Patient Name: **DOB:** **Today's Date:**

Patient Health Screenings:

Your health and wellness is our goal at High Country Community Health. In order to provide you with the best possible care, it is important that we have all information about your physical and mental health as well as your lifestyle habits. Whole person care means not only that the mind and body are connected, but that they affect all aspects of your health. Please complete the Patient Health Screenings below so that your medical provider is better able to help you reach and maintain your best level of health. Thank you.

PATIENT HEALTH QUESTIONNAIRE - 9

72883

Only the patient (subject) should enter information onto this questionnaire.

Over the last 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
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

SCORING FOR USE BY STUDY PERSONNEL ONLY

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 all	**Somewhat difficult**	**Very difficult**	**Extremely at difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

EPI0905.PHQ9P

I confirm this information is accurate.	Patient's/Subject's initials:	Date:

AUDIT

1. How often do you have a drink containing alcohol?

(0)Never (1) Monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1-2 (1) 3 or 4 (2) 5 or 6 (3) 7-9 (4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

4. How often during the last year have you found that you were unable to stop drinking once you started?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

6. How often during the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

7. How often during the last year have you felt guilt or remorse after drinking?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of drinking?

(0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

9. Have you or someone else been injured as the result of your drinking?

(0) no (2) yes, but not in the last year (4) yes, during the last year

10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?

(0) no (2) yes, but not in the last year (4) yes, during the last year

Total Score: _____

DAST-10

Circle Your Response. These questions refer to the past 12 months:

1. Yes	No
2. Yes	No
3. Yes	No
4. Yes	No
5. Yes	No
6. Yes	No
7. Yes	No
8. Yes	No
9. Yes	No
10. Yes	No

1 .Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to?
4. Have you had "blackouts" or "flashbacks" as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?

Total Score: _____

ADULT MEDICAL HISTORY FORM

Patient Name: _____ **Date of Birth:** _____

Today's Date: _____ **Reason for today's visit:** _____

Occupation:_____ **Do you go to the VA (Veteran's Affairs) Hospital? If so, where**_____

ALLERGIES: Please list any food or drugs that you are allergic to

Food or Drug	Reaction	Mild/Moderate/Severe

MEDICATIONS:

List all medications you are currently taking including birth control, vitamins, supplements, and over the counter drugs
If you need more space please write on back of form. *Please bring all medication bottles to each appointment*

Drug	Dosage	Frequency

Preferred Pharmacy: _____

DATE OF MOST RECENT VACCINES:

Flu:_____Tetanus:_____Pneumonia:_____Shingles:_____Other:_____

PLEASE LIST YOUR OTHER HEALTH CARE PROVIDERS

Speciality	Doctor's Name	Date of Last Visit
Eye Doctor		
Dentist		
Other:		
Other:		

PAST OPERATIONS/HOSPITALIZATIONS:

Type of Surgery/Reason for Hospitalization	Name of Doctor/Facility	Date

PAST MEDICAL HISTORY:

Please check all current AND previous illnesses/conditions. If you know the date you were diagnosed please write the date beside the condition.

Heart: ○ None ○ Heart Failure ○ High Blood Pressure ○ Heart Attack ○ Poor Circulation ○ Stroke ○ High Cholesterol/Lipids ○ Irregular Heart Beat ○ Valvular Disease (problems with any heart valves) Other: _____	**Lungs:** ○ None ○ Emphysema ○ COPD ○ Hay Fever ○ Chronic Bronchitis ○ Tuberculosis ○ Pneumonia ○ Pulmonary Embolism (lung blood clot) ○ Sleep Apnea ○ Home Oxygen Other: _____	**Stomach/Intestines:** ○ None ○ GERD (gastric reflux) ○ Ulcers ○ Crohn's Disease ○ Colitis ○ Diverticulitis or Diverticulosis ○ Irritable Bowel Syndrome ○ Polyps ○ Gallstones ○ Pancreatitis Other:_____	**Kidney/Bladder:** ○ None ○ Kidney Stones ○ Kidney Failure ○ History of Dialysis ○ Frequent Urinary Tract Infections ○ BPH/Enlarged Prostate Other:_____
Joints/Skeleton: ○ None ○ Arthritis ○ Osteoporosis ○ Gout ○ Scoliosis ○ Fractures (Type:_____) Other:_____	**Endocrine:** ○ None ○ Diabetes ☐ Type 1 ☐ Type 2 ○ Thyroid ☐ Too high ☐ Too low ○ Pituitary Disease ○ Adrenal Disease Other:_____	**Brain and Nerves:** ○ None ○ Headaches/Migraines ○ Neuropathy ○ Parkinson's Disease ○ Dementia/Alzheimer's ○ Seizures ○ Meningitis ○ Multiple Sclerosis ○ Chronic Fatigue Syndrome Other: _____	**Blood Disorders:** ○ None ○ Anemia ○ Sickle Cell Anemia ○ Bleeding Disorder ○ History of Blood Transfusions ○ Clot (Where:_____) Other:_____
Skin Disorders: ○ None ○ Acne ○ Eczema ○ Psoriasis ○ Warts ○ Shingles Other:_____	**Immune System:** ○ None ○ Cancer (Type:_____) ○ HIV/AIDS ○ Frequent Infections ○ Lupus ○ Rheumatoid Arthritis Other:_____	**Psychological:** ○ None ○ Depression ○ Bipolar Disorder ○ Anxiety ○ Schizophrenia ○ Post-Traumatic Stress Disorder ○ Addiction Other:_____	**Liver:** ○ None ○ Hepatitis A ○ Hepatitis B ○ Hepatitis C ○ Fatty Liver ○ Cirrhosis Other:_____

Communicable Diseases: Circle Type **Chlamydia Herpes Genital Warts Gonorrhea**

For Women Only:

Date of last period:_____ Age when period started:_____

Date of Last Pap Test:_____ Circle: NORMAL ABNORMAL Treatment:_____

Date of Last Mammogram: _____ Circle: NORMAL ABNORMAL Treatment:_____

# of Pregnancies:_____ # of Miscarriages:_____ # of Abortions:_____

# of Living Children:_____ Age of Menopause:_____

Please indicate with what frequency and quantity you participate in the following activities:

Activity	**How often?** (Daily, How many times a week, Rarely, Never, Former)	**How much?**	
Exercise			Type of Exercise:
Use Tobacco (Cigarettes, Pipe, Cigar, Snuff, Chew, E-cigs)		_____ packs per week	Quit Date: _____
Drink Alcohol (beer/wine/liquor)		_____ drinks per week	Quit Date: _____
Use Substances (Heroin, Cocaine, Opioids, Methamphetamine, Marijuana, Other:_____)			Quit Date: _____

Family Medical History:

Condition	Brother	Sister	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Heart Attack								
High Blood Pressure								
Cancer: (List type)								
Type:								
Type:								
Asthma								
Emphysema/COPD								
Tuberculosis								
Stroke (TIA/CVA)								
Seizures								
Diabetes Type 1:								
Diabetes Type 2:								
Hyperthyroid								
Hypothyroid								
Rheumatoid Arthritis								
Bleeding Disorder								
Depression								
Bipolar Disorder								
Schizophrenia								
Addiction								

HIGH COUNTRY community health

New Patient Information ****Please present your insurance card****

Patient Information

Last Name _____ **First** _____Middle_____
How would you like to be addressed (nickname)? _____
Gender: Male___ Female___ **Gender at Birth**: Male___ Female___ Decline to Answer___
Sexual Orientation: Straight or Heterosexual___ Lesbian, Gay or Homosexual___ Bisexual__ Something Else___ Don't know___ Decline to Answer___
Social Security Number: _____
Marital Status: Married___ Single___ Divorced___ Widowed___
Date of Birth: _____
Preferred Language: English___ Spanish___ Other: _____
Street Address: _____
Mailing Address (If different): _____
City: _____ **State**: _____ **Zip**: _____
Telephone:
Home: _____ Cell:_____ Work:_____ ext:_____
Email Address: _____
How do you prefer to be contacted by our office?
Home Phone____ Cell-phone____ Work:_____ Email____ Mail____

Guarantor Information (If uninsured, Skip)

Person responsible for payment: Self____ Spouse___ Parent___ Other: _____
Name (if different than patient): _____
Address (billing statements will be mailed here): _____
City: _____ State: _____ Zip: _____
Telephone (home): _____ Date of Birth: _____
Gender: ___ Male ___ Female Social Security Number: _____
Employer Name: _____ Telephone #: _____

Emergency Contact Information

Whom may we contact in case of an emergency? _____
Phone number: _____
Address: _____
Relationship to patient: Father____ Mother___ Brother____ Sister____ Friend___
Grandfather____ Grandmother____ Spouse____ Daughter___
Son____ Other____

Other Information

Patients Race: White____ African American____ Asian American____ Other___
Patient's Ethnic Group: Not Hispanic/Latino____ Hispanic/Latino____

HIGH COUNTRY COMMUNITY HEALTH

FINANCIAL POLICY AND RESPONSIBILITY

I understand and acknowledge the following:

All Patients:

- Payment is due at the time of service. Co-pays will be collected at check in.
- For my convenience High Country Community Health accepts cash, Visa, MasterCard, Discover, and in-state personal checks (no starter checks).
- High Country Community Health files with Medicaid, Medicare and many private insurance companies.
- I authorize my insurance benefits to be paid to High Country Community Health.
- It is my responsibility to check that High Country Community Health is in network with my private insurance prior to my first appointment.
- I am responsible for updating High Country Community Health as to any changes in my address, phone number and insurance as soon as possible.
- I understand that the amount not covered by insurance is the responsibility of the party listed on the "Patient Information" form. I agree to pay promptly for any balance not covered by insurance.
- I understand that in addition to my office visit charge there may be additional charges including, but not limited to, health screenings, in-house labs, behavioral health services, vaccines, and injections.
- Labs sent to outside laboratories (e.g., LabCorp, Wake Forest Labs or Quest) will be billed separately and are not part of High Country Community Health. A separate bill from the lab company will arrive by mail.

Uninsured Patients:

- If uninsured, my family and I may be eligible for our Sliding Scale Fee program. I must bring all required proof of income for every household member. We are required to apply every 12 months for the program.
- If I qualify for the Sliding Scale Fee program, my minimum fee at each visit will be between $25 and $40 for office visits. Behavioral health services provided separate from a medical visit will cost between $10 and $20 and is due at the time of check in.
- If I am uninsured and do not bring my household income to my first appointment and I self declare my income, I will be charged $40 at the time of check in. All following appointments will be charged at full price until I bring in proof of income.
- If I do not qualify for one of the sliding fee scales and I pay the balance of my visit in full at time of check out, my visit will be discounted to $80.
- I will receive a separate bill from the lab company in the mail. The Sliding Scale Fee program allows for lab discounts if I qualify.
- Responsible parties (listed on the "Patient Information" form) with unpaid balances will receive bills from High Country Community Health.
- If my unpaid balance reaches over $250 and I am not making monthly payments, I understand that High Country Community Health may require me to undergo financial counseling.

Patient or Guarantor Signature: _____ Date: _____

Relationship to Patient: _____

Staff Signature: _____ Date: _____

Consent for Evaluation and Treatment

High Country Community Health (HCCH) is dedicated to providing primary care, behavioral health and dental services to area residents. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. HCCH patients may be referred to providers from other health care specialties within the HCCH treatment team.

Patients are seen by appointment, although a limited number of walk-in appointments are available each day on a first come first serve basis. Patients must call in advance if they cannot keep their appointment.

Your signature below authorizes HCCH to share relevant health information about you with any specialty service or hospital to which you are referred. HCCH does not share information with family and friends, unless the patient, emancipated minor, parent or legal guardian gives written permission. We may release patient information to others without the patient's permission if: 1) the patient poses a threat to him/herself or others; 2) the patient is unable to protect him/herself from risk of harm; 3) the patient is in the legal custody of a government agency or facility; 4) there is evidence of child or elder abuse or neglect; or 5) the patient's clinical records are requested under court order.

There are fees for all services, and patients are asked to pay on the day they are seen. Health insurance policies may cover a portion of the fees and staff will help the patient in making claims. Patients are asked to tell HCCH staff about changes in financial status.

The professional staff of this facility will depend on statements made by the patient, the patient's medical history, and other information to evaluate his/her condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

Some services at High Country Community Health may involve the use of telemedicine equipment and interaction with providers who are not physically onsite. These sessions are transmitted via secure, dedicated high-speed lines and are not videotaped, routed through the internet or saved in any way.

In treating patients, studies including x-rays, laboratory tests, EKGs or psychological tests may be necessary. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the treatment staff.

I understand that if I am 18 years of age or older, I may consent for health services; otherwise my parent or legal guardian will need to consent for services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand and agree to be truthful in providing information.

Thus, I hereby ask and agree to evaluation and treatment for myself and/or my child(ren), including any studies or procedures that HCCH professional staff decide are necessary.

_____ _____

Patient's or Guardian's Signature Date

_____ _____

Witness Date

_____ _____

Interpreter Date

HIGH COUNTRY community health

HIPPA Notice of Privacy Practices and Patient Communication Consent

- I acknowledge that I have been informed about the Notice of Privacy Practices for High Country Community Health.
- I understand that the Notice of Privacy Practices discusses how my personal health care information may be used and/or disclosed, my rights with respect to health care information, and how and where I may file a privacy-related complaint.
- I understand I may review a copy of this Notice by requesting one from the receptionist.
- I understand I may obtain a copy of this Notice by requesting one from the receptionist.
- I understand that the terms of this Notice may be changed in the future, and that I may request a copy of the new Notice by requesting one from the receptionist.

I understand I may also obtain a copy of this notice by writing to High Country Community Health, Attention: Privacy Office

Please initial the following acceptable methods of communication:

Cell Phone:

_____Okay to leave detailed voice mail messages
_____Okay to leave a call back number ONLY on voice mail
_____Okay to leave a call back number ONLY with another person answering the phone

Home Phone:

_____Okay to leave detailed voice mail messages
_____Okay to leave a call back number ONLY on voice mail
_____Okay to leave a call back.number. ONLY with another person answering the phone

Work Phone:

_____Okay to leave detailed voice mail messages
_____ Okay to leave a call back number ONLY on voice mail
_____ Okay to leave a call back number ONLY with another person answering the phone

Mailing Address:

_____Okay to send a letter requesting me to call High Country Community Health
_____Okay to send detailed information regarding my care or condition

I GIVE HIGH COUNTRY COMMUNITY HEALTH PERMISSION TO SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PEOPLE IF REQUESTED.

_____ _____

_____ _____

_____ _____

Patient or Guardian's Signature: _______ Date: _____

Relationship to Patient:_____

Barriers to Care and Migrant Farm Worker Information

Patient Name (including middle initial):_____ Date of Birth:_____

POTENTIAL BARRIERS TO CARE: This list is used to help us identify other areas in your life that may affect your health and that may need some community resources. It will help us develop a plan of action, including referrals to appropriate departments and outside organizations. If you would like more information, or have any questions about the items below, check the box so that the Patient Resource Specialist can further guide you.

Health Insurance / Health Care Access

- ☐ I need health insurance (Medicaid, ACA Insurance, Family Planning, Medicare, or other programs)
- ☐ I need Medicare Counseling (SHIIP)
- ☐ I need to apply for a tax exemption because I don't have health insurance
- ☐ My application for Medicaid/ACA insurance was denied
- ☐ I need help completing a Charity Care application for my local hospital system
- ☐ I need help paying for my medications

Housing

- ☐ I do not have housing (living at Hospitality House, in a shelter, with friends, in a car, in a park, a hotel, etc.)
- ☐ I would like assistance to find affordable housing
- ☐ I am at risk of losing my housing
- ☐ There are unsafe conditions at my home (mold, leaks, peeling paint, insects, etc.)
- ☐ I have difficulty paying heating/utility bills

Other barriers/challenges:_____

_____

Food **Let your provider know if:**

- ☐ Within the past 12 months, did you worry whether your food would run out before you had the money to buy more?
- ☐ Within the past 12 months, did the food you bought not last and you did not have the money to buy more?
- ☐ I would like to apply for/was denied Food Stamps (SNAP) benefits
- ☐ I am unable to follow the diet my doctor has recommended

Transportation

- ☐ I need help going to medical appointments
- ☐ I need help getting to other important appointments
- ☐ The bus system does not go near where I live or work. I live in _____ County.

Other

- ☐ I would like to register to vote
- ☐ I need help filing my taxes
- ☐ I need information about end of life decisions.
- ☐ If I were admitted to the hospital, I would need help alerting a family member about pets/issues to take care of at home.
- ☐ I/my family need a winter coat or jacket

Please circle any of the following that apply to you:

1. In the past 2 years, have you or anyone in your family been considered a Seasonal Farmworker? (A person whose source of income is earned mostly in agricultural work, without moving away from home).	YES	NO
2. In the last 2 years, have you or a member of your family been considered a migrant worker? (A person who has moved away from home and established a temporary home in order to work primarily in agriculture).	YES	NO
3. Have you or a member of your family stopped migrating to work in agriculture (farm work) because of disability or age (too old to do the work)?	YES	NO
4. Are you a U.S. Veteran?	YES	NO
5. Are you living in Public Housing?	YES	NO

Patient or Guardian Signature: _____ Date: _____

Relationship to Patient: _____

HIGH COUNTRY community health

Income for Insured Patients

In order for our clinic to receive federal financial support for patients of low income, we ask that you complete the following annual **household** income form. No individual information is provided to the federal government.

Based on your family size, please circle the income level of your household. The dollar amounts are maximums. For example, if you have a family size of two and make $16,461 annually (i.e., one dollar more than the first column amount), then round up and circle $20,575. Please ask our staff for assistance if needed.

Family Size:	Annual Household income:				
1	$12,140	$15,175	$18,210	$24,280	>$24,280
2	$16,460	$20,575	$24,690	$32,920	>$32,920
3	$20,780	$25,975	$31,170	$41,560	>$41,560
4	$25,100	$31,375	$37,650	$50,200	>$50,200
5	$29,420	$36,775	$44,130	$58,840	>$58,840
6	$33,740	$42,175	$50,610	$67,480	>$67,480
7	$38,060	$47,575	$57,090	$76,120	>$76,120
8	$42,380	$52,975	$63,570	$84,760	>$84,760

For each additional household member, add $4,180.

Patient Name: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

108 Doctors Drive, Boone, NC 287607
Ph 828-262-3886; FAX 828-265-4816

Authorization to Disclose Protected Health Information

Patient Name: _____ Phone #: _____

Date of Birth:_____ Address: _____

I authorize High Country Community Health to **release** protected health information to the following individual(s) / organization (s):

Name/Organization: _____

_____

_____

I authorize High Country Community Health to **obtain** protected health information from the following organization(s):

Name/Organization: _____

_____

_____

I understand that I am authorizing my entire medical record to be released or obtained by High Country Community Health including the reports checked below:
(please only check reports you want to release)

Type of report		Type of report	
Psychological and mental health testing or treatment	☐		
HIV/AIDS testing or treatment	☐	Hepatitis C testing or treatment	☐
STD testing or treatment	☐	Immunization Records	☐
Laboratory Reports	☐	Radiology / CT Reports	☐
Substance Use	☐	History & Physicals	☐
Consults	☐	Emergency Room Reports	☐
List of Allergies	☐	Discharge Summaries	☐
Office Notes	☐	Operative Reports	☐
Other (Specify):			☐

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I have the right to cancel this authorization at any time. I understand that it is my responsibility to notify High Country Community Health if I wish to cancel this authorization. I further understand that High Country Community Health is not responsible for disclosures made based on this authorization prior to the date of cancelation. This authorization will expire one year from the date this form is completed

Signature: _____ Date: _____
**Patient/Legal Representative

**If legal representative, give relationship to patient: _____