Larry F. Berman, M.D., M.S.P.H, P.C.

Adult & Adolescent Internal Medicine

10620 Park Rd. Suite 128♦Charlotte, NC 28210 Phone 704.542.6111♦Fax 704.542.1239

Authorization to Treat

I hereby consent to the rendering of medical care, which may include routine diagnostic procedures and such medical treatment as deemed necessary by Dr. Berman. I understand that I have the right to refuse to consent or refuse treatment at any time. I understand and agree that regardless of my health insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature Date

Patient # _____ (Office use only)

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Cancellation/ No Show Policy for Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a **($50)** fee; this will not be covered by your insurance company.

Cancellation/ No Show Policy for Diagnostic Testing

If a diagnostic test is not cancelled at least 24 hours in advance you will be charged a **($100)** fee; this will not be covered by your insurance company.

Late arrivals

We understand that delays can happen however we must try to keep the other patients and the doctors on time. If a patient is **15 minutes** past their scheduled time, we will have to reschedule the appointment.

Account Balances

We will require that patients pay their account balances to zero prior to receiving further services by our practice. Patient with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ _____

Print Name Signature Date

Patient #_____(Office use only)

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Larry F. Berman, M.D., P.C. to use and/or disclose certain protected health information (PHI) about me to:

_____

(Name of entity to receive this formation)

This authorization permits Larry F. Berman, M.D., P.C. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detailed to be released, origin of information, etc.):

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire on _____(typically, patients write "indefinite" here).

The practice will _____ will not __**X**__ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Larry F. Berman, M.D., P.C. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:
10620 Park Rd. Suite 128
Charlotte, NC 28210

_____	_____	_____
Patient Name (Print)	Signature	Date
_____	_____	_____
Patient Legal Guardian Name	Signature	Date

PATIENT/GUARDIAN MAY BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION

Patient #_____(Office use only)

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Receipt of Notice of Privacy Practices

I, _____, have received a copy of Larry F. Berman, M.D., P.C.'s Notice of Privacy Practices.

_____ _____

Signature Date

Patient # _____ (Office use only)

Larry F. Berman, M.D., M.S.P.H, P.C.

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Patient Financial Responsibility

Our office is doing everything possible to hold down the cost of medical care. Recognizing the need for our patients to have clear understanding of their financial responsibility for medical services, we have established the following policy:

1. All co-pays, deductibles and co-insurance must be paid at the time services are rendered. We accept cash, checks, and all major credit cards. A $25 fee will be charged for any returned check. We are members of most, but not all insurance plans. You are responsible for verifying what your insurance will cover and that we are providers on your plan.

2. We will bill your medical insurance company with a copy of your current insurance card. If you do not have your insurance card and we are unable to verify your coverage, full payment is due at the time of service.

3. If payment is not received from your insurance company within 60 days of the date of service any balance will be your responsibility.

4. You will receive at statement from our office after your insurance company's response. If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement and prior to any additional office visit.

5. If you do not have insurance or if the services provided are not covered by your insurance, payment in full is expected at the time that services are rendered.

6. All accounts 90 days past due will be turned over to a collection agency and our office may cease providing services to you.

7. All appointments require a 24 hour notice for cancellation and scheduled procedures require a 48 hour cancellation notice. We understand that emergencies arise, but appreciate your consideration of their policy. If three such occurrences take place, you may be dismissed from the practice. Failure to present for your appointment or give the required notice will result in a $50 missed appointment fee or a $100 missed procedure fee.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. We value you as a patient and look forward to the opportunity to provide you with the best possible care.

I have read and understand the financial policy set forth by Larry F. Berman, MD.

Patient Name (Print)	Date of Birth
Signature	Date

Larry F. Berman, M.D., M.S.P.H, P.C.

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A WORD TO OUR PATIENT
ABOUT PREVENTATIVE CARE-PHYSICIAL EXAMS

Preventive care includes routine well exams, screenings, and immunizations intended to prevent or avoid illness or other health problems.

This exam is prevention focused, not problem focused. If you have a new health problem or other diagnoses that need to be addressed during your preventive office visit, e.g. (high blood pressure, diabetes, skin rash, or headaches), your provider may bill part of the exam at 100% for your annual preventive exam and part of your office visit for treatment of your diagnosis.

At your preventative visit, our healthcare team will take a complete health history and provide several other services including, but not limited to:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity
- Recommendations for other preventative services and healthy lifestyles changes

The portion of your visit related to the treatment of your diagnosis would apply towards your deductible and coinsurance.

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Signature Date

Patient # _____ (Office use only)

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PATIENT REGISTRATION FORM (Please Print)

Patient's last name: First: Middle:	☐ Mrs. ☐ Mr.	☐ Mis ☐ Ms.	Marital status ☐ Single ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security # - -	Cell Phone # ( ) -

☐ Work ☐ Home phone # ( ) -	Email address:

P.O. box:	City:	State:	Zip code:

Occupation:	Employer:	Employer phone # ( ) -

Referred by: ☐ Family ☐ Friend ☐ Dr. ☐ online search ☐ hospital	Referred by (name):

PHARMACY NAME: **ADDRESS:** **PHONE #**

HEALTH INSURANCE INFORMATION

Please provide your insurance card and ID to the receptionist

Please indicate primary insurance	☐ Aetna	☐ BCBS	☐ Cigna	☐ Coventry	☐ First Health	☐ Humana

☐ Medcost	☐ Medicare	☐ Multiplan (PHCS)	☐ UHC	☐ Other

Subscriber's name:	Subscriber's SS # - -	Birth date: / /	Group #	Policy / ID #

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable)	Subscriber's name:	Group #	Policy #

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

MY EMERGENCY CONTACT

Name:	Relationship to patient:	Cell phone # ( ) -	☐ Work ☐ Home phone # ( ) -

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid to physician. I understand that I am financially responsible for any balance. I also authorize Larry F. Berman, M.D., P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature: Date:

Health History Questionnaire

Logo here

☐ Initial ☐ Annual

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Special Communication Needs: Requires Updating Annually			
Language preference:			
If 'yes' to any of the questions below, how can we assist?			
Hearing impairment	☐ Yes ☐ No	**Cognitive impairment**	☐ Yes ☐ No
Speech impairment	☐ Yes ☐ No	**Sensory impairment**	☐ Yes ☐ No
Visual impairment	☐ Yes ☐ No	**Other:**	

Family History ☐ No change since previous year

Relationship	Living Y/N	Age	Major Medical Problems or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically have any of your relatives had the following conditions

Condition	Relative
☐ Mental Illness	
☐ Chemical Dependency	
☐ Opioid Dependency	

Personal Health History

No Change Since Previous Year ☐

Please check past or current problems or conditions

Condition	Condition
☐ Hypertension	☐ Seizures
☐ High cholesterol	☐ Headaches
☐ Diabetes	☐ Stroke
☐ Heart attack or angina	☐ Prostate problem
☐ Irregular heart rhythm	☐ Breast problem
☐ Congestive heart failure	☐ Urinary tract infections
☐ Asthma	☐ Osteoarthritis
☐ Emphysema or chronic bronchitis	☐ Cancer (Please list type)
☐ Pneumonia	☐ Thyroid problem
☐ Gastroesophageal reflux disease	☐ Bleeding disorder
☐ Stomach ulcer	☐ Addiction Issues
☐ Kidney problems	☐ Depression or anxiety
☐ Liver disease/hepatitis	☐ Mental Illness
☐ Colon cancer	☐ Other (please describe)
☐ Bowel/digestive problem	

Previous Surgical Procedures

No Change Since Previous Year ☐

Please check if you have had any of the following

Procedure	Year
☐ Heart surgery	
☐ Carotid artery surgery	
☐ Vascular surgery / stent	
☐ Abdominal aneurysm repair	
☐ Hysterectomy	
☐ Gallbladder removed	
☐ Appendix removed	
☐ Tonsillectomy	
☐ Joint replacement	
☐ Breast cancer surgery	
☐ Prostate cancer surgery	
☐ Hernia	
☐ Pacemaker	
☐ Other (please describe)	

Specialty Providers: Requires Updating Annually	
In order to best coordinate your care, please list any medical providers you see outside of this practice and list the year that you last saw them	
☐ Eye doctor	☐ Nephrologist
☐ Cardiologist	☐ Psychiatrist
☐ Oncologist	☐ Allergist
☐ Urologist / Gynecologist	☐ Vascular
☐ Gastroenterologist	☐ Pulmonologist
☐ Endocrinologist	☐ Other:
☐ No new specialist visits since last year	

Please list any new medications prescribed by specialists or providers other than your PCP. Please include name, dose, and frequency.	

It is very important that you take the medication(s) your health care professional has given you. Please check any of the below:

Are you unable to fill your prescription(s) because of the cost? ☐ Yes ☐ No

Are you unable to fill your prescriptions because of lack of transportation? ☐ Yes ☐ No

Have you ever applied for any pharmacy assistance? ☐ Yes ☐ No

Opioid History and Current Usage: Requires Updating Annually

It is very important that you take the medication(s) your health care professional has given you. Please check any of the below

Have you ever taken drugs called Opioids (ex: morphine, oxycontin, dilaudid, fentanyl)? ☐ Yes ☐ No

Are you currently taking an Opioid for chronic pain? ☐ Yes ☐ No

Did you utilize non-medication treatments for your pain before taking medication? (Heat/Cold/Physical Therapy/) ☐ Yes ☐ No

Allergies	
Please list any allergies to medications or food, including food sensitivities	

Social History: Initial

Please check appropriate answers below and provide explanations where appropriate

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Education level: ☐ Did not Graduate ☐ High School ☐ Some College ☐ Bachelor's Degree ☐ Master's Degree or Higher

Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation

How stressful would you rate your current living situation: (Check number)

Not Very Stressful ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Very Stressful**

Do you fear for your safety in your current living situation? ☐ No ☐ Yes **If yes, describe below:**

Are there financial concerns that affect your ability:

1) to go to the doctor ☐ No ☐ Yes **If yes, describe:**

2) to obtain food and shelter ☐ No ☐ Yes **If yes, describe:**

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

☐ No ☐ Yes **If yes, describe:**

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headache	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Weakness	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	**Pain, weakness, or numbness in**		Number of pregnancies
☐ Vomiting	☐ Arms ☐ Hips ☐ Back		Miscarriages
☐ Vomiting blood	☐ Legs ☐ Neck ☐ Shoulders		Birth control method
☐ Change in bowel habits	☐ Hands ☐ Feet		

Patient Signature:_____ Date:_____

Provider Reviewed:_____ Date:_____

Preventive Health Screening

☐ Initial ☐ Annual

Name_____ Date Completed _____

Address_____

Local phone number_____ Alternative phone number_____

Preferred Pharmacy_____ Pharmacy phone number_____

Please describe what problem or concern brought you to our office today:

Health Literacy Questionnaire:	
It is really important to your provider that you understand the information related to your health. Please rate the following questions on a scale of 1 to 10; 1 being strongly disagree and 10 being strongly agree	
I feel that I have a thorough understanding of the instructions that my doctors and nurses give me about my health	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
I feel that I remember the instructions given to me at my doctor's office when I get home	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
I feel that I have a strong understanding of medical language	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Health Maintenance:							
Please check whether you have had the following preventive services and enter the year of the service							
Immunizations			**Year**		**Tests**		**Year**
Tetanus vaccine / Tdap	☐ Yes	☐ No			Pap smear/pelvic	☐ Yes ☐ No	
Pneumonia vaccine	☐ Yes	☐ No			Mammogram	☐ Yes ☐ No	
Influenza vaccine	☐ Yes	☐ No			Bone dexascan	☐ Yes ☐ No	
Shingles vaccine	☐ Yes	☐ No			Colonoscopy	☐ Yes ☐ No	
					Prostate test	☐ Yes ☐ No	
Additional Vaccines taken since previous year			☐ Yes	☐ No	If yes, list vaccine name and date:		

Health Behaviors: Requires Updating Annually for 11 years and older							
Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker							
If current smoker how many packs per day for how many years_____							
Alcohol intake: ☐ No ☐ Yes If yes how many drinks/how often_____							
Have you or are you currently taking an Opioid medication smoke (ex: morphine, oxycontin, dilaudid, fentanyl)?				☐ Yes ☐ No			
If yes, Did you utilize non-medication treatments for your smoke pain before taking medication? (Heat/Cold/Physical Therapy)				☐ Yes ☐ No			
Illicit drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current							
If Past or Current drug use describe:							
Exposure to secondhand smoke	☐ Yes	☐ No			Wear a seatbelt	☐ Yes	☐ No
Eat a diet high in fruits and vegetables	☐ Yes	☐ No			See a dentist at least once a year	☐ Yes	☐ No
Get 30 minutes of exercise 5 times a week	☐ Yes	☐ No			Wear sunscreen	☐ Yes	☐ No

Urinary Incontinence Assessment: Requires Updating Annually for 65 years and older				
Do you experience leaking in the following situations:	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)	☐	☐	☐	☐
During physical activities (walking, swimming, or other exercise)	☐	☐	☐	☐
During recreational activities (movies, hobbies)	☐	☐	☐	☐
During social activities (going out with friends, family visits)	☐	☐	☐	☐

Fall Risk Screening: Requires Updating Annually for 65 years and older	
In the last 12 months have you fallen?	☐ Yes ☐ No ☐ Unsure
If yes, how many times?	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+
Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Functional Assessment: Requires Updating Annually for 65 years and older				
Do you need assistance in the following areas?	Not at all	A little	Sometimes	A lot
Bathing, dressing and grooming	☐	☐	☐	☐
Daily activities (cooking, cleaning other household tasks)	☐	☐	☐	☐
Walking or driving	☐	☐	☐	☐
Communicating needs and feelings	☐	☐	☐	☐
Understanding directions	☐	☐	☐	☐
Keeping appointments, taking medications and performing other medical treatments	☐	☐	☐	☐
If yes to any of these questions, who helps with these activities?				

Mood Screening: Requires Updating Annually for age 11 and up	
A person's mood can have a strong influence on their health status and overall wellbeing. Over the past 2 weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things	Feeling down, depressed, or hopeless
☐ Not at all	☐ Not at all
☐ Several days	☐ Several days
☐ More than half the days	☐ More than half the days
☐ Nearly every day	☐ Nearly every day

Social History: Requires Updating Annually

Please check appropriate answers below and provide explanations where appropriate

Job concerns: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Transportation

How stressful would you rate your job situation?

Not Very Stressful ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Stressful

Have you had CHANGE in Marital Status: ☐ No ☐ Yes If yes, describe below:

How stressful would you rate your current living situation?

Not Very Stressful ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Stressful

Do you fear for your safety in your current living situation? ☐ No ☐ Yes If yes, describe below:

Are there financial concerns that affect your ability:

1) to go to the doctor ☐ No ☐ Yes If yes, describe:

2) to obtain food and shelter ☐ No ☐ Yes If yes, describe:

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

☐ No ☐ Yes If yes, describe:

Patient Signature:_____ Date:_____

Provider reviewed:_____ Date:_____