

# **INTERNAL MEDICINE CLINIC**

## **New Patient Intake & Compliance Packet**

Please complete all sections. Thank you for choosing our clinic.

## 1. Patient Demographics

Full Legal Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Name & Phone: \_\_\_\_\_

## 2. Insurance Information

Primary Insurance Company: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

I authorize release of medical information to my insurance carrier.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 3. HIPAA Acknowledgment

I acknowledge that I have received the Notice of Privacy Practices.

Authorized persons to receive information: \_\_\_\_\_

Leave detailed voicemail messages? Yes \_\_\_ No \_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 4. Consent to Treat

I voluntarily consent to medical evaluation and treatment.

I understand I may refuse treatment at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 5. Financial Policy Agreement

Copays and deductibles are due at time of service.

I understand I am financially responsible for non-covered services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 6. Controlled Substance Agreement (If Applicable)

I agree to use only one pharmacy and not obtain controlled substances elsewhere.

I agree to urine drug screening if requested.

Violation may result in discontinuation of prescriptions.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 7. Medical History

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Past Medical History: \_\_\_\_\_

Past Surgical History: \_\_\_\_\_

Family History: \_\_\_\_\_

Social History (Tobacco/Alcohol/Drugs): \_\_\_\_\_

## 8. Advance Directives

Do you have an Advance Directive? Yes \_\_\_ No \_\_\_

Code Status: Full Code \_\_\_ DNR \_\_\_ Unsure \_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **9. Telemedicine Consent (If Applicable)**

I consent to receive telemedicine services.

I understand risks including technical failures and privacy risks.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **10. Chronic Care Management (Medicare Patients)**

I consent to Chronic Care Management services.

I understand only one provider may bill CCM monthly.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **11. Remote Patient Monitoring Consent**

I consent to Remote Patient Monitoring services.

I understand insurance copays may apply.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **12. Fall Risk Assessment (65+)**

History of falls in last 12 months? Yes \_\_\_ No \_\_\_

Unsteady when walking? Yes \_\_\_ No \_\_\_

### **13. Vaccination Consent**

I consent to recommended vaccines and received Vaccine Information Statement.

Vaccine(s): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **14. No-Show Policy**

I understand missed appointments may result in a fee.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **15. Acknowledgment of Office Policies**

I acknowledge receipt of all clinic policies and consents.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_