Genesis Medical Group

RHEUMATOLOGY NEW PATIENT HISTORY FORM

Today's Date: _____/_____/_____

NAME:_____ **Birthdate:** _____/_____/_____
Last First M. I.

Age:_____ **Sex:** ❑ F ❑ M **SS#** _____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Email:_____

MARITAL STATUS: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

EDUCATION *(circle highest level attended):*
Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate_____

Occupation _____

INSURANCE: Who is responsible for this account?_____

Birthdate: _____ SS#:_____

Insurance Co.: _____

Insurance I.D.#: _____ Group #: _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Insurance Co.: _____

Insurance I.D.#: _____ Group#: _____

PHONE NUMBERS

Home: (_____) _____ Cell: (_____) _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship: _____

Home: (_____) _____ Cell: (_____) _____

PHARMACY

_____ (_____) _____
Pharmacy Name Phone number

_____
Address City State Zip Code

Referred here by (check one): ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other Health Profession

Whom do we thank for the referral? _____

Name of your primary care physician: _____

Describe briefly your present symptoms:

_____

_____

_____

_____

_____

_____

Date Symptoms Started: _____

Diagnosis (if any):

_____

_____

_____

Please list the names of other practitioners you have seen for this problem:

_____

_____

_____

_____

Previous treatment for this problem (include physical therapy, surgery, injections; medications to be listed later):

_____

_____

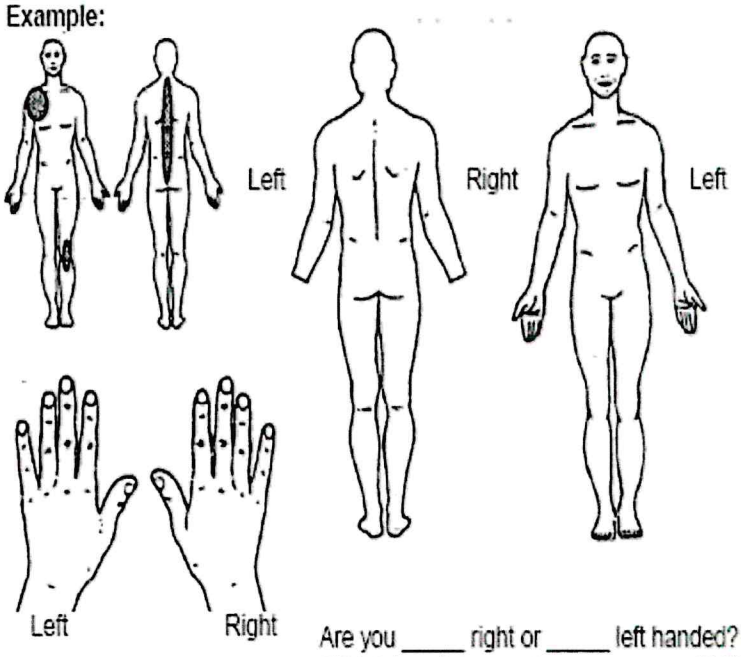
_____

_____

_____

Please shade all the locations of your pain **over the past week** on the **body figures** and **hands**.

Example:



Are you _____ right or _____ left handed?
(Which hand do you sign your name with?)

RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

	Yourself	Relative		Name/relationship
Arthritis (type unknown)	❑	❑	→	_____
Osteoarthritis	❑	❑	→	_____
Rheumatoid arthritis	❑	❑	→	_____
Gout	❑	❑	→	_____
Lupus or "SLE"	❑	❑	→	_____
Ankylosing spondylitis	❑	❑	→	_____
Childhood arthritis	❑	❑	→	_____
Sjogren's syndrome	❑	❑	→	_____
Osteoporosis	❑	❑	→	_____
Psoriasis/psoriatic arthritis	❑	❑	→	_____

Date of last eye exam _____ Date of last chest x-ray _____

Date of last bone density test _____

Result of last TB (PPD) test: ❑ Never done ❑ Negative ❑ Positive Date test performed: _____

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if "yes")

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other significant illnesses (please list): _____

_____

Previous Operations

	Type	*Year*	*Reason*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any previous fractures? ❑ No ❑ Yes Describe _____

Any other serious injuries? ❑ No ❑ Yes Describe _____

Do you smoke? ❑ Yes ❑ No ❑ In the past - How long ago? _____

Do you drink alcohol? ❑ No ❑ Yes : Usual drink: _____ How much: _____

Has anyone ever told you to cut down on your drinking? ❑ Yes ❑ No

Do you use any recreational drugs? ❑ No ❑ Yes If yes, please list: _____

Do you get enough sleep at night? ❑ Yes ❑ No Do you wake up feeling rested? ❑ Yes ❑ No

Do you exercise regularly? ❑ Yes ❑ No Amount per week_____ Type_____

FAMILY HISTORY

	IF LIVING		**IF DECEASED**	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of siblings: _____ Number living _____

Number of children _____ Number living _____ List ages of each _____

Health of children: _____

MEDICATIONS:

Drug allergies: ❑ No ❑ Yes To what?_____

Please list any medications that you are now taking. Include non-prescriptions.

Name of drug **Dose (include strength and number of pills per day)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PAST MEDICATIONS: Please review the list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medications, the results of taking the medications and list any reactions you may have had. *Record your comments in the spaces provided.*

Drug names/Dose	Length of time	Please check: *Helped?* A Lot	Some	Not At All	Reactions
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)		❑	❑	❑	
Circle any you have taken in the past Flurbiprofen Diclofenac + misoprostil Aspirin (including coated aspirin) Celecoxib Sulindac Oxaprozin Salsalate Diflunisal Piroxicam Indomethacin Etodolac Meclofenamate Ibuprofen Fenoprofen Naproxen Ketoprofen Tolmetin Choline magnesium trisalcylate Diclofenac					
Pain Relievers					
Acetaminophen		❑	❑	❑	
Codeine		❑	❑	❑	
Propoxyphene		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMArDS)					
Certolizumab		❑	❑	❑	
Golimumab		❑	❑	❑	
Hydroxychloroquine		❑	❑	❑	
Penicillamine		❑	❑	❑	
Methotrexate		❑	❑	❑	
Azathioprine		❑	❑	❑	
Sulfasalazine		❑	❑	❑	
Quinacrine		❑	❑	❑	
Cyclophosphamide		❑	❑	❑	
Cyclosporine A		❑	❑	❑	
Etanercept		❑	❑	❑	
Infliximab		❑	❑	❑	
Tocilizumab		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	

Drug names/Dose	Length of time	Please check: *Helped?*			Reactions
		A Lot	Some	Not At All	
Osteoporosis Medications					
Estrogen		❑	❑	❑	
Alendronate		❑	❑	❑	
Etidronate		❑	❑	❑	
Raloxifene		❑	❑	❑	
Fluoride		❑	❑	❑	
Calcitonin injection or nasal		❑	❑	❑	
Risedronate		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen		❑	❑	❑	
Tiludronate		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyaluronan		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	

SYSTEMS REVIEW

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Morning stiffness
  Lasting how long ____ Minutes
  ____ Hours
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

List joints affected in the last 6 months

_____
_____
_____
_____

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw while chewing

NECK
- ❑ Swollen glands
- ❑ Tender glands

HEART AND LUNGS
- ❑ Pain in chest
- ❑ Irregular heart beat
- ❑ Sudden changes in heart beat
- ❑ Shortness of breath
- ❑ Difficulty in breathing at night
- ❑ Swollen legs or feet
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain relieved by food
- ❑ Vomiting of blood/"coffee grounds"
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

BLOOD
- ❑ Anemia
- ❑ Bleeding tendency

SKIN
- ❑ Easy bruising
- ❑ Redness
- ❑ Rash
- ❑ Hives
- ❑ Sun sensitive
- ❑ Skin tightness
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold (Raynaud's)

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling in hands/feet
- ❑ Memory loss
- ❑ Muscle weakness

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

MOUTH
- ❑ Sore tongue
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑Loss of taste
- ❑ Dryness
- ❑ Recent increase in tooth cavities

NOSE
- ❑ Nosebleeds
- ❑ Loss of smell

KIDNEY/URINE/BLADDER
- ❑ Difficult urination
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Cloudy, "smoky" urine
- ❑ Pus in urine
- ❑ Discharge from penis/vagina
- ❑ Frequent urination
- ❑ Getting up at night to pass urine
- ❑ Vaginal dryness
- ❑ Rash/ulcers
- ❑ Sexual difficulties
- ❑ Prostate trouble

For women only:

Age when periods began: _____

Number of pregnancies: _____

Number of miscarriages: _____

Have you reached menopause?

❑ No ❑ Yes If yes, at what age: ____

Date of last Pap smear: _____

Date of last mammogram: _____

If you are still having periods:

Are they regular? ❑ Yes ❑ No

How many days apart? _____

HIPAA Notice of Privacy Practices

Genesis Medical Group
2255 East Mossyoaks Rd, Suite 500, Spring, TX 77386
281-975-1000

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be sent to your health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirement, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatments, payments or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for the notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction(s) requested and to whom you want the restrictions(s) to apply.

Your physician is not required to agree to a restriction that you nay request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes, You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Your signature below is acknowledgment that you have received this Notice of our Privacy Practices and been provided the opportunity to review it:

Print Name: _____ Birth Date: _____

Signature: _____ Date:_____

Genesis Medical Group℠

PATIENT AUTHORIZATION
TO COMMUNICATE AND DISCLOSE PROTECTED HEALTH INFORMATION

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

I wish to be contacted in the following manner (Check All That Apply):

☐ **Phone**
- ○ Leave a message with detailed information.
- ○ Only leave a message with callback details.

☐ **Written Correspondence**
- ○ Mail to my home address on file.

PATIENT ONLINE PORTAL

Genesis Medical Group has a convenient, free, easy-to-use Patient Portal you can access online. The Patient Portal is an online tool you can use to easily view and update some of your health/clinical information. The Patient Portal should not be used for emergency questions, concerns, or anything that needs a same day response; for all those inquiries, please contact the office you are seen at. **This portal is separate from the one used by Genesis Medical Group Primary Care Physicians.**

Please check one selection:

☐ **I would like** to be enrolled with Genesis Medical Group's Patient Portal

My email address is _____ (please print)

☐ **I would NOT like** to enroll for the Genesis Medical Group's Patient Portal because…

- ☐ I do not have an email address.
- ☐ I am declining enrollment and do not want to provide my email address.

AUTHORIZED DESIGNEES

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or any information in my medical records. Understand that the identity of designees must be verified before release of PHI. **These designees may include spouse, family, or friends.**

Authorized Designees:

Name: _____ Relationship:_____ Telephone: _____

Name: _____ Relationship:_____ Telephone: _____

Name: _____ Relationship:_____ Telephone: _____

This authorization shall remain in effect from the date signed below until revoked.
You have the right to revoke authorization in writing.

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.

_____ _____ _____

Patient/Responsible Party Name Patient/Responsible Party Signature Date

☐ **REVOKE/CANCEL AUTHORIZATION** _____ _____

Patient/Legal Representative Signature Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Genesis Medical Group to: ____ Release to: ____Receive from:

Person or organization	Address
Phone	Fax

Information / Copies from the medical records on:

Patient	Date of Birth	Social Security Number

Dates(s) of Service

Information to be released:

☐ Emergency Room	☐ Radiology Reports	☐ Lab Work	☐ Radiology Films
☐ History and Physical	☐ Drug/Alcohol Program	☐ Pathology Report	☐ Billing Records
☐ Consultations	☐ Psychiatric Information	☐ HIV test results	☐ Cath Lab Films
☐ Operative Reports	☐ Discharge Summary	☐ AIDS Information	

☐ OTHER: _____

This information is being released for the following purpose:

☐ Continued Care	☐ Attorney / Litigation	☐ Insurance	☐ Disability Services

☐ OTHER: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that the action has been taken in reliance on it and that in any event this authorization shall expire (365) days from the date of my signature, unless specified in writing here:

_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider, the released information may no longer be protected by federal and/ or state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Signature of Patient or Legally authorized Representative	Date
Relationship to Patient	Date
Print Name of Legally Authorized Representative	Date
Witness- Printed Name/Signature	Date

Genesis Medical Group℠

GENERAL CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT

_____**MEDICAL CONSENT**: I consent to all medical care, treatment, laboratory, imagine, and other medical procedures performed or prescribed by a physician of Genesis Medical Group and his/her designees as directed in his/her judgment.

_____ **PHARMACY CONSENT:** We are now providing a low cost drug options for our patients on specific treatments. This program benefits are available at no cost to you or or your insurance and also include access to additional resources. To be eligible for this program, we simply require your permission to enroll you, which you can grant by initialing.

_____**RIGHT TO REFUSE TREATMENT:** I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my health care professional to further clarify or explain anything I do not understand. This right includes the right to refuse any treatments that I do not want.

_____**ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS & NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received both notices, Notice of Patient Rights/Responsibilities and Notice of Privacy Practices.

_____**ADVANCE DIRECTIVES:** I understand that I have an opportunity to make known my wishes, in writing, regarding my health care and/or end of life decisions. This directive is in the form of a living will and/or durable power of attorney for healthcare.

_____**RELEASE OF MEDICAL INFORMATION:** I authorize Genesis Medical Group to release any information necessary to facilitate healthcare processing of claims, and audit of payments relative to my care/treatment with Genesis Medical Group. I also consent to the release of any information as needed for my care to other facilities, agencies, or healthcare providers as I direct or as required by law. This order will remain in effect until revoked by me in writing.

_____**FINANCIAL AGREEMENT**: I certify that the insurance information that I have provided is accurate, complete, and current and that no other coverage or insurance exists. I understand I am financially responsible to Genesis Medical Group for charges not paid under this agreement. I am responsible for all charges for services provided to me which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan. Genesis Medical Group will make every attempt to notify me in advance if a service is not covered. I agree to pay all applicable co-payments, deductibles, and co-insurance. I am responsible to pay all copays, deductibles, and patient responsibility at the time of service unless other arrangements have been made in advance.

_____**ASSIGNMENT OF INSURANCE BENEFITS**: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, private insurance and any other health / medical plan, to issue payment check(s) directly to Genesis medical Group for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

_____**MEDICARE CERTIFICATION**: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorized any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions of this form and that I am authorized as the patient or the Patient's Legal Representative to sign this document. I also acknowledge that Genesis Medical Group reserves the right to dismiss me as a patient from Genesis Medical Group.

_____ _____

Patient/Responsible Party Signature Date

Genesis Medical Group℠

ADVANCE DIRECTIVES CONFIRMATION FORM

Under Texas law, you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas, any person age 18 years or older who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

Advance Healthcare Directives Confirmation:

☐ ***YES,*** *I have Advance Healthcare Directives (select all advance directive(s) that you have)*

- ○ Texas Durable Medical Power of Attorney
- ○ Living Will (officially known as the Directive to Physicians and Family or Surrogates)
- ○ Out of Hospital Do Not Resuscitate (DNR)

☐ ***NO,*** *I do not have Advance Healthcare Directives. I understand that I can request more information about advance directives.*

- ○ I have received the information sheet about advance directives.
- ○ I would like additional information about the three advance directives recognized in Texas.

_____	_____	_____
Patient Signature	Patient's Printed Name	Date

For Genesis Medical Group Use Only
Complete this section, if this form is not signed and dated by the patient.

____ Patient Refused to Sign
____ Patient Unable to Sign

_____	_____
Employee Name	Date

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)*	**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

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**
☐	☐	☐	☐

Genesis
Medical Group

RHEUMATOLOGY NO SHOW AND CANCELLATION POLICY

Genesis Medical group is committed to the delivery of high-value care by producing the best health outcomes and patient experiences. In order for us to be able to do so, we have had to implement a no show/cancellation policy. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation
When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call Dr. Bahr or Dr. Sardinas office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24-hour in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment:
If you need to cancel your appointment, please call us at 346-814-1174 between the hours of 9am-5pm if necessary, you may leave a detailed voicemail message. We will return your call as soon as possible.

LATE POLICY:
If a patient is more than 15 minutes late to their appointment, the appointment may be cancelled and need to be rescheduled. After 2 or more late visits, you are subject to dismissal from the practice.

NO SHOW POLICY:
We request that you please give our office at least 24-hour notice in the event that you need to reschedule your appointment. If you do not provide us with a 24-hour notice, or if you do not show up for a scheduled appointment, you will be charged a $50 fee. After 2 or more no show visits, you are subject to dismissal from the practice.

Patient Signature: _____ **Date:** _____