MICHAEL ROBINSON
FAMILY MEDICAL CLINIC

## Patient Information

Patient's Name: (First) _____ (Last)_____ (MI)_____
Phone Number: _____ Work/Cell Number: _____
Male: _____ Female: _____ Marital Status: _____
Address: _____ City: _____ State: ___ Zip:_____
Age: _____ Birthdate: _____ SSN: _____

Employer's Name: _____ Employers Phone Number: _____

## Emergency Contact

Contact Name: _____ Phone Number: _____
Address: _____City: _____ State: _____ Zip: _____

## Responsible Party or Spouse Information

Name: (First): _____ (Last) _____ (MI) _____
Phone Number: _____ Work/Cell Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birthdate: _____ SSN: _____
Employer's Name: _____ Phone Number: _____

## Insurance Information (Must present card at time of visit)

Insurance Name: _____ Name of insured: _____
ID Number of insured: _____ Group Number: _____
Date of insured's Birthday: _____ Group Name: _____
Address: _____ City: _____ State: _____ Zip: _____

Email: _____

Pharmacy: _____

1900 West 2nd, Suite A
Elk City, Oklahoma 73644
Phone: (580) 303-9060
Fax: (877) 592-0771

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Employers Name: _____ Employers Phone Number: _____

**Emergency Contact**

Contact Name: _____ Phone Number: _____
Address: _____City: _____ State: _____ Zip: _____

**Responsible Party or Spouse Information**

Name: (First): _____ (Last) _____ (MI) _____
Phone Number: _____ Work/Cell Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Age: _____ Birthdate: _____ SSN: _____
Employers Name: _____ Phone Number: _____

**Insurance Information (Must present card at time of visit)**

Insurance Name: _____ Name of insured: _____
ID Number of insured: _____ Group Number: _____
Date of insured's Birthday: _____ Group Name: _____
Address: _____ City: _____ State: _____ Zip: _____

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For canceling appointments, please call the office 24 hours prior to appointment. Persistent no shows (3 or more times) may be cause for dismissal from our care.

If you arrive more than 15 minutes late to your scheduled appointment, your appointment will be rescheduled.

For prescription refills, there will be a 24-48 hour turnaround time. If your prescription was previously filled at a pharmacy, call and request the pharmacy to fax a refill request form to the doctor's office.

For lab results, it takes 2 days up to a week for results to be completed. We will call you with results once the physician has reviewed them.

Signature: _____

Date: _____

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Please circle all that apply to patient
Past 3 months to current

| General | Neurological | change in skin | **reproductive** | | |
|---|---|---|---|---|---|
| weight loss | headache | genitourinary | **(women)** | Marital/Living situation | |
| | | | | | |
| weight gain | dizziness | urgency/frequency | excessive menstrual bleeding | Occupation | |
| fatigue | seizures | pain with urination | spotting | Education Level | |
| weakness | memory loss | incontinence | menopause | Tobacco Use | |
| appetite changes | sleep problems | abnormal discharge | last menstrual period: _____ | ETOH (alcohol) use | |
| chills | psychological | gastrointestinal | **reproductive** | Drug use | |
| night sweats | mood disturbances | heartburn | **(men)** | violence | |
| fever | depression | nausea/vomiting | circumcised | | |
| skin | insomnia | abdominal pain | impotence | | |
| rashes | alcohol problems | diarrhea | difficulty urinating | | |
| itching | excessive anger | constipation | | | |
| bruising | sadness or crying | cardiovascular | **lease list current medications** | | |
| dryness | trouble concentrating | chest pain | 1. _____ | | |
| ears/eyes | musculoskeletal | shortness of breath | 2. _____ | | |
| vision changes | arthritis | heart murmur | 3. _____ | | |
| excessive tearing | joint pain | swelling in extremities | 4. _____ | | |
| dry eyes | back pain | DVT | 5. _____ | | |
| glaucoma | gout | respiratory | 6. _____ | | |
| cataracts | endocrine | asthma | | | |
| hearing loss | excessive urination | COPD | If you require more room, | | |
| vertigo | temp intolerance | history of pneumonia | please continue on the | | |
| ringing in ears | excessive thirst | cough/cold | back of this page. | | |
| ear drainage | change in hair texture | allergies | | | |

| **Symptom** | **Father** | **Mother** | **Father's Parents** | **Mother's Parents** | **Siblings** |
|---|---|---|---|---|---|
| Heart disease | | | | | |
| High blood pressure | | | | | |
| Stroke | | | | | |
| Cancer | | | | | |
| Epilepsy/convulsion | | | | | |
| Bleeding disorder | | | | | |
| kidney disease | | | | | |
| Thyroid disease | | | | | |
| mental illness | | | | | |
| osteoporosis | | | | | |
| arthritis | | | | | |
| other not listed | | | | | |

Drug Allergies: _____

Hospitalizations or Surgeries:

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Patients Name: _____ Today's Date: _____

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# Patient Rights and Responsibilities

We support the rights of each patient.

1. To reasonable response to requests and needs for medical care without regard to race, creed, age, sex, national origin, religion, handicap, or ability to pay.
2. To respect, dignity and comfort, and personal privacy.
3. To be informed of his or her health status and to participate in the development and implementation of his or her plan of care.
4. To receive information necessary to make treatment decisions regarding his or her care, to accept or refuse treatment and to be informed of medical consequences of refusal.
5. The patient or his or her representative has the right to make informed decisions regarding his or her care.
6. To formulate advanced directives, to the extent permitted by law, and to have hospital staff and practitioners who provide care for the hospital to comply with these directives.
7. To have a family member or representative of his choice and his or her physician notified promptly of his or her admission to the hospital.
8. To personal privacy and confidentiality of information, within the limits of the law and the operational requirements of the clinic.
9. To access information contained in the patient's medical records within a reasonable time and within limits of the law and the operational requirements of the clinic, unless it is not medically advisable to do so; in such case the information shall be given to the legally authorized representative.
10. To be free from all forms of abuse and harassment.
11. To reasonable safety in practices and the environment.
12. To participate in the consideration of the ethical issues that arise in the care of the patient.
13. To be informed of any experimentation or other research or educational projects affecting care or treatment.
14. To receive individual management of their pain.

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# Medical Home Agreement

## This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL your healthcare needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventative services.
3. Focus on treating you as a whole person: physically, mentally, and emotionally.
4. Focus on providing you with ongoing, quality and safe medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls, and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with treatment, medications, equipment and any other resources deemed medically necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your PCP, to meet all your healthcare needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report any changes related to your health, treatments, medications, etc.
   This includes use of all medications-prescription, over the counter, herbal, and street drugs
   This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us before going to the emergency room, unless it is life threatening.
5. Notify us after any emergency room, urgent care clinic, or hospital visit.
6. Schedule medical appointments in a timely manner, including follow-up appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment, call before your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

## Your healthcare is a TEAM approach involving BOTH YOU and YOUR PROVIDER.

_____ _____
Patient or Guardian Signature Date

_____ _____
Provider Signature Date

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**Important Notice**
Dr. Michael Robinson must release to your referring physician. Additionally, information may be released to any physician, medical facility, or hospital directly involved in your healthcare as well as your insurance company.

**Disclosure of Information**
Please release my medical information to the following person(s) if information is requested.
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Patent Name: _____ Date of Birth: _____ SSN#: _____

Patient Request for Restrictions
(Please check all the applicable sections)
___ I request the following restrictions to the use and/or disclosure of my health information
PROHIBIT SPECIFIC RECEIVERS: of the line at the left is checked, I request that you not disclose ANY of my protected health information to the specific persons/organizations listed here:
_____
_____
___ Other request: If the line at the left is checked, I request that you restrict the use to disclose my protected health information in the specific manner described below:
_____
_____
(Please select an option below)
___ You may ___ You may not leave appointment reminders/medical information on my message service, answering machine, or email.
Termination of Restrictions
___ I request to terminate restrictions that are listed above.
___ I request to revise the restrictions that are listed above. They are as follows:

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# Medical Authorization and Assignment of Benefits

The goal of Dr. Michael Robinson is to provide patients with exceptional medical care. For us to maintain this high standard of care, we respectfully request that all co-pays and balances be paid at the time services are rendered. Our office accepts Medicare assignment. After you have met your deductible, Medicare will pay 80% of approved charges. You or your supplemental insurance will be responsible for your deductible and remaining 20%. In addition, we participate with many PPO plans and will accept other insurance plans, which we may not participate in. If you are in a preferred provider organization (PPO) your benefits may vary if you choose to see a non-PPO doctor. As in the policy holder, it is ultimately your responsibility to know your plan benefits, requirements, exclusions, and limitations. We utilize Primary Medical Billing: they submit claims on our behalf. They also send out statements after your insurance has paid. You may contact our office if you have any questions regarding your bill at 580-303-9060.

## Authorization:

I hereby authorize Dr. Michael Robinson to release all medical information necessary for processing of insurance claims to all insurers or agents. I also authorize them to contact my insurance company or health plan administrator to obtain all pertinent financial information to Dr. Michael Robinson and allow a xerographic copy of my signature to be used. I understand these provisions will remain in full effect until otherwise revoked by me. I further authorize payment directly to the physician of the surgical and/or medical benefits.

State law requests us to advise you that the information authorized for release may include records, which may indicate the presence of communicable or venereal disease, which may include but are not limited to, disease such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

I certify that I have read and understand the above and have had each item explained to my satisfaction. If I am not the patient, but am signing on behalf of the patient, I further certify that I am legally authorized to sign on the patient's behalf and to bind the patient to the above terms and conditions. I agree that the patient and I are jointly and severally responsible for complying with the above terms and conditions including any and all payment obligations. You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

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_____ _____

Patient or Guardian Signature Date

_____ _____

Provider Signature Date

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The Patient Health Questionnaire-2 (PHQ-2)

Patient Name: _____ Date of Visit: _____

| Over the past 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 |

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