Providers: ☐ Heidi Gallo, APRN ☐ Natoya Stewart APRN ☐ Cyndi Byers, APRN
908 Dupont Road, Ste 100 Louisville, KY 40207
Appointment (502) 883-3147 Office (502) 883-3147 FAX (502) 882-0909

Today's Date:	PCP:

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

SEX: ___ M____ F MARITAL STATUS: ___SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED

STREET ADDRESS: _____

CITY: _____ STATE_____ ZIP_____

SOCIAL SECURITY#: _____

MAILING ADDRESS (IF DIFFERENT FROM STREET) _____

CITY: _____ STATE_____ ZIP_____

EMAIL ADDRESS: _____@ _____.____

PHONE: HOME: _____ CELL: _____

WORK _____

PRIMARY LANGUAGE _____

RACE: [ ] BLACK/AFRICAN AMERICAN [ ] WHITE/CAUCASIAN [ ] HISPANIC/LATINO [ ] NATIVE HAWAIIAN

[ ] AM INDIAN/ALASKA NAT [ ] ASIAN/E INDIAN [ ] OTHER [ ] DECLINED TO PROVIDE ETHNICITY

PRIMARY CARE PHYSICIAN: _____

DME COMPANY (CPAP SUPPLIES / OXYGEN) : _____

PHARMACY / DRUG STORE: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
Allergies Yes____ NO_____			
Do you Smoke cigarettes, Chew Tobacco	Yes	NO	
When did you quit smoking – Date:			

** As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least a 48 hour notice. If you do not cancel or reschedule your appointment with at least a **48** hour notice, we may assess a $50.00 "no-show" service charge to your account. **This "no-show charge" is not reimbursable by your insurance company. You will be billed directly.**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Access Care Plus. I understand that I am financially responsible for any balance. I also authorize Access Care Plus or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____

FINANCIAL INFORMATION

I understand the "no-show" policy of Access Care Plus and agree to provide a credit card number, which may be charged $50.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 48 hours in advance.

This information is to provide clarification for patients of Access Care Plus regarding matters of insurance, co-pay, deductibles and co-insurance amounts due at the time of service. Co-Pays-You will be required to pay your co-payment upon arrival for your appointment Deductibles and Co-Insurance-You will be asked at check in or check out for any deductible or co-insurance that may be applicable to your office visit Previous Balances-You will be expected to provide payment for previous balances or balances sent to collections prior to your office visit.

If you are unable to pay your balance in full, you may be asked to set up a payment plan. Please call 502 833 -3147 to speak with the practice manager.

While, filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and that the services you intend to receive are covered. In order for us to file a claim, you must present a CURRENT copy of your insurance at each visit and communicate any changes in your personal information. PLEASE SIGN THE ACKNOWLEDGMENT BELOW I acknowledge that the above information is true and accurate demographic and insurance information for the patient listed on this registration form. I also acknowledge that by signing this form, I authorize payment of medical benefits to the undersigned physician or supplier for services described.

Patient Signature_____ Date:_____

HIPPA INFORMATION

HIPAA RELEASE OF INFORMATION (Please choose an option below)

HIPAA DELEGATES

[ ] OPTION 1: THESE ELECTIONS WILL BE IN EFFECT FOR Access Care Plus I authorize the person (s) listed below to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Access Care Plus

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

ACCESSCARE

908 Dupont Road, Ste 100 Louisville KY 40207

Pharmacy _____ **Phone#**_____

Location_____

List the Specialist that you have seen:

Name _____ Phone#_____

Name _____ Phone#_____

Name _____ Phone#_____

Medication List – Please list all of your Medications

Name of Medications	Dosage	How often do you take?	Physician that Prescribed	Date that you started taking

ACCESSCARE+
908 Dupont Rd, Ste 100 Louisville KY 40207
PH 502. 883-3147 Fax **502. 882-0909**

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

_____ _____ _____
(Patient's Full Legal Name) (DOB) (Day Phone #)
Address: _____ _____

I, AUTHORIZE:

_____
(Name of Hospital or Physician Practice to Disclose Information)

Disclose Information to: FAX 502 882-0909 (secured)

Recipient Name: Access Care Plus ~ Address: 908 Dupont Rd, Ste 100 ~ Louisville KY 40207

DISCLOSE THE FOLLOWING INFORMATION:

☒ I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following
☒ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, and telephone messages
☒ All physical, occupational, and rehab requests, consultations, and progress notes.
☒ I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____ _____
Signature Date Signature of Witness

If an Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/ Representative Legal Relationship Date Witness

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

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**
☐	☐	☐	☐