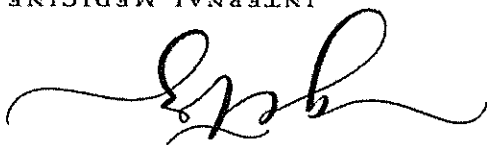


INTERNAL MEDICINE



PATIENT INFORMATION SHEET

Name: _____ DOB: _____ Sex: _____ SSN: _____

Age: _____

Address: _____ City: _____ State: _____

Pharmacy Name and Address: _____ Pharmacy Phone: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Contact Preference: Home / Cell / Work / Email (circle one)

Employer/School: _____

Employer/School Address: _____ Phone: _____

Full time / Part Time / Retired / Disabled / Student (circle one)

Patient Status (circle one): Married / Single / Divorced / Widow / Separated / Partner

How did you hear about us? _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Guarantor/Guardian Last Name: _____ First: _____ Middle Initial + Suffix: _____

DOB: _____ Guarantor Address: _____ Zip: _____ City: _____

State: _____ SSN: _____ Phone: _____ Work: _____

Employer: _____ Employer Address: _____

Primary	Secondary
Insurance Company: _____	Insurance Company: _____
Claims Address: _____	Claims Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____
ID/Policy #: _____	ID/Policy #: _____
Group/Plan #: _____	Group/Plan #: _____
Subscriber's DOB: _____	Subscriber's DOB: _____
M or F _____	M or F _____
Name of Subscriber: _____	Name of Subscriber: _____

REASON FOR VISIT: _____

[Handwritten Signature]
INTERNAL MEDICINE

Where were you born and raised: _____ By whom: _____

Siblings: _____ History of any type of Abuse: _____

Schools attended and highest level of education: _____

Work History: _____

Current Financial Support: _____

Marital History: _____ Number of Children: _____ Legal / Military History: _____

Developmental History: _____

Birth Weight: _____ Special Ed: _____ Failed a Grade: _____ Current Grade and School: _____

MEDICAL HISTORY - HAVE YOU EVER HAD? Please circle YES or NO for all questions.

CHILDHOOD DISEASES	Measles Mumps Chicken Pox Whooping Cough Scarlet Fever Rheumatic Fever	YES NO YES NO YES NO YES NO
METABOLIC DISEASES	Diabetes High Blood Pressure Thyroid Disease Osteoporosis Other	YES NO YES NO YES NO YES NO
PULMONARY DISEASES	Pneumonia Asthma COPD Tuberculosis Other	YES NO YES NO YES NO YES NO
CNS/NEUROLOGICAL DISEASE	Stroke Seizure Other	YES NO YES NO YES NO
GI DISEASES	Heart Attack Angina Heart Murmur Arrhythmia Valve Problems Other	YES NO YES NO YES NO YES NO
CARDIAC DISEASES	After surgery Venereal Disease HIV (AIDS) Osteomyelitis Other	YES NO YES NO YES NO YES NO
INFECTIONS		
BLOOD DISORDERS	Anemia Clotting Problems Hemophilia Other	YES NO YES NO YES NO YES NO
ARTHRITIS	Rheumatoid Osteoarthritis Gout Other	YES NO YES NO YES NO YES NO
MISCELLANEOUS	Blood Clots Thrombophlebitis Sleep Apnea Any other disease List: _____	YES NO YES NO YES NO YES NO
CANCER	UTI Kidney Stone Dialysis Other	YES NO YES NO YES NO YES NO
UROLOGIC DISEASES	Liver Gall Bladder Hidal Hernia GI Bleed Obstruction Other	YES NO YES NO YES NO YES NO
GI DISEASES	If Yes, location Year Diagnosed Reoccurrence Current Treatment	YES NO YES NO YES NO YES NO
MENTAL HEALTH/PSYCHIATRIC	Depression Anxiety Bipolar Disorder Eating Disorder ADD/ADHD Insomnia	YES NO YES NO YES NO YES NO

Have you ever been hospitalized for a mental illness/psychiatric illness? _____ If yes, please explain and provide dates.

Have you ever been diagnosed with a mental health/psychiatric disorder (anxiety, depression, bipolar, insomnia, ADHD, etc)? _____ If yes, please explain and provide dates.

MENTAL HEALTH/PSYCHIATRIC

Any other illnesses not listed above? If yes, please list illness and family member:

Heart problems	YES	NO	Who: _____
Diabetes	YES	NO	Who: _____
High Blood Pressure	YES	NO	Who: _____
High Cholesterol	YES	NO	Who: _____
Obesity	YES	NO	Who: _____
Dementia	YES	NO	Who: _____
Stroke	YES	NO	Who: _____
Epilepsy	YES	NO	Who: _____
Tuberculosis	YES	NO	Who: _____
Cancer	YES	NO	Who: _____
Arthritis	YES	NO	Who: _____
Obesity	YES	NO	Who: _____

FAMILY HISTORY

Age of first period _____ 1st day of last menstrual period _____

Taking estrogen? YES NO Menopause? YES NO If yes, year _____

Any history of abnormal menstrual cycle or PAP smear? YES NO If yes, explain _____

Is there any chance that you could be pregnant (Circle one)? YES NO Not Sure

List Physicians seen in the last 5 years (most recent first)

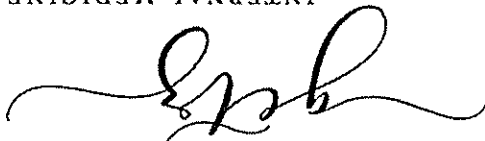
Have you ever been hospitalized for an illness, surgery, or childbirth? If yes, please list reason and provide dates.

HOSPITALIZATIONS

Please list all prior surgeries and year.

SURGICAL HISTORY

INTERNAL MEDICINE

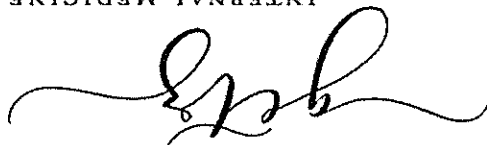


Family Psychiatric History (anxiety, depression, bipolar, ADHD, etc.)

Previous Psychiatric Medications and Dose:

Current Psychiatric Medications and Dose:

INTERNAL MEDICINE




INTERNAL MEDICINE

GIMBS, LLC

We appreciate the opportunity to serve you and desire to provide you with the best service possible. The information below is intended to ensure you are aware of certain treatment, financial, and privacy policies. If you have any questions, please inform a member of our front-desk staff.

Consent for Medical Treatment

I authorize the health care providers of GIMBS, LLC and their health care team to render the evaluation and medical treatment necessary. I further authorize the use of x-rays, injections, or other diagnostic tests and treatment as determined necessary by my health care provider.

Patient/Guardian Initials

Consent for Electronic Prescribing

I authorize the health care providers and other licensed providers of GIMBS and their healthcare team to submit my prescriptions to my pharmacy using secure e-prescribing software. I further authorize access to my medical history, prescription history, and current medications from any and all health care providers.

Patient/Guardian Initials

Consent for Student Participation

I understand that my health care provider and/or other GIMBS personnel may be accompanied and/or assisted by students in various fields of study related to healthcare, such as nursing, interns, and other allied health fields, and at various stages in their education. I consent to the presence and/or participation in my treatment by these persons while under the direction or supervision of my health care provider.

Patient/Guardian Initials

No Show and Cancellation Policy

There is a \$50 No Show fee applied to any visit that is not cancelled at 24 hours prior to appointment. We understand there are emergencies that arise that one is sometimes unable to control. We will take that into consideration when the appointment is cancelled. After 3 no show/cancelled appointments GIMBS reserves the right to no longer see you as patient.

Patient/Guardian Initials

Consent for Financial Responsibility

I acknowledge full financial responsibility for services rendered by GIMBS. I assign and authorize payments of medical insurance benefits to GIMBS directly, and release of any medical information necessary to process insurance claims. Additionally, I understand that I am responsible for expenses that may be incurred in collecting this account to include attorney's fees, court costs, and collection agency costs in the event default of payment or my charges. It is my responsibility to contact my insurance company and/or my employer to verify that GIMBS and its licensed medical providers are participants in my insurance plan prior to treatment at GIMBS. GIMBS does not accept third party liability, such as automobile insurance, pending litigation, and other indirect insurance products, and I am responsible for the full payment of services at the time rendered.

If my insurance plan requires a referral in order to be treated by a GIMBS provider, it is my responsibility to obtain the referral prior to being treated at GIMBS. If a referral is required and I fail to obtain one, I will be financially responsible for any services rendered. GIMBS will submit a claim to my insurance company but will require payment of any unpaid deductible, copayments, and coinsurance for services provided in the office at the time rendered. If I am without verified health insurance or with a plan GIMBS does not participate, I am required to pay in full at the time services are rendered. In the event my insurance company denies my claim or pays my claim as "out-of-network," I am responsible for the balance. Some insurance companies may determine that certain medical supplies and services that healthcare professionals prescribe for the patient's well-being are not covered. I agree to pay for these supplies and services in the event my insurance company denies coverage.

Signature of Patient/Guardian: _____
Date: _____



INTERNAL MEDICINE

Financial Policy

1. As a courtesy to our patients, we file both primary and secondary insurance claims. We are committed to help each patient obtain the maximum allowable benefit from the insurance company
 2. Each patient is financially responsible for any amount not covered by their insurance policy. If applicable, including but not limited to, the amount of any copayment and/or deductible. Patients who are entitled to Medicare benefit are financially responsible for the amount of any applicable copayment/deductible.
 3. Payment in full of each patient's account balance must be made within 60 days of service even if the insurance carrier has not paid the claim by that time.
 4. GIMBS accepts cash, check, bank debit card, MasterCard, Visa, American Express, and Discover. In the instance of a returned check you will be subject to a \$50 processing fee and a check will longer be accepted.
- I have read and understood the financial policy. I further understand that I am financially responsible for payment of services.

Patient/Guardian Signature

Date

Due to the high number of calls our office has received for medications and treatment between appointments and/or after hours, there will be a \$35 fee assessed for all calls needing medical treatment between appointments Monday - Thursday. The fee for Friday-Sunday and holidays is \$50. This is a convenience GIMBS provides to assist your needs when you are out of town or unable to come in for an appointment. We require a valid credit card to remain on file on your account for this service.

Patient Signature

Date

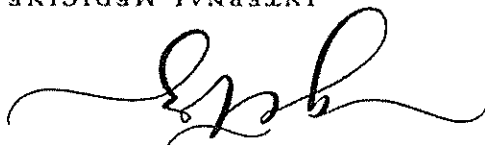
In the event we cannot contact you, please list family members or other persons, if any, whom we may inform about your general medical condition and diagnosis.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

INTERNAL MEDICINE



Controlled Substance Agreement

I understand that this Agreement is essential to trust and confidence necessary in a doctor/patient relationship that my doctor undertakes to treat me based on my compliance with this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these controlled medications.

I understand if I violate this agreement my doctor, depending on the medication and violation, may taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms or may recommend a drug-dependence treatment program. I will communicate fully with my doctor about the character and intensity of my symptoms, the effect of the symptoms on my daily life, and how well the medicine is helping relieve the symptoms.

I will not use any illegal drugs, including marijuana, cocaine, methamphetamine, etc. Testing positive for any of these drugs will be grounds for immediate dismissal.

I will not share, sell, or trade my medication with anyone. I will not take other people's medication.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor, dentist, or hospital. I will immediately notify GIMBS and provide office/hospital notes from any visit to other physicians or hospital along with list of medications prescribed. I will notify any other physician, dentist, or hospital that I am on a "Controlled Substance Agreement" with GIMBS prior to treatment.

I will safeguard my medicines from loss or theft. Lost or stolen medicines will NOT be replaced.

I agree that refills of my prescriptions for controlled substances will be made only at the time of an office visit during regular hours. No refill will be available during evenings or weekends. GIMBS does not call in controlled medicines, so DO NOT ask. I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including state Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my controlled medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy, and if so desired by my physician, obtain a prescription history from my pharmacist which will include all prescriptions filled by any and all physicians seen in the prior 24 months. I authorize any health clinics or doctors offices that I have received treatment in to release any and all of my personal health information including drug test and mental health records to GIMBS as requested by GIMBS. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my medication. These tests will be at my own expense.

I understand that I may be called for a pill count. If you are called for a pill count, you will have 24 hours to bring all of your medications to be counted. If you fail to make this mandatory pill count, you will be discharged from this agreement and will not receive any prescriptions for controlled substances from this office.

I agree that I will use my medicine as a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused controlled substances to every office visit.

I agree that, if directed by my physician, I will undergo medically indicated conservative treatment aimed at reducing my symptoms thus reducing my need for medications. Failure to comply may result in dismissal from the program.

I agree to follow these guidelines that have been fully explained to me

Patient's Name:

Patient's Signature:

Date:

Physician's Signature:

Witnessed by:

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"); the keeping and use of patient records ("privacy rules"); and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care. Providers and health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. Our Patient Notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you now what patient protections HIPAA affords all of us. In primary care and mental health care, confidentiality and privacy are central to the success of a therapeutic relationship; and as such, you will find we will do all we can to protect the privacy of all medical and mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask us for further clarification.

By law, we are required to secure your signature indicating you have received this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

I understand and have been provided a copy of Getz Internal and Behavioral Services LLC's Patient Notification of Privacy Rights document which provides detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

Print Name

Date

Signature of Patient or Guardian

Relationship to Patient of Person Signing Notification

If Legal Charge, describe representative authority

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)

1. Little interest or pleasure in doing things

2. Feeling down, depressed, or hopeless

3. Trouble falling or 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 yourself or your family down

7. Trouble concentrating on things, such as reading the newspaper or watching television

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

9. Thoughts that you would be better off dead or of hurting yourself in some way

FOR OFFICE CODING 0 + + + + = Total Score: _____

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

The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than 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 is 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

Total Score: = **Add Columns** + + +

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 at all Somewhat difficult Very difficult Extremely Difficult

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...
 YES NO

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?

YES NO

...you were so irritable that you shouted at people or started fights or arguments?

YES NO

...you felt much more self-confident than usual?

YES NO

...you got much less sleep than usual and found you didn't really miss it?

YES NO

...you were much more talkative or spoke much faster than usual?

YES NO

...thoughts raced through your head or you couldn't slow your mind down?

YES NO

...you were so easily distracted by things around you that you had trouble concentrating or staying on track?

YES NO

...you had much more energy than usual?

YES NO

...you were much more active or did many more things than usual?

YES NO

...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?

YES NO

...you were much more interested in sex than usual?

YES NO

...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?

YES NO

...spending money got you or your family into trouble?

YES NO

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

YES NO

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

YES NO

ADHD CHECKLIST

Date _____

Client _____

Respondent _____ Relationship _____

Behaviors, Signs, and Symptoms

1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.

2. Often has difficulty sustaining attention in tasks or play activities.

3. Often does not seem to listen when spoken to directly.

4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.

5. Often has difficulty organizing daily activities.

6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental attention (e.g., schoolwork or homework).

7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, tools).

8. Is often easily distracted by extraneous stimuli.

9. Is often forgetful in daily activities.

10. Often fidgets with hands or feet or squirms in seat.

11. Often leaves seat in classroom or in other situations in which remaining seated is expected.

12. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness.)

13. Often has difficulty playing or engaging in leisure activities quietly.

14. Is often "on the go" or often acts as if "driven by a motor."

15. Often talks excessively.

16. Often blurts out answers before questions have been completed.

17. Often has difficulty awaiting turn.

18. Often interrupts or intrudes on other (i.e., butts into conversations or games.)

Number of YES responses to Items 1 - 9:

Number of YES responses to Items 10-18:

Past 6 months (circle)

Before age 12 (circle)

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____
 Date of birth: _____

One drink equals:



12 oz. beer



5 oz. wine



1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No	Yes, but not in the last year	Yes, but not in the last year	Yes, in the last year	Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year	Yes, but not in the last year	Yes, in the last year	Yes, in the last year

Have you ever been in treatment for an alcohol problem? Never Currently In the past

I II III IV
 M: 0-4 5-14 15-19 20+
 W: 0-3 4-12 13-19 20+