a hearing problem cause you to have arguments with family members?	_____	_____	_____
S	Does a hearing problem cause you difficulty when listening to TV or radio?	_____	_____	_____
E	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	_____	_____	_____
S	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	_____	_____	_____
TOTAL SCORE = _____ (sum of the points assigned to each of the items)				

E = Emotional; S = Social

Interpretation of score:

0-8 suggest no hearing handicap

10-24 suggest mild-moderate hearing handicap

26-40 suggest significant hearing handicap

0 to 8 = 13% probability of hearing impairment (no handicap/no referral)

10 to 24 = 50% probability of hearing impairment (mild-moderate handicap/refer)

26 to 40 = 84% probability of hearing impairment (severe handicap/refer)

Refer for additional hearing evaluation if score is ≥ 10 points

Reprinted with permission from Ventry, I.M., & Weinstein, B.E. (1983). Identification of elderly people with hearing problems. *ASHA*, 25, 37-42. Copyright 1983 by American Speech-Language-Hearing Association. All rights reserved.

The Hartford Institute for Geriatric Nursing recognizes Kathleen Demers as the original author of this issue.



Journal of Assessment and Evaluation
Best Practices in Nursing
Care to Older Adults

A series provided by The Hartford Institute for Geriatric Nursing,
NYU Rory Meyers College of Nursing

EMAIL: nursing.hign@nyu.edu HARTFORD INSTITUTE WEBSITE: www.hign.org
CLINICAL NURSING WEBSITE: www.ConsultGerl.org

WELLNESS QUESTIONNAIRE**PATIENT NAME** _____*Living Situation***1. What is your living situation today?**

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. Think about the place you live. Do you have problems with any of the following?**CHOOSE ALL THAT APPLY**

- Pests such as bugs, ants, or mice
- Lead Paint or pipes
- Oven or stove not working
- None of the above
- Mold
- Water Leaks
- Smoke detectors missing or not working

Food

Some people have made the following statements about their food situation. Please answer whether the statements were **OFTEN**, **SOMETIMES**, or **NEVER** true for you and your household in the last 12 months.

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- Often true
- Sometimes true
- Never true

*Transportation***5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?**

- Yes
- No

*Utilities***6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off service in your home?**

- Yes
- No
- Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

- 7. How often does anyone, including family and friends, physically hurt you?**
 - Never (1)
 - Rarely (2)
 - Sometimes (3)
 - Fairly often (4)
 - Frequently (5)

- 8. How often does anyone, including family and friends, insult or talk down to you?**
 - Never (1)
 - Rarely (2)
 - Sometimes (3)
 - Fairly often (4)
 - Frequently (5)

- 9. How often does anyone, including family and friends, threaten you harm?**
 - Never (1)
 - Rarely (2)
 - Sometimes (3)
 - Fairly often (4)
 - Frequently (5)

- 10. How often does anyone, including family and friends, scream or curse at you?**
 - Never (1)
 - Rarely (2)
 - Sometimes (3)
 - Fairly often (4)
 - Frequently (5)

Financial Strain

- 11. How hard to pay for the very basics like food, housing, medical care, and heating would you say it is?**
 - Very hard
 - Somewhat hard
 - Not hard at all

Employment

- 12. Do you want help finding or keep work or a job?**
 - Yes, help finding work
 - Yes, help keeping work
 - I do not need or want help

Family and Community Support

13. If for any reason you need help with day-to day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?

- I don't need any help
- I get all the help I need
- I could use a little more help
- I need a lot more help

14. How often do you feel lonely or isolated from those around you?

- Never
- Rarely
- Sometimes
- Often
- Always

Education

15. Do you speak a language other than English at home?

- Yes
- No

16. Do you want help with school or training? For example starting or completing job training or getting a high school diploma, GED, or equivalent.

- Yes
- No

Physical Activity

17. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

- | | |
|----------------------------|----------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 |

Substance Use

The next questions relate to your experience with alcohol, cigarettes, and other drugs. Some of these substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order to identify community services that may be available to help you.

18. How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

19. How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snug, chew, electronic cigarettes)?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

20. How many times in the past year have you used prescription drugs for non-medical reasons?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

21. How many times in the past year have you used illegal drugs?

- Never
- Once or Twice
- Monthly
- Weekly
- Daily or Almost Daily

Mental Health

22. Stress means a situation in which a person feels tense, restless, nervous, anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

Disabilities

23. Because of a physical, mental, or emotional condition, do you have a serious difficulty concentrating, remembering, or making decisions?

- Yes
- No

24. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- Yes
- No

Eating

25. Do you eat a balanced diet daily?

- Yes
- No
- Don't know

26. In the last 7 days, how often did you eat 3 or more servings of fruits and vegetables?

0 1 2 3 4 5 6 7

Sleep

27. Each night how many hours of sleep do you usually get?

1 2 3 4 5 6 7 8 9+

28. Do you snore, or has anyone told you that you snore?

- Yes
- No
- Don't know

29. In the past 7 days have you felt sleep during the daytime?

- Never
- Occasionally
- Often
- Nearly everyday

30. During the past year have you experienced changes in thinking, remembering, or decision making? For example, have you had more difficulty remembering people, places, or things? Have you had more difficulty making decisions?

- Yes
- No

31. Do you, or any of your friends or family members, have any concerns about your memory?

- Yes
- No

Dentist

32. Do you see a dentist every year?

- Yes
- No

Advance Directives

33. Do you have a living will or advance directive? (If you have one, please bring a copy of it with you to your visit.)

Name

For Office Use Only

CLOCK DRAW

1:55

THREE WORD RECALL

Performed

Name _____

For the following questions please circle the correct answer(s).

- Any fall in the last year? YES NO
- Any fall within the last 3 months? YES NO
- Are you afraid of falling? YES NO
- Any dizziness/vertigo? YES NO
- Any history of frequent falls while walking? YES NO
- Any use of: cane/walker/wheelchair/crutches? Please circle device(s).