HIPAA – Notice and Acknowledgement

Petoskey Family Medicine

1890 U.S. 131 South, Petoskey, MI 49770

I acknowledge that I have read and understand the following documents. By initialing each and then signing below I agree to:

1. Authorize Petoskey Family Medicine (PFM) to make referrals on my behalf and share relevant clinical and demographic information as outlined in the **HIPAA PATIENT CONSENT FORM AND THE PRACTICE PRIVACY DOCUMENT.** Initial: _____
2. The **RETRIEVAL OF PRESCRIPTION HISTORY** via the Prescription Benefits Manager (RxHub) and to the submission of electronic prescriptions to my preferred pharmacy. Initial: _____
3. Authorize PFM to obtain health information from the CareQuality Network (exchange between health information networks) for continuation of treatment or health care follow up: _____
4. Authorize PFM to record my immunization history with the **MICHIGAN CARE IMPROVEMENT REGISTRY.** Initial: _____
5. Authorize **RELEASE OF INFORMATION** regarding my medical treatment when requested by my insurance carrier and authorize assignment of benefits directly to PFM for the provision of surgical and medical benefits. **I acknowledge that I have read the FINANCIAL POLICY and that I am responsible to pay non-covered services as outlined in the financial policy and I am aware of the no show policy.** Initial: _____
6. I authorize PFM to leave information on my answering machine about my healthcare including appointments, test results, and other messages. Initial: _____
7. **RELEASE OF MEDICAL INFORMATION:** I authorize PFM to speak to the below individuals regarding my medical care.

   A. _____ Phone: _____
   Relationship: _____

   B. _____ Phone: _____
   Relationship: _____

Patient Name (print): _____ D.O.B. _____

Patient Signature: _____ Date: _____

Petoskey Family Medicine Intake for Annual Exam

Welcome! Please indicate if you are having or have had any of the following in the **past 2 weeks**.

General

- Appetite loss
- Chills
- Dietary changes
- Fatigue
- Fever
- Medication changes
- Night sweats
- Tiredness
- Weight gain >10 pounds
- Weight loss >10 pounds
- Unable to sleep lying flat

Skin

- Change in wart/mole
- Clamminess
- Course hair/skin
- Cracked lips
- Dryness
- Hair growth/loss
- Hives
- Itching
- Nail changes
- New lesions
- Rash
- Ulcer
- Cold skin

Neck

- Neck pain
- Neck stiffness
- Neck swelling
- Swollen glands

Respiratory

- Cough
- Decreased exercise tolerance
- Dyspnea/short of breath
- Snoring
- Sputum production
- Wheezing
- Current/former smoker

Head/ears/eyes/nose/throat

- Headache
- Blurred vision
- Decreased night vision
- Double vision
- Excessive tearing
- Eye pain
- Eye redness
- Glaucoma
- Visual disturbance/loss
- Wears glasses/contacts
- Hearing loss
- Decreased hearing
- Ear discharge
- Earache/pain
- Ringing in ears
- Vertigo
- Runny nose/rhinitis
- Nosebleed
- Frequent colds
- Nasal congestion
- Sneezing
- Seasonal allergies
- Sleep apnea
- Sinus pain
- Bleeding gums
- Voice changes/Hoarse
- Dry mucous membranes
- Decreased sense of smell
- Decreased sense of taste
- Difficulty chewing
- Drooling

Breast

- Breast mass
- Breast pain
- Breast swelling
- Nipple discharge

Cardiovascular

- Abnormal blood pressure
- Chest pain
- Difficulty breathing lying down
- Difficulty breathing on exertion
- Edema
- Fainting/blacking out
- Hypertension
- Irregular heartbeat
- Leg pain/swelling
- Night cramps
- Palpitations
- Rapid heart rate
- Slow heart rate
- Swelling of extremities

Gastrointestinal

- Abdominal mass
- Abdominal pain
- Belching
- Bloating
- Bloody stool
- Change in bowel habits
- Constipation
- Diarrhea
- Difficulty swallowing
- Food intolerance
- Gas
- Hemorrhoids
- Heartburn
- Indigestion
- Jaundice
- Laxative use
- Nausea
- Painful swallowing
- Pain with bowel movement
- Rectal bleeding
- Vomiting

Female genitourinary

- Absence of menstruation
- Blood in urine
- Change in bladder habits
- Change in urine stream
- Difficulty emptying bladder
- Vaginal discharge
- Excessive non-menstrual bleeding
- Flank pain
- Urinary frequency
- Urinary hesitancy
- Incontinence
- Menstrual irregularities
- Painful intercourse
- Painful menstruation
- Painful urination
- Pelvic pain
- Urinary urgency
- Vaginal bleeding
- Vaginal discharge
- Vaginal dryness
- Vaginal itching/burning
- Excessive urination at night
- Urine leakage

Male genitourinary

- Blood and urine
- Change in bladder habits
- Change in urinary stream
- Difficulty with erection
- Penile discharge
- Flank pain
- Urinary frequency
- Urinary hesitancy
- Impotence
- Incontinence
- Painful urination
- Penile lesions
- Testicular mass
- Testicular pain
- Urethral discharge
- Urinary urgency
- Urinary retention
- Excessive urination and night
- Urine leakage

Musculoskeletal

- Back pain/back ache
- Calf pain/cramps
- Decreased range of motion
- Joint pain
- Joint redness
- Joint stiffness
- Joint swelling
- Leg cramps
- Muscle cramps
- Muscle pain
- Muscle weakness

Neurological

- Attention deficit/hyperactivity
- Decreased memory
- Difficulty speaking
- Dizziness
- Easily distracted
- Fainting
- Headache/migraine
- Incoordination
- Loss of consciousness
- Numbness
- Seizures
- Syncope
- Stroke
- Tremor
- Trouble walking
- Unusual sensation
- Unsteadiness/falls
- Weakness
- Weakness in extremities
- Muscle twitching
- Tingling
- Slow reflex

Psychiatric

- Anxiety
- Change in sleep pattern
- Depression
- Disorientation
- Early awakening
- Easily irritated
- Fearful
- Frequent crying
- Fussiness/moodiness
- Hallucinations
- Hypersomnia
- Impaired cognitive function
- Inability to concentrate
- Insomnia
- Memory loss
- Mood changes
- Nervousness
- Panic attack
- Suicidal ideation
- Suicidal planning
- Trouble falling asleep
- Withdrawn
- Personality changes

Endocrine

- Appetite changes
- Cold intolerance
- Decreased sweating
- Excessive sweating
- Excessive thirst
- Hair changes
- Heat intolerance
- Libido changes
- Sexual dysfunction
- Thyroid problems

Hematology

- Abnormal bleeding
- Anemia
- Blood clots
- Easy bruising
- Enlarged lymph nodes
- Painful lymph node

DEPRESSION SCREENING PHQ-9

PATIENT NAME:_____ DATE: _____

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?	(0)	(1)	(2)	(3)
(Check the appropriate box to the right)	Not at all	1-3 days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling/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 your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other peoplehave noticed or being the opposite. Being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you'd be better off dead or hurting yourself				

Total from columns

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
	☐	☐	☐	☐