Scott D Beede, MD

Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment or Healthcare Operations

I, _____, understand that as part of my healthcare, this facility originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that such services were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations

I understand that this facility is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that this facility reserves the right to change their notice and practices and prior to implementation, in accordance with Section164.520 of the Code of Federal Regulations. Should this facility change their notice, they will send a copy of any revised notice to the address I've provided.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I authorize this facility to discuss my treatment, payment and healthcare operations with:

_____

_____

_____

I fully understand and **accept / decline** (circle choice) the terms of this consent.

_____

Patient's signature date

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

Scott D Beede MD PA

Lifetime Authorization	Chart Number:

Indicate plan *(circle all that apply)*: Medicare Cigna United Other *(specify)*:

Patient name *(last, first MI)*:

Home address:	*street*	*apartment*
	city	*state*	*zip*

Social Security Number: - - Sex (circle): M F Date of Birth: / /

Medicare: "I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance."

Signature:	Date: / /
Printed name:	HIC (Medicare) Number: - - -

If signed by anyone other than the patient, indicate relation to patient:

If signed by anyone other than the patient, indicate reason:

Medigap: "I request that payment of authorized Medigap benefits be made on my behalf to Scott D Beede MD PA for services furnished me by Scott D Beede MD PA. I authorize any holder of medical information about me to release to _____ *(insurance company)* any information needed to determine these benefits or the benefits payable for related services."

Signature of Beneficiary:	Date: / /

Beneficiary's printed name:

HIC (Medicare) Number: - - -	Medigap Number:

If signed by anyone other than the patient, indicate relation to patient:

If signed by anyone other than the patient, indicate reason:

Insurance: "I certify that the information given by me for payment by my insurance plan(s) is correct. I authorize any holder of medical or other information about me to release to the above plan or its intermediaries or carriers any information needed for this or any related insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the services or authorize such physician to submit a claim to the above insurance company for payment to me."

All: "I understand that if any unpaid obligation is forwarded to a collection agency or attorney for collection, I will be responsible for all collection costs and/or attorney fees incurred."

Signature:	Date: / /
Printed name:	Contract/Policy/ID number:

If signed by anyone other than the patient, indicate relation to patient:

If signed by anyone other than the patient, indicate reason:

Scott D Beede MD PA

Patient Information				Chart Number:
Name*(last, first MI)*:				Today's date: / /
Social Security Number: - -		Sex (circle): M F		Date of Birth: / /
Home address:	*street*			*apartment*
	city		*state*	*zip*
Work address:	*employer*			
	street			*suite*
	city		*state*	*zip*
Phone:	*home* ( ) -	*work* ( ) -		*cell* ( ) -
	pager or other(specify):			( ) -
Email:	*home* @			
	work @			

Marital status(circle):	Single Married Widowed Divorced Separated

Spouse Parent Guardian (circle)	*(last, first MI)*:		
Phone:	*home* ( ) -	*work* ( ) -	*cell* ( ) -
	pager or other(specify):		( ) -

Emergency contact not living with patient*(last, first MI)*:			
Relation to patient:			
Phone:	*home* ( ) -	*work* ( ) -	*cell* ( ) -
	pager or other(specify):		( ) -

Medicare Number: - - -

First Insurance(circle): Group Private			
Name of carrier:			
Address:	*street*		*suite*
	city	*state*	*zip*
Contact phone number: ( ) -		Contract/Policy/ID number:	
Name of covered individual*(last, first MI)*:			
Relation to patient:			

Second Insurance(circle): Group Private			
Name of carrier:			
Address:	*street*		*suite*
	city	*state*	*zip*
Contact phone number: ( ) -		Contract/Policy/ID number:	
Name of covered individual*(last, first MI)*:			
Relation to patient:			

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Medical History

*** * * Instructions: It is very important that ALL questions be fully answered. * * ***

Patient name *(last, first MI)*:	Today's date: / /
Social Security Number: - -	Date of birth: / /

Gender (circle): Male Female **Ethnicity (circle):** Hispanic Non-Hispanic

Race (circle all that apply): Caucasian African American Asian or Pacific Islander American Indian or Alaskan Native Multicultural

Current medication. Please include all prescription and over the counter medications, vitamins, supplements and herbs including regular and as needed medications, oral medications, inhalers and topical medications prescribed by all physicians you are seeing *** * * Please fill out all columns completely* * *.**

Name	Dose or strength	Frequency taken, indicate if only taken as needed	If taken as needed, how often do you take it?
Check if continued on back ☐			

Medication allergies (indicated type of reaction in parenthesis, i.e. rash, shortness of breath, stomach upset)

	Check if continued on back ☐

Current medical problems and conditions

	Check if continued on back ☐

Surgical history (include ALL surgeries in lifetime)

Surgery	Date	Surgery	Date
		Check if continued on back □	

Non-surgical hospitalizations and serious past medical illnesses and trauma

Diagnosis	Date	Diagnosis	Date
		Check if continued on back □	

Family medical history. For deceased family indicate age at death, check appropriate boxes

Family member	**Living?**	**Age**	**Diabetes**	**Heart disease**	**Cancer (type)**	**Other**
Father	Y N		□	□	□ ( )	
Mother	Y N		□	□	□ ( )	
Brother Sister *(circle)*	Y N		□	□	□ ( )	
Brother Sister *(circle)*	Y N		□	□	□ ( )	
Brother Sister *(circle)*	Y N		□	□	□ ( )	
Son Daughter *(circle)*	Y N		□	□	□ ( )	
Son Daughter *(circle)*	Y N		□	□	□ ( )	
Son Daughter *(circle)*	Y N		□	□	□ ( )	
Other *(indicate)*:	Y N		□	□	□ ( )	
Other *(indicate)*:	Y N		□	□	□ ( )	
Other *(indicate)*:	Y N		□	□	□ ( )	
Other *(indicate)*:	Y N		□	□	□ ( )	

Check if continued on back □

Social History:

Marital status*(circle)*: Single Significant other Married Widowed Separated Divorced
Other *(specify)*:

Occupation (former occupation if retired): Retired: Yes No

Highest education level obtained:

Living conditions *(circle)*: Independent In-home assistance Assisted living Skilled nursing facility

Have you ever used tobacco *(circle)*: Yes No (if no go to next section)
Have you used tobacco in the last year *(circle)*: Yes No (if no, quit date _____)
Type of tobacco *(circle)*: Cigarettes Cigars Chewing-tobacco Other: _____
Average daily amount:
Health problems related to tobacco use*(circle)*: No Yes *(indicate type of problem)*:

Have you ever used caffeine *(circle)*: Yes No (if no go to next section)
Have you used caffeine in the last year *(circle)*: Yes No (if no, quit date _____)
Type of caffeine *(circle)*: Coffee, tea, soda, energy drinks Other: _____
Average daily amount:
Health problems related to caffeine use*(circle)*: No Yes *(indicate type of problem)*:

Have you ever used recreational drugs *(circle)*: Yes No (if no go to next section)
Have you used recreational drugs in the last year *(circle)*: Yes No (if no, quit date _____)
Type of recreational drug(s): _____
Health problems related to recreational drug use*(circle)*: No Yes *(indicate type of problem)*:

Do you exercise regularly? yes no Type: Frequency:

Assistive devices and services *(hearing aids, dentures, canes, walkers, wheel chairs, home oxygen, home nursing, health aide etc.)*:

Local support network *(family and friends in the area that you can call on for assistance when needed):*

What is your primary spoken language?

Other physicians involved in your care:

Name	Specialty	Last seen

Check if continued on back ☐

Advanced directives:

Do you have a living will? Yes No
Do you have a durable power of attorney for healthcare (healthcare surrogate)? Yes No
Have you previously established a "Do Not Resuscitate" order? Yes No

Activities of daily living:

I am fully independent: Yes No (if yes skip to next section)

I need full help with all daily activities: Yes No (if no, indicate activities below)

I need help with (circle all that apply):

Dressing Grooming Shopping Bathing

Housework Feeding Toilet use Preparing meals

Fall risk:

I have had 2 or more falls in the last year. Yes No

I have had any fall with injury in the last year. Yes No

Preventive health measures. Write "never" if have not had. If unsure of date, please approximate.

Vaccinations	Date	**Screenings**	Date
Tetanus		Colonoscopy (age 50+)	
Pneumovax (age 65+ or high risk)		Bone density (women age 60+)	
Prevnar (age 65+ or high risk)		Pap smear (women up to age 65)	
Flu shot		Mammogram (women)	
Hepatitis A		PSA (men age 50 to 70)	
Hepatitis B		Prostate exam (men age 50 to 70)	
Others:		Others:	

Other concerns and medical history not noted above that you feel is important:

Scott D Beede MD PA

Review of Systems	Today's date:
Patient name *(last, first MI)*:	Date of birth:

Do you now or have you recently experienced any of the following problems *(circle yes or no)*:

Constitutional symptoms

Unexplained weight change	Y	N
Difficulty sleeping	Y	N
Loss of appetite	Y	N
Fatigue	Y	N
Fever or chills	Y	N
Drenching night sweats	Y	N

Eyes

Change in vision	Y	N
Sensitivity to light	Y	N
Double vision	Y	N
Eye pain	Y	N
Discharge or drainage	Y	N

Ears/Nose/Throat/Mouth

Change in hearing	Y	N
Ringing in ears	Y	N
Ear pain or drainage	Y	N
Nasal congestion	Y	N
Nose bleeds	Y	N
Snoring	Y	N
Change in voice or hoarseness	Y	N
Dry mouth	Y	N
Mouth sores or ulcers	Y	N
Sore throat	Y	N

Cardiovascular

Exertional chest pain/pressure	Y	N
Calf pain with walking	Y	N
Sudden loss of consciousness	Y	N
Dizziness	Y	N
Rapid or irregular heartbeat	Y	N
Shortness of breath lying down	Y	N
Lower extremity edema	Y	N
Foot wounds or ulcers	Y	N

Respiratory

Shortness of breath	Y	N
Cough	Y	N
Wheezing	Y	N
Coughing up blood	Y	N

Gastrointestinal

Difficulty or pain swallowing	Y	N
Nausea or vomiting	Y	N
Vomiting blood	Y	N
Heart burn or acid reflux	Y	N
Abdominal pain	Y	N
Change in bowel habits	Y	N
Diarrhea	Y	N
Constipation	Y	N
Bloody, black, or tarry stools	Y	N

Genitourinary

Urinary frequency or urgency	Y	N
Burning or painful urination	Y	N
Weak stream or hesitancy	Y	N
Blood in urine	Y	N
Urinating at night	Y	N
Unable to fully empty bladder	Y	N
Urinary incontinence	Y	N
Erectile dysfunction (ED)	Y	N
Painful intercourse	Y	N
Discharge	Y	N
Menstrual irregularities	Y	N

Endocrine

Cold or heat intolerance	Y	N
Change in body hair	Y	N
Excessive thirst	Y	N
Excessive volume of urine	Y	N

Musculoskeletal

Joint pain/swelling/stiffness	Y	N
Loss of range of motion	Y	N
Decreased muscle strength	Y	N
Painful walking	Y	N
Muscle cramps	Y	N

Skin/Breast

Rashes	Y	N
Itching	Y	N
Change in size, shape, or color of a skin lesion	Y	N
Non-healing sore	Y	N
Nail or skin loss or change	Y	N
Breast lump or discharge	Y	N
Pain in breast	Y	N

Neurological

Weakness in an extremity	Y	N
Numbness, burning, or tingling in an extremity	Y	N
Loss of balance	Y	N
Tremor	Y	N
Headache	Y	N
Memory loss	Y	N

Psychiatry

Depression	Y	N
Anxiety	Y	N
Irritability	Y	N
Changes in sex drive	Y	N
Problematic alcohol or drug use	Y	N

Hematology/Lymphatic

Abnormal bleeding or bruising	Y	N
Blood clots	Y	N
New growths, bumps, or masses	Y	N

Allergy/Immune

Environmental allergies	Y	N
Food allergies	Y	N
Recurrent infections	Y	N
Hives	Y	N

Alcohol Use Screening

1. How often do you have a drink containing alcohol?		
Points		Score
0	Never (skip to question 9 and 10)	
1	Monthly or less	
2	2 to 4 times a month	
3	2 to 3 times a week	
4	4 or more times a week	

2. How many drinks (1.5 oz. of liquor, 5 oz. of wine, or 12 oz. of beer) do you have on a typical day when you are drinking?		
Points		Score
0	1 or 2	
1	3 or 4	
2	5 or 6	
3	7, 8, or 9	
4	10 or more	

3. How often do you have five or more drinks on one occasion?		
Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

4. How often during the last year have you found that you were not able to stop drinking once you started?		
Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

5. How often during the last year have you failed to do what was expected of you because of drinking?		
Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

6. How often during the last year have you needed to have a first drink in the morning to get yourself going after a heavy drinking session?		
Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

7. How often during the last year have you had a feeling of guilt or remorse after drinking?		
Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?		
Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

9. Have you or someone else been injured as a result of your drinking		
Points		Score
0	No	
2	Yes, but not in the last year	
4	Yes, during the last year	

10. Has a relative or a friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?		
Points		Score
0	No	
2	Yes, but not in the last year	
4	Yes, during the last year	
	Total Score:	

Patient Health Questionaire – 9

Depression screening tool.

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and indicate your response.

	Not at all	Several days	More than half of days	Nearly every day
Little interest or pleasure in doing things.				
Feeling down, depressed or hopeless.				
Trouble falling asleep, staying asleep, or sleeping too much.				
Feeling tired or having little energy.				
Poor appetite or overeating.				
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down.				
Trouble concentrating on things such as reading the newspaper or watching television.				
Moving or Speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual.				
Thinking that you would be better off dead or that you want to hurt yourself in some way.				