Meditouch Upload & Update

Entered by: ______________

Date: ____________________

____

YEAR

Patient Information

Patient Name: _________________________________ Date of Birth: ___ / ___ / ____ Gender: M / F

Address: ____ Apt, Suite, Unit # ____________________

City: ____________________________________ State: ______________ Zip: ____________________

Cell #: ___________________ Work #: _______________Email:_________________________________

How did you hear about us? ____ Friend/Family ___ Email ___ Mailer ___ Health Fair ___ Other _________

Name of Friend/Family who referred you: ____

Emergency Contact

Name: _____________________________________ Date of Birth: ___ / ___ / ____

Relationship: ________________________________ Phone #: _______________________________

Are you currently covered by health insurance? Yes / No

Insurance Company: ____

Subscriber/ Policy ID: _________________________________ Group #:_________________________

Are you the primary insured policy holder? Yes / No

(If you answered no, please feel out the policy holder's information)

Policy Holder's Name: _______________________________ Policy Holder's Date of Birth: ___ / ___ / ____

*** **PLEAE ALLOW OUR STAFF TO MAKE A COPY OF YOUR INSURANCE CARD & DRIVERS LICENSE** ***

Release of Medical Information

I, _____________________________, give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below.

Name of Authorized Individuals	Relationship to Patient	Date of Birth
___________________________________	______________________	___ / ___ / ___
___________________________________	______________________	___ / ___ / ___
___________________________________	______________________	___ / ___ / ___

____

____________________________	_________________________________	___ / ___/ ___
Printed Name	**Signature**	**Date**

Men's Vitality Center®
The Nation's Leader in Men's Health

Patient Responsibility & Assignment of Benefits

Our practice is committed to providing you with the best possible health care. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions or concerns about our fees, and any content written in our Financial Policy below.

As a courtesy, we will submit claims for all services rendered to your insurance company. Please note your individual health insurance policy is a contract between you and your insurance policy, we cannot guarantee benefit coverage and or payment. Coverage is based on medical necessity, plan limitations, and guidelines. Please keep in mind that some of our services may not be covered by your insurance policy. By consenting to care, you agree that you are responsible for all services and charges, regardless of your insurance.

While providing care to you for your medical needs, certain tests and or services are necessary for diagnosis, treatment, and maintenance of good health. All lab work performed in our office will be sent to LabCorp, Sonora quest, or a third-party laboratory and billed to your insurance. If these test and/or services are not covered by your health insurance; You may receive a separate bill from LabCorp, Sonora quest, or a third-party laboratory for those services rendered.

It is important that you understand that you are responsible for all charges that may occur during your visit. In addition to paying for any insurance co-payment, co-insurance, or deductible balances at the time of service, you may also be responsible for services not covered by your insurance carrier. Insurance companies may set certain guidelines and/or limitations, therefore, it is your responsibility to abide by the guidelines set by your individual insurance policy. If your insurance carrier denies the medical claim, the patient is responsible for a timely payment of the account.

____ _____ / _____ / ______
Printed Name Date

____
Signature

HIPAA- Notice of Privacy Practices

This notice, effective immediately, describes how medical information about you may be used and required by law to maintain the privacy and confidentiality of your protected health information in addition to providing our patients with notice of our legal duties and privacy practices.

Disclosure of Your Health Care Information

We may disclose your healthcare information to other healthcare professionals within our practice, Vitality Internal Medicine, for your treatment and overall well-being.

We may disclose your health care information to your insurance company provider for payment and healthcare operations. We have your permission to disclose your healthcare information to your insurance company for appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Worker's Compensation Laws, Public Health Authorities, Emergency Situations, Judicial and Administrative proceedings, Law Enforcement and Medical Examiners. Your health care information may also be disclosed for research that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military and national security and government benefit purposes, for company approved marketing purposes, show gratitude and appreciation for referrals, and change of ownership.

We reserve the right to change and amend this notice of privacy practices at any time.

I understand and have been provided with the Notice of Privacy Practices, which offers a description of the information uses and disclosures. I understand and was given the right to review the notice prior to signing the consent, the right to object to the use of my health information for directory purposes and the right to request restrictions as to how my health insurance may be used disclose to carry out treatment, payment, or healthcare operations.

___________________________________ ____ / ____ / ____

Printed Name Date

____

Signature

Men's Vitality Center®
The Nation's Leader in Men's Health

ALERT TO ALL PATIENTS
NO CALL / NO SHOW FOR APPOINTMENTS

Hello All Patients,

Your appointments are very important to the Men's Vitality Center/ Vitality Internal Medicine team and they are reserved especially for you. We do understand that sometimes scheduling adjustments are necessary. Therefore, we respectfully request at least 24 hour notice for cancellation or rescheduling appointments. Please understand that when you cancel or change your appointment without giving enough notice, we miss the opportunity to fill that appointment time. Therefore, we have a strictly enforced 24-hour cancellation and rescheduling policy. If the appointment is not cancelled 24 hours in advance or you no show an appointment, there will be a fee of $50. Also, if you are more than 15 minutes late for your appointment there will be a late fee of $25. It is then up to the provider's discretion if you can still be seen that day or if it will be necessary to reschedule to another day.

Please understand that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointment which results in a cancellation fee. Not receiving an electronic notification of your appointment from us before your appointment is not sufficient reason to miss your appointment. We send reminders as a courtesy, but clients are responsible to keep or cancel their appointment regardless of whether they received a reminder or not.

We appreciate your cooperation.

____________________________	___________________________	___ / ___ / ____
Signature	Print	Date

Employee Initials: ______

Name: ___________________________________

Health History Form

Your answers to this form will help your healthcare providers better understand your medical concerns and conditions.

SOCIAL HISTORY (please check)
Tobacco Use: ___ Never ___ Former ___ Current ___ # packs/day ___ # years Date Stopped Smoking __________
Alcohol Use: ___ None ___ Socially ___ Moderate ___ Heavy Is your alcohol use a concern for others? Yes / No
Illicit Drug Use: ___ Never ___ Former ___ Current: ____________________ Date Stopped: ___________________
Caffeine Use: ___ None ___ Coffee ___ Tea ___ Soda ___ # cups/day
Occupation: _____________________________ Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
Number of Children/Ages: ____
Special Interest/ Hobbies: ____
Do you have Advanced Directives? ___ Yes ___ No Power of Attorney for Medical Care?: _____________________

PAST MEDICAL HISTORY

Medical Problems/Hospitalizations (ex: diabetes, cancer, high blood pressure, high cholesterol, depression, etc.)	Surgical History (ex: tonsillectomy, appendectomy, vasectomy, hernia, etc.) Include month/year

FAMILY HISTORY

	Alive	Deceased	Age of Death	Health Condition(s)
Father				
Mother				
Brothers				
Sisters				

Local Pharmacy
Pharmacy Name:
____
Phone Number: _______________________
Address / Cross Streets:
____
____

Mail Order Pharmacy
Pharmacy Name:
____
Phone Number: _______________________
Address / Cross Streets:
____
____

ALLERGIES (If any, please list name and reaction such as rash/hives, swelling…etc) ___ No Known Drug Allergies
____

CURRENT PRESCRIPTION MEDICATIONS

Name	Dose	Frequency

Name: ______________________________

REVIEW OF SYSTEMS (Please check any recent or recurring problem)

Head
- Dizziness
- Fainting
- Head Injury
- Headaches
- Pain
- Sweats

Eyes
- Blurry Vision
- Double Vision
- Eyeglass Use
- Pain with Light
- Unusual Sensations
- Cataracts
- Excessive Tearing
- Glaucoma
- Recent Injury
- Vision Loss
- Discharge
- Infections
- Redness

ENT
- Nasal Discharge
- Sinus Infections
- Frequent Colds
- Nasal Obstruction
- Hay Fever
- Nosebleeds
- Bleeding Gums
- Postnasal Drips
- Hoarseness
- Voice Change
- Ear Discharge
- Hearing Impairment
- Ringing in Ears
- Ear Infections

Respiratory
- Asthma
- Coughing Blood
- Positive TB Test
- Sputum
- Bronchitis
- Recent Chest Xray
- Tuberculous
- Cough
- Pleurisy
- Shortness of Breath
- Wheezing

Cardiovascular
- Chest Pain
- High Blood Pressure
- Palpitations
- Swelling in Legs
- Varicose Veins
- History of Heart Attack
- Heart Murmur

Gastrointestinal
- Abdominal Pain
- Changes in Stool
- Change in Appetite
- Indigestion
- Heartburn
- Hemorrhoids
- Trouble Swallowing
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Rectal Pain

Musculoskeletal
- Arthritis

Psychiatric

€ Behavior Change
€ Disturbing Thoughts
€ Memory Loss
€ Depression
€ Excessive Stress
€ Mood Changes
€ Disorientation
€ Hallucinations
€ Nervousness

Skin
- Dryness
- Itching
- Bruising
- Lumps
- Eczema
- Hives
- Rashes

Neurological
- Blackouts
- Paralysis
- Tingling
- Burning
- Memory Loss
- Unsteady Gait
- Stroke
- Numbness

Endocrine
- Cold Intolerance
- Heat Intolerance
- Goiter
- Weakness
- Neck Pain
- Weight Gain
- Weight Loss
- Fatigue

Allergic/Immunologic
- Coughing
- Itchy Eyes
- Watery Eyes
- Runny Nose
- Sneezing
- Wheezing

Genitourinary
- Burning with urination
- Urine Odor
- Urine Frequency
- Blood in Urine
- Discharge

Men Only
- Prostate Problems
- Sexual Problems

Women Only
- Bleeding between periods
- Sexual Problems
- Menstrual Pain
- Menopause

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name ______________________________________ Date ______________________________

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

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself				
	Add columns			
	Total			

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 ___________