# Central Family Care & Weight Loss Clinic

## PATIENT REGISTRATION

| | | |
|---|---|---|
| Fist name:<br>*Imie* | Last name:<br>*Nazwisko* | Date of birth:<br>*Data urodzenia* |
| Sex: M☐F ☐<br><br>*Płeć:*<br>*M* ☐*K*☐ | Marital status:<br>*Stan cywilny* | Pharmacy address & phone:<br>*Adres i tel. apteki* |
| Address:<br>*Adres* | Home phone:<br>*Tel. domowy* _____<br><br>Cell phone:<br>*Tel. kom.*_____ | How did you find us?<br>*Jak się Państwo o nas dowiedzieliście?* |
| Insurance:<br>*Ubezpieczenie* | E-mail: | **I agree to receive**<br>☐ e-mail notifications<br>☐ appt. reminders via text message<br><br>***Zgadzam się na otrzymywanie***<br>☐ komunikatów na mój email<br>☐ potwierdzenia wizyt przez SMS |

**Emergency contact *(Osaba do kontaktu w nagłych sytuacjach):***

Name:_____Phone_____Relationship to patient_____
*Nazwisko* *Tel.* *Pokrewieństwo*

**Person authorized to receive my medical information (*Imię i nazwisko osób upoważnionych do otrzymania moich informacji medycznych):***

Name: _____ Phone: _____ Relationship to patient_____
*Nazwisko* *Tel.* *Pokrewieństwo*

The above information is true to the best of my knowledge. I agree to be examined and treated. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Central Family Care & Weight Loss Clinic and my insurance company to release any information required to process claims.

*Oświadczam, że zgodnie z moja wiedza wszystkie powyższe informacje są zgodne z prawda. Zgadzam się na badanie i leczenie lekarskie. Upoważniam Central Family Care & Weight Loss Clinic do pobrania opłaty poprzez moje ubezpieczenie. Rozumiem ze jestem odpowiedzialna/y za kwotę nie zapłaconą przez ubezpieczenie. Upoważniam Central Family Care & Weight Loss Clinic do ujawnienia moich danych niezbędnych do zaaprobowania opłaty ubezpieczeniowej.*

Patient/Guardian signature:_____Date:_____
*Podpis pacjenta lub opiekuna* *Data*

# Health History Questionnaire
# Historia zdrowotna

**Name:**_____ **DOB:** _____**Date:**_____
*Imie, nazwisko* *Data urodzenia* *Data dzisiejsza*

**Allergies:** (*Uczulenia)*_____

**Do you smoke?**_____Ever smoked?_____When quit_____
*Czy Pan/i pali?* *Palił/a w przeszłości* *Kiedy przestał*

D**o you drink alcohol?**_____How many drinks a day_____
*Czy Pan/i pije alkohol* *Ile drinków dziennie*

**Current health problems/ illnesses:**_____
*Proszę wymienić obecne choroby*

_____

_____

**Surgeries, date**s:_____
*Operacje, data*

_____

**Illnesses in your family**: *(Choroby w rodzinie)*

Mother (Matka)_____

Father (Ojciec)_____

Siblings *(Rodzenstwo)*_____

**Current medications** *(Leki obecnie zażywane)* _____

_____

_____

**When was your last:** (*Kiedy mial/a Pan/i ostatnia):*

Menstrual Period *(Miesiączkę)*_____

Colonoscopy *(Kolonoscopie*)_____

Bone density scan *(Badanie gęstości kości)* _____

Mammogram _____

Pap smear *(Wymaz z szyjki macicy)* _____

**Please list other doctors/specialists you currently see** *(Jakich ma Pan/i innych lekarzy specjalistow):*

_____

_____

_____

# Central Family Care & Weight Loss Clinic

## Payment Policy & Notice of Privacy Practices Acknowledgement

1. **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 expected 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.
2. **Co-payments and deductibles**. All co-payments and deductibles 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.
3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
4. **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 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 a claim.
5. **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.
6. **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.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 10 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.
8. **Laboratory charges.** All lab work is sent to an outside laboratory and you may be billed separately by the laboratory.
9. **Missed appointments**. Our policy is to charge $50 for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

**I have read and understand the payment policy and agree to abide by its guidelines.**
**I have received a copy of Central Family Care and Weight Loss Clinic's Notice of Privacy Practices.**

_____

Patient's name (please print)

_____ _____

Signature of patient or responsible party Date

# Depression Screening 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 |
|---|---|---|---|---|
| **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 |
|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ |