Joshua Z. Steiner, D.O., P.A.

History Form

Name:_____ DOB:_____ Date:_____
Address:_____ Phone:_____
Age:_____ (M S W D) Occupation:_____ Referred:_____

ALLERGIES:

Please list all the medications you are taking:

FAMILY HISTORY	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Cancer						
Diabetes						
Blood Pressure						
Stroke						
Heart Disease						
Cholesterol						
Mental Illness						
Kidney						

HOSPITALIZATIONS	YEAR	SURGERIES	YEAR

Are you experiencing any of the following?

Y N
- ☐ ☐ Hearing problems
- ☐ ☐ Dizziness
- ☐ ☐ Vision problems
- ☐ ☐ Nose bleeds
- ☐ ☐ Sore throat
- ☐ ☐ Hoarseness
- ☐ ☐ Shortness of breath
- ☐ ☐ Chest Pain
- ☐ ☐ Swelling in the legs
- ☐ ☐ Leg Pain
- ☐ ☐ Appetite changes
- ☐ ☐ Heartburn
- ☐ ☐ Abdominal pain
- ☐ ☐ Diarrhea
- ☐ ☐ Vomiting
- ☐ ☐ Constipation
- ☐ ☐ Urinary problems
- ☐ ☐ Nighttime urination
- ☐ ☐ Weight changes.
- ☐ ☐ Fatigue
- ☐ ☐ Easy bruising
- ☐ ☐ Rash
- ☐ ☐ Depression
- ☐ ☐ Headaches
- ☐ ☐ Sleep problems
- ☐ ☐ Sexual problems

Have you ever been diagnosed with any of the following?

Y N
- ☐ ☐ Allergies
- ☐ ☐ Pneumonia
- ☐ ☐ COPD
- ☐ ☐ Asthma
- ☐ ☐ Anemia
- ☐ ☐ High blood pressure
- ☐ ☐ Heart murmur
- ☐ ☐ Ulcer
- ☐ ☐ Acid reflux
- ☐ ☐ Diverticulosis
- ☐ ☐ Kidney stones
- ☐ ☐ Frequent urine infections
- ☐ ☐ Cancer (Type_____)
- ☐ ☐ Diabetes
- ☐ ☐ Thyroid disease
- ☐ ☐ Arthritis
- ☐ ☐ Gout
- ☐ ☐ Seizures
- ☐ ☐ Depression
- ☐ ☐ Anxiety

Other history

_____
_____
_____

Smoking
How much?_____
How long?_____
When did you quit?_____

Alcohol
How much?_____
What kind?_____

Drug Use
What kind?_____
How often?_____

Exercise
How often?_____
What kind?_____

Coffee/Tea/Colas
cups per week?_____

FEMALE PATIENTS

Last period?_____

Last Pap?_____

Last mammo?_____

pregnancies?_____

children?_____

Joshua Z. Steiner, D.O., P.A.

PATIENT INFORMATION SHEET

Date Completed: _____/_____/_____

NAME: _____ SEX: _____ MARITAL STATUS: S M W D

BIRTHDATE: _____/_____/_____RELIGION: _____PRIMARY LANGUAGE:_____

REFERRED BY: _____

ADDRESS: _____

CITY_____ STATE _____ ZIP _____

HOME PHONE:_____ CELL PHONE: _____

EMAIL: _____

EMPLOYER/SCHOOL: _____

TITLE:_____WORK PHONE: _____

ADDRESS:_____

CITY/STATE/ZIP: _____

SPOUSE/PARTNER: _____ BIRTHDATE:_____

SPOUSE EMPLOYER/SCHOOL: _____ CITY/STATE: _____

SPOUSE PHONE:_____

RACE/ETHNICITY: Caucasian African American Native American Asian Hispanic Latino Other_____

Refuse to Answer

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY *OTHER THAN SOMEONE LIVING WITH YOU:*

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY INSURANCE: _____ ID #:_____

SECONDARY INSURANCE:_____ID #:_____

Joshua Z. Steiner, D.O., P.A.

PATIENT INSURANCE RESPONSIBILITY

I hereby authorize my insurance company to make payments directly to my physician and further permit a copy of this authorization to be used in place of the original. This authorization applies to all claims submitted by my physician. I hereby authorize my physician to release any information required in the course of examination and treatment. I further authorize my physician to release any of medical records to any insurance company that may request them. This includes all information of HIV, drug use, psychiatric treatment, or other problems. I understand that my physician will comply with all applicable HIPAA regulations. There is no time limit on this record release.

I understand that a physical exam, school exam, or pre-operative exam including lab and diagnostic testing may not be a covered benefit under my insurance. I will be held responsible for any payment due. I understand that I should check before any lab work, diagnostic tests, or specialist visit that the provider is still affiliated with my insurance company as these can and do change frequently. My physician will not be held responsible for the fees of any lab, diagnostic facility, or specialist that is not covered by my insurance for any reason. If I find that a service will not be covered. I should call the office for a new referral.

A 1.5% late payment charge may be added to all unpaid balances not paid within 30 days of request. In addition, if this account is delinquent and is forwarded to a collection agency or attorney, I agree to pay any and all costs.

I understand the following message from my physician: To avoid any misunderstanding regarding medical insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and the patient is personally responsible for payment of fees. As a courtesy, we will prepare the necessary forms to help you obtain your benefits from your insurance company. We do not render our services on the basis that insurance companies will pay our fee, except in instances such as with specific PPO/HMO groups. If the insurance company does not cover our fee in full, the balance is due and payable by you.

Please sign below to indicate that you have reviewed the above information and give Joshua Z. Steiner, D.O.. P.A. permission to treat you.

_____ _____

Patient Signature Date

_____

Patient Name (printed)

MEDICARE BENEFICIARIES ONLY

I request that payment of authorized Medicare benefits be made to my treating physician for any services rendered. I authorize any holder of medical information about me to release to the Center for Medicare Services and its agents any information needed to determine these benefits or benefits payable for related services.

_____ _____

Patient Signature Date

Joshua Z. Steiner, D.O., P.A.

OFFICE FINANCIAL POLICIES

In order to better serve your needs and clarify any questions that you may have regarding your insurance, we have adopted the following financial policies. If you have any questions, please speak with one of our billing or managerial staff, and she will gladly assist you.

We will gladly file your insurance claim. Copayments, deductibles, and co-insurance amounts are collected at the time of service. We will verify your insurance coverage at each visit. All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified, you will be responsible for all charges.

As a courtesy to you, insurance forms for services rendered will be completed by our office and submited to your primary insurance carrier. We will not file the secondary insurance – unless it is secondary to Medicare.

In the event that your health insurance plan determines a service to be "not covered", you will be responsible for the uncovered charge.

All forms and letters that we are asked to complete, including Disability forms, FMLA forms, Leave of Absence forms, jury duty excusals, letters regarding travel, and/or any requested correspondence that is not associated with reimbursement of a claim will incur a $25.00 fee to the patient.

NON-CANCELLATION OF APPOINTMENTS
There is a $25.00 charge to patients for a missed appointment without prior notice. Please call us no later than 9:00 AM on the day of your appointment to notify us of your cancellation.

RETURNED CHECK FEE
There is a charge of $50.00 in the event a check is returned for insufficient funds.

STATEMENT PROCEDURE
We will mail a statement to the address you have provided once we receive payment from your insurance carrier. If we do not have payment from you within 90 days, we will make every effort to notify you that the account is being turned over to our collection agency and may impact your credit rating.

MEDICAL RECORDS REQUEST
Any patient requesting records must submit a signed records release form and there will be a clerical fee of $1.00 per page to process.

I AGREE TO MY FINANCIAL RESPONSIBILITIES. I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICIES

_____ _____
Patient Signature Date

_____
Patient Name (printed)

Joshua Z. Steiner, D.O., P.A.

ALTERNATIVE COMMUNICATION RELEASE FORM

Patient Name: _____ Date of Birth_____

I authorize Joshua Z. Steiner, D.O., P. A. in regards to my protected health information (PHI):

(check as many as you wish)

[ ] To call me at work
[ ] To call me at home
[ ] To call my cell phone
[ ] To speak with anyone on the Right To Share Information list below
[ ] To speak only with me
[ ] To fax information to me at this secured number _____
[ ] Other_____

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Joshua Z. Steiner, D.O., P.A. reserves the right to communicate PHI with family or friends when it is deemed in the best interest of the patient as described in the Notice of Privacy. In order to have your PHI shared in other circumstances with members of your family or friends, please list below those individuals to whom we are authorized to release information.

_____

_____

_____

_____

_____

Signature of Patient_____ Date_____

Joshua Z. Steiner, D.O., P.A.
4410 Sheridan St.
Hollywood, Fl 33021

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____, have reviewed and read this office's Notice of Privacy Practices. I also give my authorization for this office to disclose any of my personal health information as necessary for treatment, payment, or other healthcare operations as detailed in this office's Notice of Privacy Practices.

_____ _____

Patient's signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign this form (initial____)

Communication barriers prohibited obtaining the acknowledgment (initial_____)

An emergency situation prevented us from obtaining the acknowledgment (initial____)

Joshua Z. Steiner, D.O., P.A.

MEDICAL STUDENT RELEASE

Dr. Steiner is proud to have been appointed a Clinical Assistant Professor at Florida International University College of Medicine and Adjunct Professor of Nova Southeastern University College of Osteopathic Medicine. From time to time, medical students spend time with all of the providers in this office to gain additional knowledge and hone their skills in the practice of medicine. These medical students may enter the exam room with the provider at the time of your exam.

All medical students adhere to the strictest rules of ethics and HIPAA confidentiality adhered to by all providers and staff in this office.

YOU WILL ALWAYS BE GIVEN THE OPPURTUNITY TO REQUEST THAT A MEDICAL STUDENT NOT BE PRESENT IN THE ROOM DURING YOUR EXAM. IF, AT ANY TIME DURING YOUR EXAM, YOU WOULD LIKE THE MEDICAL STUDENT TO LEAVE, YOU MAY REQUEST IT.

Today's medical students will be your children's and grandchildren's doctors tomorrow. Your help in assisting us to teach them benefits us all.

Thank you!

Dr Steiner and associates

I have reviewed this notice and understand my rights as entailed herein

Signature Date

Joshua Z. Steiner, D.O., P.A.

ANNUAL WELLNESS QUESTIONNAIRE

Date:_____Patient:_____DOB:_____

Patient Signature:_____

What other doctors have you seen in the current year? (Name and Specialty)

_____

_____

_____

_____

If you use other medical suppliers (Oxygen, CPAP, Home Health etc.) Please list those below:

_____

_____

_____

_____

	Circle One	
1. During the past month, have you often been bothered by feeling down, depressed or hopeless?	YES	NO
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	YES	NO
3. Have you fallen in the last year, are you afraid of falling	YES	NO
4. Do you have any complaints of balance problems or difficulty walking?	YES	NO
5. Do you have trouble hearing the television or radio when others do not?	YES	NO
6. Do you have to strain or struggle to hear / understand conversations?	YES	NO
7. Do you need help with preparing meals, transportation, shopping, taking your medicine, bathing, getting dressed, using the bathroom, moving around from place to place, managing your finances or other activities of daily living?	YES	NO
8. Do you live alone, do you feel safe in your home environment?	YES	NO
9. Does your home have throw rugs, poor lighting or a slippery bathtub/shower?	YES	NO
10. Does your home HAVE grab bars in bathrooms, handrails on stairs and steps?	YES	NO
11. Does your home HAVE functioning smoke alarms?	YES	NO
12. Do you have an Advance Directive (aka Living Will)?	YES	NO

13. Do you want information on Advance Directive? YES NO

14. How do you rate overall health the past 4 weeks? (Check One)

[ ] EXCELLENT, [ ] VERY GOOD, [ ] GOOD, [ ] FAIR, [ ] POOR

15. Can you manage your overall health problems? YES NO

16. In the past 2 weeks how often have you been bothered by the following: (Check One)

Feelings that caused you distress or the ability to get along socially with family and friends?

[ ] Not At All, [ ] Several Days, [ ] More Than Half The Days, [ ] Nearly Every Day.

Feeling stress over health, finances, relationships or work?

[ ] Not At All, [ ] Several Days, [ ] More Than Half The Days, [ ] Nearly Every Day.

Body pain? [ ] Not At All, [ ] Several Days, [ ] More Than Half The Days, [ ] Nearly Every Day.

Fatigue? [ ] Not At All, [ ] Several Days, [ ] More Than Half The Days, [ ] Nearly Every Day.

17. In the past 7 days, how many days did you exercise? (Circle One)

0 1 2 3 4 5 6 7 Days

18. In the past 7 days, how often did you eat 3 or more servings of fruits and vegetables in a day?

[ ] Not At All, [ ] Several Days, [ ] More Than Half The Days, [ ] Nearly Every Day.

19. In the past 7 days, how often did you eat 3 or more servings of high fiber or whole grain foods?

[ ] Not At All, [ ] Several Days, [ ] More Than Half The Days, [ ] Nearly Every Day.

20. How would you describe the condition of your mouth and teeth, including false teeth or dentures?

[ ] EXCELLENT, [ ]VERY GOOD, [ ]GOOD, [ ] FAIR, [ ] POOR

21. Please check any aids or devices that you usually use for any activities?

[ ] Cane, [ ] walker, [ ] wheelchair, [ ] crutches, [ ] special utensils, [ ] devises used for dressing,

[ ] None of the above.

22. Do you always use your seat belt in the car? YES NO

23. Do you wear special underwear due to leakage? YES NO

24.Have you experienced any memory issues? YES NO

25. Have any concerns about your memory been raised by family/friends? YES NO

Joshua Z. Steiner, D.O., P.A.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Date_____ Patient Name_____ Date of Birth_____

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:_____

Physician Signature _____ [ ]_____ _____F

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**
[ ]	[ ]	[ ]	[ ]

Care For Older Adults Assessment Form

Date:_____ **Patient:**_____ **Date of Birth**____ /____ /____

ID:_____

FUNCTIONAL ASSESSMENT (Circle those that apply)

Cognitive Status: EXCELLENT, DIMINISHED, DEMENTIA, ALZHEIMER'S, PARKINSONIAN, ALERT & ORIENTED _____

Ambulatory Status: EXCELLENT, GOOD, FAIR, RELIES ON ANOTHER PERSON, CANE, WALKER, WHEELCHAIR, SCOOTER, PROSTHETICS

Sensory Ability: (Please complete all three skill sets)

Hearing: EXCELLENT, GOOD, POOR, DEAF, HEARING AIDS OR DEVICE _____

Speech: EXCELLENT, GOOD, POOR, POST-STROKE SPEECH PATHOLOGY, STUTTER, MUTE, SLURRED, NORMAL _____

Vision: EXCELLENT, GOOD, POOR, GLASSES, CATARACTS, GLAUCOMA, MACULAR DEGENERATION, RETINOPATHY, _____

ACTIVITIES OF DAILY LIVING (ADL) (Circle YES or NO)

Patient Needs Help With: Grooming: Y/N **Dressing**: Y/N **Toilet** Y/N **Continent (bowl and bladder):** Y/N **Shopping** Y/N
Preparing meals: Y/N **Feeding**: Y/N **Walking:** Y/N **Bathing** Y/N **Transferring (in and out of chairs)** Y/N
Housework Y/N

The Patient Has:: Advance directives Y/N **Living will** Y/N **Surrogate decision letter** Y/N
Copy/Documented in chart Y/ N **Date discussed with patient/family member** _____ /_____ /_____

MEDICATION REVIEW/LIST (indicates YES or NO) --- A copy must be placed in the chart

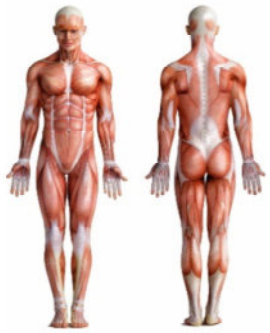
Medication review: Y/ N **Medication list** Y/ N

A **medication review** is a review of patient's medication A **medication list** is a list of patients medications

(Medications include prescription medication with dosage, frequency, start and stop dates over the counter (OTC) medications and herbal therapies or supplements. Counseling on medication also should be provided) Must have a medication list to accompany or reference to a separate medication list in the physician chart.

PAIN ASSESSMENT

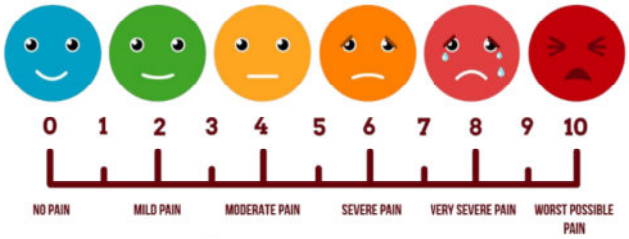
Please draw where the patient's primary pain is using the diagram below.



Chronic Pain: Y/N **Generalized Location: Yes/No**

If pain is localized, please circle at least one body part in the diagram at left.

Mark the Level of Pain



Date: ____/_____/_____ **Physician's Name:**_____ **Physician's Signature:**_____

CPT IDENTIFICATION CODES: Functional Status Assessment: CPT Cat II: 1170F Advance Directives: CPT II: 1157F, 1158F Pain Screening: CPT Cat II: 1125F. 1126F Medication Review CPT: 99605, 99606 CPT II: 1160F Medication List Cat II: 1159F

Please note: Medication review and medication list must be submitted together for the same date of service

Claims/Code Submitted Date: _____ **Initials:** _____

PATIENT'S CHART COPY