Hillside Primary Care
Your partner in a healthier tomorrow

Dear **MEDICARE** Patient,

Please note that your insurance requires us to have you fill out this packet ONCE a year. We apologize if this leads to any inconvenience.

Sincerely,

Dr. Derin Patel and Hillside Staff.

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

FALL RISK ASSESSMENT

Fall Risk Assessment

PATIENT NAME:	DOB:	DATE:

PARAMETER	SCORE		PATIENTSTATUS/CONDITION
Level of Consciousness/Mental Status	☐	0	Alert & Oriented X 3
	☐	5	Intermittent Confusion
	☐	10	Disoriented x 3 at all Times
History of Falls (past 12 months)	☐	0	No Falls
	☐	5	1-2 Falls
	☐	10	3 or More Falls or any falls that result in injury — Type of injury:
Ambulation/Elimination Status	☐	0	Ambulatory and Continent
	☐	5	Chair Bound and Requires Assistance with Toileting
	☐	10	Ambulatory and Incontinent
Vision Status	☐	0	Adequate (with or without glasses)
	☐	5	Poor (with or without glasses)
	☐	10	Legally Blind
Gait and Balance			**Have patient stand on both feet w/o any type of assistance then have the pt. walk: forward, thru a doorway, then make a turn (Mark all that apply)**
	☐	0	Normal/Safe Gate and Balance
	☐	5	Balance Problem While Standing
	☐	5	Balance Problem While Walking
	☐	5	Decrease muscular Coordination
	☐	5	Change in Gait Pattern When Walking Through Doorway
	☐	5	Requires Assistance (person, furniture/walls or device)
Orthostatic Changes	☐	0	No noted drop in blood pressure between lying and standing
	☐	5	Drop <20 mmHg in BP between lying and standing. Increase of cardiac rhythm <20
	☐	10	Drop >20 mmHg in BP between lying and standing. Increase of cardiac rhythm >20.
Medications			**Based upon the following types of medications: anesthetics, antihistamines, cathartics, diuretics, antihypertensives, antiseizure, benzodiazepines, hypoglycemic, psychotropics, sedative/hypnotics**
	☐	0	None of these medications taken currently or within the past 7 days
	☐	5	Takes 1-2 of these medications currently or within the past 7 days
	☐	10	Takes 3-4 of these medications currently or within the past 7 days
	☐	15	Patient has had a change in these medications or doses in past 5 days
Predisposing Diseases			**Based upon the following conditions: hypertension, vertigo, CVA, Parkinson's Disease, loss of limb(s), seizures, arthritis, osteoporosis, fractures**
	☐	0	None Present
	☐	5	1-2 Present
	☐	10	3 or More Present
Equipment Issues	☐	0	No risk factors noted
	☐	5	Oxygen tubing
	☐	5	Use assistive devise (cane/walker)
	☐	5	Bedside commode
	☐	5	Requires hospital bed
Total Score			**☐ Low Fall Risk 0-5 ☐ Moderate Fall Risk 6-14 ☐ High Fall Risk 15+** **Patient has been informed about fall risk assessment results and safety/fall prevention recommendations: ☐ YES ☐ NO**
Comments			

_____ _____

Practitioner Signature MD/DO/NP/PA **Date**

Rev 5/31/2017

ACTIVITIES OF DAILY LIVING (FUNCTIONAL STATUS)

NAME:		DOB:	DATE:
ACTIVITIES	**INDEPENDENCE:** No supervision, direction or personal assistance	**DEPENDENCE**: WITH supervision, direction, personal assistance or total care	**POINTS** (points 1 or 0)
BATHING	**(1 Point)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 Points)** Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.	
DRESSING	**(1 Point)** Gets clothes from closets and drawers and puts clothes on and outer garments complete with fasteners. May have help tying shoes.	**(0 Points)** Needs help with dressing self or needs to be completely dressed.	
TOILETING	**(1 Point)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 Points)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.	
TRANSFERRING	**(1 Point)** Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	**(0 Points)** Needs help in moving from bed to chair or requires a complete transfer.	
EATING	**(1 Point)** Gets food from plate into mouth with help. Preparation of food may be done by another person.	**(0 Points)** Needs partial or total help with feeding or requires parenteral feeding.	
Scores: ☐ **6 = High (patient independent)** ☐ **4 = Moderate (patient dependence)** ☐ **2 or less = Low (very dependent)**		**TOTAL POINTS**	

_____ _____

Practitioner Signature MD/DO/NP/PA **Date**

_____

Practitioner Printed Name and Credentials

Rev 5/31/17

PAIN ASSESSMENT

Name:	**DOB:**	**Date:**
Is the patient currently experiencing pain/discomfort?		☐ YES ☐ NO
If yes, has the pain/discomfort lasted ☐ < 3 months ☐ > 3 months ☐ other		
Current Pain Scale: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐6 ☐7 ☐8 ☐9 ☐10		

Origin/Area/Body Part (s) where pain is located		
☐ Head	☐ Arm (☐ Left ☐ Right ☐ Both)	☐ Leg (☐ Left ☐ Right ☐ Both)
☐ Neck	☐ Hand (☐ Left ☐ Right ☐ Both)	☐ Knee (☐ Left ☐ Right ☐ Both)
☐ Abdomen	☐ Back	☐ Buttocks
☐ Foot (Left Right Both)	☐ Chest	☐ Other

Description / Duration of Pain		
☐ Aching	☐ Intermittent	☐ Burning
☐ Cramping	☐ Stabbing	☐ Constant
☐ Dull	☐ Pressure	☐ Sharp
☐ Throbbing	☐ Other	

Non-Verbal Cues		
☐ Grimacing	☐ Gritting/Clenching Teeth/Jaw	☐ Tenseness
☐ Loss of Appetite	☐ Muscle Rigidity	☐ Crying
☐ Loss of Sleep	☐ Loss of interest in activities	☐ Guarding
☐ Rubbing Area	☐ Recoil Reflex	☐ Other

Exacerbating Factors/ Patterns of pain/discomfort		
☐ Walking	☐ Heat	☐ Medications
☐ Resting	☐ Cold	☐ Food
☐ Noise	☐ Time of Day	☐ Light
☐ Other		

Pain Medication History			
Current Medication	Dose	Frequency	Does it help alleviate pain?
			☐ YES ☐ NO ☐ Sometimes
			☐ YES ☐ NO ☐ Sometimes
			☐ YES ☐ NO ☐ Sometimes
			☐ YES ☐ NO ☐ Sometimes

What alternatives to medication administration have been utilized in the past for pain/discomfort?			
☐ Massage	☐ Heat (☐ Dry ☐ Moist)	☐ TENS	☐ Physical Therapy
☐ Relaxation	☐ Cold (☐ Dry ☐ Moist)	☐ Nerve Block	☐ Other
☐ Positioning	☐ Menthol Application	☐ Distraction	Do these help alleviate pain?
☐ Pain Clinic	☐ Radiation	☐ Imagery	☐ YES ☐ NO ☐ Sometimes

Does the patient have spiritual/Ethnic/Cultural beliefs about pain and pain management?	☐ YES ☐ NO
If yes, describe:	
Does the patient have a history of recreational drug use?	☐ YES ☐ NO
If yes, what type?	

_____ _____

Practitioner Signature MD/DO/NP/PA **Date**

_____

Practitioner Printed Name and Credentials

Bladder Control Assessment and Treatment Form

Member Information

Member ID: _____

Patient Name: (last) _____, (first) _____

Patient DOB (mm/dd/yyyy): ____/____/_____

Assessment Information

Assessment Date: ____/____/_____ Completed By: _____

Physician Name: _____ Physician Role: ◯ PCP ◯ Specialist

Physician Phone #: _____ Physician Fax #: _____

Management of Urinary Incontinence in Older Adults (MUI)

- Percent of people who reported having urinary leakage in the past six months and discussed with their health care provider between January 1st and December 31st of the measurement year..
- ≥ 65 year of age and older as of January 1st of the measurment year.

Note: Gaps for this measure can be closed by using the following CPT codes: 0509F 1090F 1091F
Supplemental data is accepted through SDS or eSDS

Question	Answer		
	Yes	No	Prefer not to discuss
1. In the past six months, have you accidentally leaked urine? If the answer is "Yes," proceed to question 2. If the answer is "No" or "Prefers not to discuss," end discussion and repeat the survey every six months.	◯	◯	◯
2. Have you received any treatments such as bladder training, exercise, medication or surgery for your current urine leakage problem? If the answer is "Yes," proceed to question 3a; if the answer is "No" proceed to 3b; if the answer is "Prefers not to discuss," please print out educational material such as Bladder Matters, hand it to the patient, and verbally emphasize the importance of discussing such matter.	◯	◯	◯
3a. What treatments have you received?	___ Bladder Training ___ Medication ___ Exercise ___ Surgery ___ Other: _____		
3b. Would you like to discuss the available treatment options (intervention algorithm)? If the answer is "Yes", discuss treatment options. If "No", please print out education material such as Bladder Matters, and hand it to the patient and verbally emphasize the importance of discuss such matter.	◯	◯	

Intervention/Comments:

Provider Signature: **Date:**

Mini-Cog©

Instructions for Administration & Scoring

ID: _____ Date: _____

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.[1-3] For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

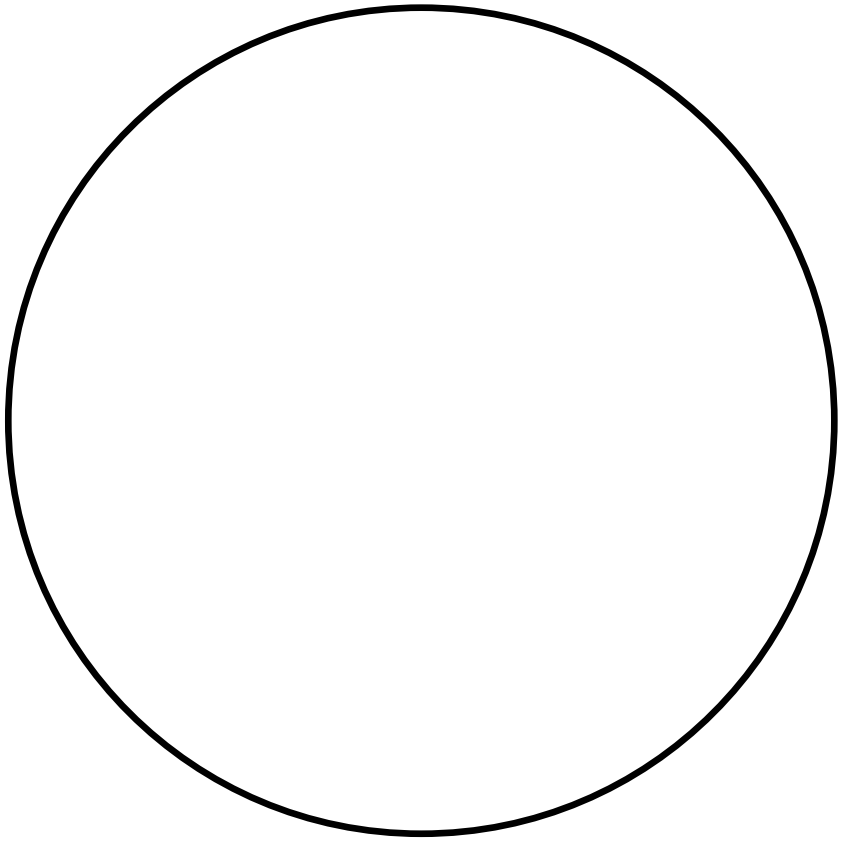
Word List Version: _____ Person's Answers: _____ _____ _____

Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score. A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Clock Drawing

ID:_____ Date:_____



References

1. Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population based sample. J Am Geriatr Soc 2003;51:1451–1454.

2. Borson S, Scanlan JM, Watanabe J et al. Improving identification of cognitive impairment in primary care. Int J Geriatr Psychiatry 2006;21: 349–355.

3. Lessig M, Scanlan J et al. Time that tells: Critical clock-drawing errors for dementia screening. Int Psychogeriatr. 2008 June; 20(3): 459–470.

4. Tsoi K, Chan J et al. Cognitive tests to detect dementia: A systematic review and meta-analysis. JAMA Intern Med. 2015; E1-E9.

5. McCarten J, Anderson P et al. Screening for cognitive impairment in an elderly veteran population: Acceptability and results using different versions of the Mini-Cog. J Am Geriatr Soc 2011; 59: 309-213.

6. McCarten J, Anderson P et al. Finding dementia in primary care: The results of a clinical demonstration project. J Am Geriatr Soc 2012; 60: 210-217.

7. Scanlan J & Borson S. The Mini-Cog: Receiver operating characteristics with the expert and naive raters. Int J Geriatr Psychiatry 2001; 16: 216-222.

Hillside Primary Care
210-742-6555
www.hillsideprimarycare.com

Patient Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of the treatment process. The following is a statement of our "Financial Policy" which we require that you read and sign prior to our rendering any service or treatment is rendered.

Payment in Full is Due At The Time Of Service Unless Prior Arrangements Are Made. We Accept Cash, Visa, Master Card.

Insurance Participation

We may accept assignment of benefits from designated insurance carriers. However, we do require that the estimated co-payments and Deductibles be paid at the time of service. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide current and accurate insurance information. Our office will require copies of the front and back of your insurance Cards. Blood lab fee will be charged to your insurance company but in the event of non coverage test, you will be responsible to pay for tests. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract unless you are insured by a plan with which we participate and have signed an agreement. If your insurance company has not paid your account in full within 60 days, the balance due will be automatically transferred to your account. Please be aware that some, and perhaps all of the services provided to you may be considered non-covered or not reasonable and necessary under the policies of your medical insurance carrier or Medicare. In the event that your insurance coverage changes to a plan with which we do not participate, we will require assignment of benefits to our office or full payment will be due according to the payment arrangements.

Please note again that balance is your responsibility. We will mail 3 statements on a monthly basis. If the balance due is not paid in full after 3 statements, the patient consents to charging their credit card on the file. Patient may clarify any billing questions by calling us or sending us a email at liveoakoffice@hillsideprimarycare.com

Patient consents to Email, text and voice reminders and messaging. Patient gives consent to retrieve prescription history when the request is triggered.

Missed Appointments

Please help us serve you better by keeping scheduled appointments. Unless cancelled, at least 24 hours in advance, our policy is to charge $50.00 fee for appointments not canceled 24 hours in advance. You can Call us/Leave a voicemail or Email us at liveoakoffice@hillsideprimarycare.com to cancel your appointment in advance. NO SHOW FEE is non refundable and will be charged automatically on the day of NO SHOW using the Credit card that is given on file.

Thank you in advance for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

Name: _____ Date: _____

Signature: _____

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CONSENT FOR TREATMENT

General Consent to Treat

I voluntarily consent to treatment and/or related services by Hillside Primary Care which may be advised and recommended by the attending physician. I understand that in the event of a medical or psychiatric emergency which may be life threatening, that it may become necessary for Hillside Primary care to render such emergency treatment and/or transfer myself or my child to a hospital for treatment.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this organization.

I am aware that I may stop my treatment with Hillside Primary care at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court).

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, Hillside Primary care may stop treatment.

I acknowledge that I have received a copy of Hillside Primary care Notice of Privacy Practices which summarizes the ways my health information may be used and disclosed by Hillside Primary care and states my rights with respect to my Protected Health Information (PHI). I understand that Hillside Primary care has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event Hillside Primary care changes this Notice, a revised Notice will be posted in the office waiting area and that I may obtain a current Notice of Privacy Practices at any time from the front desk.

Name: _____ Date: _____

Signature: _____

Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Birthdate _____

Reviewed by _____ Date _____

1. Do you experience any of these symptoms more than twice per year? (Check all that apply)

❑ Cough	❑ Cold	❑ Congestion
❑ Difficulty breathing	❑ Headaches	❑ Wheezing
❑ Runny nose	❑ Sore throat	❑ Itchy/irritated eyes
❑ Sinus pain	❑ Ear pain	❑ Unexplained fatigue
❑ Skin irritation	❑ Snoring	

2. Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No

3. Do you experience symptoms of allergies? ❑ Yes ❑ No

4. Regarding possible food allergies, do you experience any of the following? (Check all that apply)

❑ Bloating after eating	❑ Diarrhea	❑ Cough
❑ Constipation	❑ Upset stomach	❑ Wheezing
❑ Stomach pain	❑ Indigestion	❑ Nausea
❑ Vomiting	❑ Tingling of the mouth or any other unusual sensation	

ABI (93922)

NAME: _____
DOB: _____/_____/_____

AGE > 50 OR WITH HISTORY OF HTN/ HLD/ T2DM, SMOKING PV EVAL DONE.

	ANKLE	BRACHEL
RIGHT		
LEFT		

_____ _____

PROVIDER SIGNATURE ***DATE***

Name: _____

DOB: ____/____/____

Today's Date: ____/____/____

Hillside Primary Care

Health Questionnaire

PATIENTS >50

1. Do you get short of breath at rest or while exerting yourself? ___ YES ___NO
2. Have you experienced chest pain/ tightness/ pressure recently? ___ YES ___NO
3. Have you ever had an abnormal EKG? ___ YES ___NO
4. Do you have high blood pressure? ___ YES ___NO
5. Do you currently smoke or have a history of smoking? ___ YES ___NO
6. Have you had any fainting spells or loss of balance? ___ YES ___NO
7. Do you have high cholesterol? ___ YES ___NO
8. Do you ever have numbness or pain in your legs? ___ YES ___NO
9. Have you been diagnosed with diabetes? ___ YES ___NO

FOR OFFICE USE ONLY

PATIENT MAY QUALIFY FOR FOLLOWING TESTS FOR ANSWERS CIRCLED YES ABOVE

	#1-4	ECHOCARDIOGRAM
	#5 AND IF 65 Y/O MALE	AAA SCREENING
	#6	CAROTID DOPPLER
	#7	LIMITED CAROTID W/ IMT (intima media thickness)

Tests Ordered:

	ECHOCARDIOGRAM
	AAA SCREENING
	CAROTID DOPPLER
	LIMITED CAROTID W/ IMT (intima media thickness)

Scheduled: _____/_____/_____

Time: ____: _____

_____

Provider Signature

IMAGING

Name: _____ **DOB:**_____

Cost for Ultrasound is : _____

Date of your Appointment: _____

Reason for exam: to look for any abnormalities with your heart or blockage in arteries of neck that take blood to the brain.

What to expect on Echo/Carotid Ultrasound:

Please make sure to wear a comfortable t-shirt on the day of your appointment. There is no need to Fast or hold any of your medications for this exam. You will arrive at the main lobby and check in as your routine appointment. Staff will take you to the Ultrasound waiting room for your testing.

Please make sure to cancel your appointment at least 48 hours in advance if you are unable to make it. You can call us or email us at liveoakoffice@hillsideprimarycare.com to cancel your appointment. Availability for Ultrasound tech is extremely limited so we will enforce NO SHOW FEE of $50.00 if you do not cancel your appointment.

Thank you.

Signature:_____