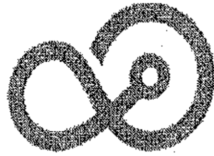


Infinity Family Clinic

ALWAYS BY YOUR SIDE

Patient General Information (please print)

Name:____________________DOB:____________Sex: M / F

SSN:____________Status: single/ married/ divorced/ widowed

Primary address:____________________________________

City:____________________State:________Zip:________

home #:_______________Cell:__________work:____________

E-mail:____

Emergency contact:

Name:____________________Phone #:__________________

Relationship:____

Sharing of Medical Information:

I give the physician and office staff of Infinity Family Clinic permission to discuss my medical condition with the following individuals:

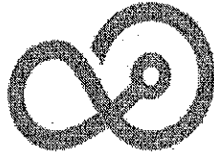
Name:________________________Relationship:__________

Name:________________________Relationship:__________

Pharmacy:

Name:________________________Phone #:_____________

Address:____


Infinity Family Clinic
ALWAYS BY YOUR SIDE

Specialist you see:

Name:______________________________Phone #:__________________

Name:______________________________Phone #:__________________

Name:______________________________Phone #:__________________

Patient Authorization for MEDICARE PATIENTS:

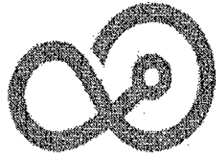
I authorize he physician and/or staff of Infinity Family Clinic to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits wither to myself or to the party who may cause Medicare payment information to cross over automatically to my supplement insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare:

Patient Signature:__________________________Date:________________

Patient Authorization for PPO and HMO patients

I authorize the physician and/or staff of Infinity Family Clinic to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my insurance company to pay directly to Infinity Family Clinic the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient Signature:__________________________Date:________________



Patient Authorization for ALL PATIENTS:

IFC is committed to providing quality care and pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility as our patient. It is your responsibility to notify us of any changes to your information, such as changes in address, phone number and/or insurance.

*Payment is due at time of service unless arrangement has been made with management.

*It is your responsibility to understand your insurance benefits.

*There is a $ 35 fee for any returned checks.

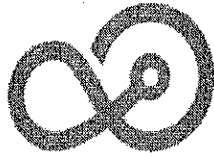
I understand that I am financially responsible for services in the offices non-covered by insurance. I also understand the financial policy of Infinity Family Clinic.

Patient Signature:______________________________Date:___________________

ACKNOWLEGEMENT OF RECEIPT OF PRIVACY PRACTICES:

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign to acknowledge receipt of notice. I acknowledge that I received a copy of the Infinity Family Clinic Notice of Privacy Practices.

Patient Signature:______________________________Date:___________________



Infinity Family Clinic

ALWAYS BY YOUR SIDE

PATIENT CONSENT TO TREAT:

I hereby give my consent to Infinity Family Clinic and authorize provided medical treatment. I understand that Infinity Family Clinic will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment that is thought necessary if, in an emergency, a condition is discovered that was not known previously.

I have carefully read, and I fully understand this Patient Consent to Treat and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient Signature:____________________________Date:__________________

CANCELLATION AND NO SHOW POLICY:

Our policy is as follows: Non-cancellation/ No shows within 24 hours notification: $30.00Patients who do not show up for their appointment without a call to cancel and office appointment will be considered as a NO SHOW. Patients who NO SHOW three (3) or more times in a 12-month period, may be dismissed from the practice thus they will be denied any future appointments. The Cancellation and No SHOW fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived with management approval. Our practice believes that good physician/patient relationship is based upon understanding and good communication.

Patient Signature of NO SHOW acknowledgment:____________________

Infinity Family Clinic
ALWAYS BY YOUR SIDE

PATIENT QUESTIONNAIRE

Fall Risk Screening Questions

1. Have you had two or more falls within the past 12 months with or without injury? ☐ Yes ☐No
2. Do you feel unsteady walking or standing? ☐ Yes ☐No
3. Do you worry about falling? ☐ Yes ☐No
4. Do you use a cane or a walker? ☐ Yes ☐No

Physical Health

1. Does physical health interfere with your daily activities? ☐ Almost Never ☐Occasionally ☐Frequently
2. How many days per week are you physically active? ☐ 0-1 Days ☐ 2-3 Days ☐ 4 or more Days
3. Are you as active as other persons your age? ☐ Yes ☐No
4. Do you choose stairs over escalators / elevators? ☐ Almost Never ☐Occasionally ☐Frequently

Emotional Health

1. How would you describe your emotional health? ☐ Calm ☐ Energetic ☐ Downhearted
2. In the last month, has your emotional health interfered with your daily activities? ☐ Yes ☐No
3. How many hours of sleep do you typically get at night? ☐5 or less ☐6-7 hours ☐8 or more hours
4. In the last month, have you accomplished less than you would like or been more careless at work or while performing daily activities? ☐ Yes ☐No

Bladder Control

1. Is bladder control a problem for you? ☐ Yes ☐No
2. In the past 60 days, has urine leakage changed your daily activities or interfered with sleep? ☐ Yes ☐No
3. If urine leakage is a problem, would you be willing to try:
   - Medication ☐ Yes ☐No
   - Exercise ☐ Yes ☐No
   - Surgery ☐ Yes ☐No

Medications

1. In the last 2 weeks have you forgotten to take your medications? ☐ Yes ☐No
2. Do you have any questions on prescribed medications and how and when to take them? ☐ Yes ☐No
3. Do you have any medications that are unaffordable even with help from copays? ☐ Yes ☐No
4. Do you have any worries or questions related to your medication or side effects? ☐ Yes ☐No

Patient Name____________________ DOB______ Signature____________________ Date______

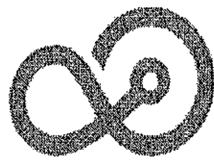
ASSIGNMENT OF BENEFITS

I agree to pay Infinity Family Clinic for all charges and expenses incurred. I understand and agree that I am responsible for the total charges for services rendered. Regardless of any assignment of benefits provided. I further agree that the amounts charges are due upon request and are the usual and customary rates for the geographic area for the services. In consideration of services rendered, I hereby irrevocably assign and transfer to Infinity Family Clinic for myself and my "dependent," if applicable, all rights, title and interest to the benefits payable for services rendered which are provided in any insurance policy (ies) or group health plans under which we insured or provided coverage for health benefits. This irrevocable assignment and transfer shall be for the purpose of my rights granting Infinity Family Clinic an independent right of recovery based upon their pursuit of my rights under such policies or group health plans. I hereby appoint Infinity Family Clinic as my dully authorized representative (s) and attorney-in-fact to act on our behalf, to seek payment of my benefit claims an pursue my rights to medical coverage and the benefits that flow from such coverage, to file appeals related to such claims and to request documents relevant to such claims as permitted under the claim procedure regulations under section 503 of ERISA and in accordance with 29 CFR 2560.503-1 (b) (4) and direct authorize any payor to communicate with such authorized representative (s) with a copy to me regarding all of our benefit claims with respect to Infinity Family Clinic. I specifically direct payment by any such entity or under any such plans, policies, and programs to be made directly to Infinity Family Clinic for services and items provided to me and my dependents. In the event of payment is made to me contrary to this assignment, I will promptly turn over payment in full to Infinity Family Clinic. This assignment and power of attorney includes, but are not limited, claims, or causes of action of action that I ma have relating to any insurance policy or health benefits plan or any other party under ERISA, under state insurance law and under state common law. I further assign to Infinity Family Clinic and it's agents all rights, claims or causes of action I may have to request and obtain documents from my health plan and its affiliated insurers, employees and third party administrators that relate to coverage or non-coverage of benefits or payment of charges for medical rendered, including, without limitation, my certificate of coverage, policy and/or summary plan description; any master policy governing plan document that differs from the certificate of coverage, policy and/or summary plan description; copies of any policies or procedures used to decide my claim; and a complete copy of any other claims adjudication information so that Infinity Family Clinic can determine if a full and fair review of my claim took place. I assign to Infinity Family Clinic and its agents my rights and any claims or causes of action I may have to collect any penalties for my health plan's failure to timely produce this required information.

If my account becomes delinquent and it is referred to an attorney or collection agency, I agree that I will pay all charges, interest from the due date (i.e., thirty (30) days after receipt of the clean claim) at eighteen percent (18%) or the maximum rate allowable by law, reasonable attorney fees, costs, and collection expenses.

Patient Print:____________________ Signature:____________________

Staff Witness Print:____________________ Signature:____________________



Infinity Family Clinic

ALWAYS BY YOUR SIDE

Dear patient,

To meet the increasing demands of insurance companies and keeping in compliance with Medicare, we at Infinity Family Clinic, PLLC are asking that patients follow the protocol necessary to meet their guidelines. We are requesting from all patients:

a) ID and Insurance- Please provide your current ID and if you have insurance, we need your insurance card to ensure efficient billing.
b) Patients with insurance- We draw labs in office as a courtesy to patients and send those labs to Quest(or CPL). Make sure your insurance is always up to date with Infinity Family Clinic, PLLC. The insurance provided is what will be sent to Quest who then will bill the insurance. Should you encounter an issue with billing, please refer to your insurance company for lab coverage. All patients with no insurance will be charged directly from the office.
c) Medications- We need a list of all medications. Please provide a list of all medications you are taking including from any specialists.
d) Refills- We are not able to refill medications prior to you being seen at Infinity Family Clinic, PLLC. Medication refills are based on the NP discretion and varies with everyone.
e) Annual Visit- Our patients are required to have an annual/ physical/ wellness visit every year. This is usually mandated by your insurance company. Any patient that does not comply with this very important visit will be subject to not being seen by our practice or penalties by your insurance company. This is separate and different from a follow up appointment.
f) Specialist- We need to know if you have seen a specialist, if so, we need your records. Please provide us with their names and information.

We hope you understand that these guidelines were set to help our providers and the office to coordinate the best possible healthcare for all patients.

Thank you for choosing Infinity Family Clinic, PLLC.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________ DATE:__________

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 figety 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	0	1	2	3
add columns		____ +	____ +	____
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. 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	______

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A2663B 10-04-2005

Your Logo

Address and Contact Information

Name: ______________________ Date of birth: ______________

MALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Sweating (night sweats or excessive sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Increased need for sleep or falls asleep easily after a meal					
Depressive mood (feeling down, sad, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicked, feeling nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)					
Sexual problems (change in sexual desire or in sexual performance)					
Bladder problems (difficulty in urinating, increased need to urinate)					
Erectile changes (weaker erections, loss of morning erections)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches/migraines					
Rapid hair loss or thinning					
Feel cold all the time or have cold hands or feet					
Weight gain, increased belly fat, or difficulty losing weight despite diet and exercise					
Infrequent or absent ejaculations					
Total score	0				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

Your Logo

Address and Contact Information

Name: ______________________ Date of Birth: ______________

FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Hot flashes					
Sweating (night sweats or increased episodes of sweating)					
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)					
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)					
Irritability (mood swings, feeling aggressive, angers easily)					
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)					
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)					
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)					
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)					
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)					
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)					
Difficulties with memory					
Problems with thinking, concentrating or reasoning					
Difficulty learning new things					
Trouble thinking of the right word to describe persons, places or things when speaking					
Increase in frequency or intensity of headaches or migraines					
Hair loss, thinning or change in texture of hair					
Feel cold all the time or have cold hands or feet					
Weight gain or difficulty losing weight despite diet and exercise					
Dry or wrinkled skin					
Total score	0				

Severity Score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

This document is meant to inform our patients of their rights and responsibilities while they are undergoing medical care. To the extent permitted by law, patient rights may be delineated on behalf of the patient to the patient's guardian, next of kin, or legally authorized responsible person if the patient (a) has been adjudicated incompetent in accordance with the law, (b) is found to be medically incapable of understanding the proposed treatment or procedure, (c) is unable to communicate his, her, or their wishes regarding treatment, or (d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member.

Patient Rights

1. **Access to Care.** You will be provided with impartial access to treatment and services within this practice's capacity and availability and in keeping with applicable laws and regulations. This is true regardless of race, creed, sex, national origin, religion, sexual orientation, gender identity, disability or handicap, or source of payment for care or services.

2. **Respect and Dignity.** You have the right to considerate, respectful care and services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.

3. **Privacy and Confidentiality.** You have the right, within the law, to personal and informational privacy. This includes the right to:

   - Be interviewed and examined in surroundings that ensure reasonable privacy
   - Have a person of your own sex present during a physical examination or treatment
   - Not remain disrobed any longer than is required for accomplishing treatment or services
   - Request transfer to another treatment room if a visitor is unreasonably disturbing
   - Expect that any discussion or consultation regarding care will be conducted discreetly
   - Expect all written communications pertaining to care to be treated as confidential
   - Expect medical records to be read only by individuals directly involved in care, quality-assurance activities, or the processing of insurance claims. No other persons will have access without your written authorization.

4. **Personal Safety.** You have the right to expect reasonable safety regarding the practice's procedures and environment.

5. **Identity.** You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for your care.

6. **Information.** You have the right to obtain complete and current information concerning your diagnosis (to the degree known), your treatment, and any known prognosis. This information should be communicated in terms that you understand.

7. **Communication.** If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.

8. **Consent.** You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.

    - Consent discussions will include an explanation of the condition, the risks and benefits of treatment, and the consequences of no treatment.
    - Except in the case of incapacity or life-threatening emergency, you will not be subjected to any procedure unless you provide voluntary, written consent.
    - You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.

9. **Consultation.** You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice.

10. **Charges.** Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed explanations of any billed services.

11. **Rules and Regulations.** You will be informed of the practice's rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints.

Patient Responsibilities

1. **Keep Us Accurately Informed.** You have the responsibility to provide, to the best of your knowledge, accurate and complete information about your present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health, including unexpected changes in your condition.

2. **Follow Your Treatment Plan.** You are responsible for following the treatment plan recommended by the physician. This may include following the instructions of health care personnel as they carry out the coordinated plan of care, implement the physician's orders, and enforce the applicable practice rules and regulations.

3. **Keep Your Appointments.** You are responsible for keeping appointments and, when unable to do so for any reason, for notifying this practice.

4. **Take Responsibility for Noncompliance.** You are responsible for your actions if you do not follow the physician's instructions. If you cannot follow through with the prescribed treatment plan, you are responsible for informing the physician.

5. **Be Responsible for Your Financial Obligations.** You are responsible for ensuring that the financial obligations of health care services are fulfilled as promptly as possible and for providing up-to-date insurance information.

6. **Be Considerate of Others.** You are responsible for being considerate of the rights of other patients and personnel and for assisting in the control of noise, smoking, and the number of visitors. You also are responsible for being respectful of practice property and property of other persons visiting the practice.

7. **Be Responsible for Lifestyle Choices.** Your health depends not just on the care provided at this facility but on the long-term decisions you make in daily life. You are responsible for recognizing the effects of these decisions on your health.