

PATIENT INFORMATION

IN ORDER FOR US TO PROVIDE YOU WITH COMPREHENSIVE, FAMILY ORIENTED HEALTH CARE, PLEASE SUPPLY THE FOLLOWING INFORMATION.

LAST NAME		FIRST NAME		MIDDLE INITIAL	SOCIAL SECURITY NO.	
ADDRESS & MAILING ADDRESS				CITY	STATE	ZIP CODE
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> M <input type="checkbox"/> W	DATE OF BIRTH / /	AGE	MEDICINES ALLERGIC TO →		
HOME PHONE ()		WORK PHONE ()	CELL PHONE ()	OCCUPATION	EMPLOYER	
EMAIL ADDRESS			PRIMARY CARE PROVIDER			
EMPLOYER'S ADDRESS				CITY	STATE	ZIP CODE
RACE <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American		<input type="checkbox"/> More than one race <input type="checkbox"/> Asian <input type="checkbox"/> White		<input type="checkbox"/> Other race		ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
						PREFERRED LANGUAGE

LAST NAME		FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH / /	SOCIAL SECURITY NO.
ADDRESS & MAILING ADDRESS				CITY	STATE	ZIP CODE
HOME PHONE ()		WORK PHONE ()		CELL PHONE ()		
RELATIONSHIP TO PATIENT			OCCUPATION		EMPLOYER	

LAST NAME		FIRST NAME		MIDDLE INITIAL	DATE OF BIRTH / /	SOCIAL SECURITY NO.
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EMERGENCY CONTACT AT DIFFERENT ADDRESS				RELATIONSHIP	PHONE ()
ADDRESS			CITY	STATE	ZIP CODE

PHARMACY NAME			PHONE ()	FAX ()
ADDRESS			CITY	STATE ZIP CODE

For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.

COMPANY NAME		COMPANY NAME	
ID NO.	GROUP NO.	ID NO.	GROUP NO.
SUBSCRIBER'S NAME		DATE OF BIRTH / /	
RELATION TO PATIENT		RELATION TO PATIENT	

I WAS REFERRED TO THIS PRACTICE BY:

DEEMED CONSENT

Under Virginia law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV or hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed.

HIPAA Acknowledgement: All patients must initial one of the following:

- I hereby acknowledge that I have been provided with a copy of the TPMG Notice of Privacy Policies.
- I hereby acknowledge that I have been provided with a copy of the TPMG Notice of Privacy Policies but decline to accept it at this time.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY	RELATIONSHIP OF PATIENT	DATE
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FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT

I have authorized treatment to patient by any TPMG provider and/or any affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for third party reimbursement from my insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that the payor determines does not constitute covered services as well as attorney's fees of 33 1/3% and any other related costs of collection should such action become necessary.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY	RELATIONSHIP OF PATIENT	DATE
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BENEFICIARY NAME
HGN#
IF YOU ARE A MEDICARE PATIENT, THIS SECTION MUST BE COMPLETED FOR PROPER PROCESSING OF YOUR ACCOUNT WITH THIS PRACTICE.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to TPMG for any services furnished me by their physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE	DATE
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TPMG
YOUR HEALTH. SKILLFULLY GUIDED

Notice of Privacy Practices Acknowledgement and Consent

_____ PATIENT NAME	_____ DATE	_____ PHYSICIAN/CLINIC
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT	<p>I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:</p> <ul style="list-style-type: none"> • Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. • Obtain payment from third-party payers. • Conduct normal healthcare operations such as quality assessments and physician certifications. <p>I have had the opportunity to understand your <i>Notice of Privacy Practices</i> containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its <i>Notice of Privacy Practices</i> from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the <i>Notice of Privacy Practices</i>.</p> <p>I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.</p>		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">_____ SIGNATURE</td> <td style="width: 40%;">_____ REVISION SIGNATURE</td> </tr> </table>	_____ SIGNATURE	_____ REVISION SIGNATURE
_____ SIGNATURE	_____ REVISION SIGNATURE		

OFFICE USE ONLY	<p>I attempted to obtain the patient's signature in acknowledgement on this <i>Notice of Privacy Practices Acknowledgement</i>, but was unable to do so as documented below:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">DATE</th> <th style="width: 30%;">INITIALS</th> <th style="width: 50%;">REASON</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	DATE	INITIALS	REASON			
DATE	INITIALS	REASON					

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION	<p><i>Patients 18 and over must complete the following:</i></p> <p>_____ I am authorizing the use or disclosure of my protected health information to:</p> <p><input type="checkbox"/> All Protected Healthcare <input type="checkbox"/> Other _____</p> <p>_____ I am authorizing the use or disclosure of my protected health information to:</p> <p>(List all names) _____</p> <p>This protected health information is being used or disclosed to provide healthcare.</p> <p>_____ This authorization shall be in force and effect until:</p> <p><input type="checkbox"/> Enter date of expiration: _____</p> <p>I understand that, as set forth in TPMG's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to: Sibby Wilson, Tidewater Physicians Multispecialty Group, PC, 860 Omni Boulevard, Suite 401, Newport News, VA 23606</p> <p>I understand that I have the right to:</p> <ul style="list-style-type: none"> • Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or Virginia Law). • Refuse to sign this authorization. 		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">_____ SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE</td> <td style="width: 30%;">_____ DATE</td> </tr> </table>	_____ SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	_____ DATE
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Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
 - 0 I do not feel sad.
 - 1 I feel sad
 - 2 I am sad all the time and I can't snap out of it.
 - 3 I am so sad and unhappy that I can't stand it.
2.
 - 0 I am not particularly discouraged about the future.
 - 1 I feel discouraged about the future.
 - 2 I feel I have nothing to look forward to.
 - 3 I feel the future is hopeless and that things cannot improve.
3.
 - 0 I do not feel like a failure.
 - 1 I feel I have failed more than the average person.
 - 2 As I look back on my life, all I can see is a lot of failures.
 - 3 I feel I am a complete failure as a person.
4.
 - 0 I get as much satisfaction out of things as I used to.
 - 1 I don't enjoy things the way I used to.
 - 2 I don't get real satisfaction out of anything anymore.
 - 3 I am dissatisfied or bored with everything.
5.
 - 0 I don't feel particularly guilty
 - 1 I feel guilty a good part of the time.
 - 2 I feel quite guilty most of the time.
 - 3 I feel guilty all of the time.
6.
 - 0 I don't feel I am being punished.
 - 1 I feel I may be punished.
 - 2 I expect to be punished.
 - 3 I feel I am being punished.
7.
 - 0 I don't feel disappointed in myself.
 - 1 I am disappointed in myself.
 - 2 I am disgusted with myself.
 - 3 I hate myself.
8.
 - 0 I don't feel I am any worse than anybody else.
 - 1 I am critical of myself for my weaknesses or mistakes.
 - 2 I blame myself all the time for my faults.
 - 3 I blame myself for everything bad that happens.
9.
 - 0 I don't have any thoughts of killing myself.
 - 1 I have thoughts of killing myself, but I would not carry them out.
 - 2 I would like to kill myself.
 - 3 I would kill myself if I had the chance.
10.
 - 0 I don't cry any more than usual.
 - 1 I cry more now than I used to.
 - 2 I cry all the time now.
 - 3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.
12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.
14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.
15.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.
16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.
18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.
19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

- 20.
- 0 I am no more worried about my health than usual.
 - 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
 - 2 I am very worried about physical problems and it's hard to think of much else.
 - 3 I am so worried about my physical problems that I cannot think of anything else.
- 21.
- 0 I have not noticed any recent change in my interest in sex.
 - 1 I am less interested in sex than I used to be.
 - 2 I have almost no interest in sex.
 - 3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score _____ Levels of Depression

1-10 _____	These ups and downs are considered normal
11-16 _____	Mild mood disturbance
17-20 _____	Borderline clinical depression
21-30 _____	Moderate depression
31-40 _____	Severe depression
over 40 _____	Extreme depression