



299 Carew Street, Suite 234
Springfield, MA 01104
Tel. (413) 787-2575
Fax (855) 569-3033

Date _____

Dear _____

Welcome to Personal Primary Care & Weight Management.

Your appointment with _____

is scheduled for _____ at _____ AM/PM

Please arrive 20 minutes prior to your scheduled appointment time.

Please complete the enclosed forms prior to this visit and bring the following information to the appointment.

Completed new patient forms

Insurance card(s)

Co-pay

Photo ID

Previous Medical Records

Immunization records

Medication list

Allergy list

* Please note: Insurance cards, co-pays and picture ID are required at ALL visits, your office visit may be rescheduled if this information is not provided at each visit. *

Be sure you have **notified your Insurance Company** of your new primary care physician name **prior** to this appointment.

If you have any questions, please contact this office at (413) 787-2575. Again, welcome to our practice. We look forward to serving your health care needs and hope to assist you to be proactive in your care!

Very truly yours, The Physicians and Staff

Patient Information Form

Please print clearly and fill in all fields.

Name _____ Date of Birth ____ / ____ / ____

Social Security Number ____ / ____ / ____ Primary Care Physician _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Mailing Address:

Street _____ City _____ State _____ Zip Code _____

Billing Address: (If different from Mailing Address)

Street _____ City _____ State _____ Zip Code _____

E-Mail _____ Home Phone _____ Cell Phone _____

Ethnic Group: ☐ American Indian ☐ Asian or Pacific Islander ☐ Black ☐ Hispanic ☐ White ☐ Unknown

Primary Language(s) spoken at home _____ Do you need an interpreter? ____

Employer _____ Address _____

Work Phone _____ ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student

Emergency Contact Information

Contact Name _____ Relationship _____ Phone _____

Contact Name _____ Relationship _____ Phone _____

Insurance Information

Primary Insurance _____ ID Number _____

Name of Subscriber _____ Relationship _____ Date of Birth _____

Secondary Insurance _____ ID Number _____

Name of Subscriber _____ Relationship _____ Date of Birth _____

Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other insurance Company benefits be made on my behalf for any services furnished to me by its physicians or employees. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me, to release to my insurance company, the Social Security Administration and Health Care Company claim, as applicable. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding information.)

Signature _____ Date _____

New Patient Questionnaire

Name _____ Date of Birth _____ Date _____

Do you have any current concerns you would like addressed?

MEDICATIONS: (Include prescription medications, over the counter medications, vitamins, herbs and supplements)

Drug Name	Dose & Frequency	Drug Name	Dose & Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: (List all allergies to medications, x-ray dye, or other substances)

_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____

MEDICAL HISTORY

Please check next to any problems with or are presently experiencing any of the following:

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Weight gain/loss	<input type="checkbox"/>	Blood Clots
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	Skin Diseases
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Chest pain/angina	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Hearing Problems
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Fractures/broken bones	<input type="checkbox"/>	Vision Problems
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Other
<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	Gout	<input type="checkbox"/>	

Use this space if you wish to explain in detail:

OPERATIONS/HOSPITALIZATIONS: (Females: If you have had a hysterectomy please include information here)

Reason	Date
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH MAINTENANCE

Please check if you have had any of the following tests and write the date it was done:

Pap Smear	Date:	Cholesterol Check	Date:
Mammogram	Date:	Stool Check for Blood (FOBT)	Date:
Breast Exam	Date:	Colonoscopy	Date:
Bone Density	Date:	Prostate Exam	Date:
Diabetic A1C	Date:	Flu Shot	Date:
Diabetic Urine Micro Albumin	Date:	Pneumonia Shot	Date:
Diabetic Eye Exam	Date:	Tdap Vaccine	Date:
Glaucoma Screening	Date:	Shingles Vaccine	Date:

FAMILY HISTORY

Please check if your family (parents, grandparents, siblings, or children) has ever had one of the following:

Cancer	Mental Disease (Depression/Anxiety)
Heart Disease	Memory Problems/Alzheimer's Disease
Hypertension	Osteoporosis/Broken Bones
Diabetes	Other
Stroke	

LIST FAMILY MEMBERS, PARENTS, SIBLINGS, AND CHILDREN

Father:	L or D	Age:	Illness:
Mother:	L or D	Age:	Illness:
Siblings: Male or Female:	L or D	Age:	Illness:
	L or D	Age:	Illness:
	L or D	Age:	Illness:
	L or D	Age:	Illness:
	L or D	Age:	Illness:
	L or D	Age:	Illness:
Number of Children:			

SOCIAL HISTORY

Marital Status Please Check: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Highest Grade Level Completed: _____ Occupation: _____

Do you currently live alone? Y or N Do you have any concerns about your living situation? _____

Do you smoke or have you ever smoked cigarettes or cigars? (including chewing tobacco) Y or N

#packs/day _____ #of years _____ Quit-When? _____

Do you currently or have you ever used Alcohol? Y or N

#per day _____ #per week _____ When did you stop? _____

Do you currently or have you ever used recreational or street drugs? "i.e. marijuana or cocaine" Y or N

When did you stop? _____

Patient Signature _____ Date _____

Physician Signature _____ Date _____

PHQ9-Patient Health Questionnaire

(NPV, CPE an H/O Depression)

Patient Name _____ Date of Birth _____ Date _____

Over the last 2 weeks how often have you been bothered by any of the following problems?

Circle the number to the right for your answer.

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking slowly that other people 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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total each line:	+	+	+	

= Total Score _____

If you have 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 ☐ Very ☐ Extremely

Personal Primary Care & Weight Management

Payment Policy

Thank you for choosing us as your primary care/specialty provider. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is required at each visit. If you are insured by a plan we do business with, but don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles: All co-payments, deductibles and any balance due must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services: Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days the balance will automatically be billed to you.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to provide the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of responsible party _____ Date _____

Personal Primary Care & Weight Management

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

(To be filed in Patient’s Medical Record)

This acknowledges receipt of Personal Primary Care & Weight Management’s Notice of Privacy Practices, including my rights under the privacy regulations, 45C.F.R., Parts 160 and 164, issued pursuant to the Health Insurance Portability and Accountability Act.

Signature

Date

Please Print Name

Internal Use only

If patient/patient’s representative refuses to sign acknowledgement, document date and time notice was presented and sign below.

Presented on

By



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Late, Cancellation and No Show Appointment Patient Letter

Dear Patient:

We sincerely appreciate that you have chosen a provider with Personal Primary Care & Weight Management to participate in providing you with comprehensive and quality healthcare. We ask for your help in accomplishing this goal for all of our patients by following the practice guidelines below:

1. Cancellation for Provider Appointment

Personal Primary Care & Weight Management providers require a minimum of 24 hours in advance to cancel an appointment.

2. Late Arrival for Provider Appointments

We understand that delays can happen, arriving late may prevent you from being seen by the physician, when you arrive it may be determined by the physician if he/she can fit you into the schedule at that time, or you may be requested to reschedule.

3. No Show for Provider Appointments

A "no show" for appointments is when you do not call to cancel or reschedule your appointment a minimum of 24 hours prior to your appointment and/or if you just do not show for the scheduled appointment.

Patients that arrive late and do not call to cancel or do not show up for their appointments cause disruption in patient care and satisfaction for all patients. If you are habitually late to your appointments or "no show" for your appointment 2 times in a 12 month period causing a disruption in all patients care, you may be terminated from this practice. There will be a \$25.00 charge for "no show" to your appointment which has to be paid in full before future appointments.

Sincerely,
Personal Primary Care & Weight Management

By signing this letter I understand and agree to the terms stated herein:

Patient Signature: _____ Date: _____



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Consent Form

I, _____ give permission to Personal Primary Care & Weight Management to allow the undersigned to speak with my Primary Care Provider/Medical Staff in regards to my medical history, care, and treatment. This consent is valid until I request in writing that it be voided. This is in compliance with the HIPAA (Health Insurance Portability and Accountability Act) to protect patient's confidentiality of medical information.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I, _____ give permission to Personal Primary Care & Weight Management to allow the undersigned to pick up prescriptions and other paperwork from the office if the need arises. Photo ID will be required for prescription pick up.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature

Date of Birth

Date

Witness

Date