



A Department of Adena Regional Medical Center
4439 State Route 159 Suite 150
Chillicothe, OH 45601
Phone: (740) 779-4700
Fax: (740) 779-4798

WELCOME TO OUR CLINIC!

We are pleased that you have chosen Adena Internal Medicine as your medical home. Your health is our priority. We will make every effort to meet your expectations based on your individual healthcare needs. We are looking forward to establishing long-term relationships with our patients.

Enclosed you will find a health history form that needs completed and brought to your first visit. This information will be placed into electronic medical records to ensure accuracy for this visit and future visits. If you have any questions regarding this information, please speak to the receptionist. We must have a copy of current insurance card, a photo ID and current medications. If the patient is a child please provide us with a current shot record.

If your insurance does not pay for office calls or supplies, or if you have a copay, we ask that these services be paid at the time of the visit. As a courtesy to you, our office accepts personal checks, Visa, Master Card and Discover.

Payments are required at the time of service. This includes self pay and co-payment. Uninsured patients will be expected to pay a minimum of \$125.00 for new patient appointments and \$75.00 for established appointments at the time of service. If you are unable to pay at the time of service, please contact the office for financial aid information prior to your visit. Arrangements must be made prior to your appointment date.

If you no show for your new patient appointment, we will not be able to reschedule you at this clinic. Any patient that fails to arrive for a scheduled appointment without cancelling the appointment 24 hours prior to the scheduled time will be considered a "no show". Patients arriving more than 15 minutes past their appointment time may be asked to reschedule.

Chronic cancellations and/or no shows for scheduled appointments could result in a discharge from this clinic. Any patient that "no shows" 3 times in a 12 month period at this clinic will be sent through the discharge process.

We strive to see patients at their scheduled times; however, we ask for your understanding as emergencies do arise and may affect your provider's schedule. If this occurs, we will offer you the opportunity to wait or to reschedule your appointment. If you are ever waiting more than 15 minutes past your scheduled appointment, please let the receptionist know.

Our clinic is an NCQA recognized Patient Centered Medical Home. Enclosed you will find important information about your medical home and how it can help you become and stay healthy. Our clinic also offers our patients easy and secure access to their medical information online, so you can view your personal health record whenever and wherever you have access to the Internet.

If you receive a patient satisfaction survey via email or US Postal office, we would appreciate your response to the care you received. Your opinion matters to us. Thank you for choosing us as your healthcare provider.

***Wishing you the best of Health,
Adena Internal Medicine Providers and Staff***



REMINDER LIST

So that we may better serve you,
please arrive at least 15 minutes prior to your appointment time.

Additionally,
please bring the following with you to your upcoming appointment:

1. Completed Health History Form of Past and Present Medical Condition
2. Completed Authorization for Release of Information
3. Signed Patient Center Medical Home Pact Acknowledgement
4. Your current insurance card and applicable payment for services (ie, copay, coinsurance, balance)
5. A state issued photo ID
6. Your current medications (please bring your actual medications in their pharmacy bottle so that we may get the most accurate list of medications and dose)
7. List of Immunizations
8. Advanced Directive or Medical Durable Power of Attorney (*if applicable*)
9. Translator needs (*if applicable - please call us 2 business days prior to appointment*)
10. Email address so we can enroll you in patient portal for 24/7 access to your health information.

Thank you for choosing Adena Internal medicine. We look forward to serving you.



Patient Demographic Information

Name <i>(Last, First, M.I.):</i>		DOB:
Street Address:		Social Security No.
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Email:	Would you like to be web enabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your preferred method of contact? <input type="checkbox"/> Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Web Portal <input type="checkbox"/> Email <input type="checkbox"/> Text	Do you have an Advanced Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Transgender Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Employer:	Address:	
Emergency Contact:	Relationship:	
Emergency Contact Address:	Emergency Contact Phone:	
Responsible Party: <input type="checkbox"/> Self <input type="checkbox"/> Guarantor	Guarantor Name:	
Insurance Name:	Subscriber Number:	
Copay:	Insured Name:	Relationship to Patient:
Group Number:	Group Name:	
Do you have separate prescription coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, please bring card. If Mail order, bring member ID</i>	
Local Pharmacy:	Mail Order Pharmacy:	
Race:	Ethnicity:	Language: <i>If you require a translator, please let us know 2 business days prior to your appointment.</i>

Please list the names of people that we may discuss your healthcare information with. If not listed, we cannot not discuss any part of your healthcare with anyone calling on your behalf.

This remains in effect until revoked by you.

Name	Relationship	Phone Number

Office Use Only:		
<input type="checkbox"/> Photo ID scanned	<input type="checkbox"/> PCP Identified	<input type="checkbox"/> Consent
<input type="checkbox"/> Insurance scanned	<input type="checkbox"/> MSPQ	<input type="checkbox"/> Minor Consent
<input type="checkbox"/> Authorization of Information Complete	<input type="checkbox"/> Default Facility to PCP	<input type="checkbox"/> Web Enable
<input type="checkbox"/> Advance Directive	<input type="checkbox"/> PCMH Acknowledgement	

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Patient Name:	DOB:
Previous or referring doctor:	Date of last physical exam:
What would you like to discuss on your first visit? <input type="checkbox"/> Well Visit (preventive only) <input type="checkbox"/> Establish (Existing Chronic/Acute Condition)	
Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
Immunizations and dates:	
<input type="checkbox"/> Tetanus <input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Chickenpox/Shingles
<input type="checkbox"/> Influenza <input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (attach additional page if necessary)

Name the Drug	Strength	Frequency Taken

Medical History Please check all that apply.

Heart Problems	Have Now	Had in the Past
Heart Attack Year _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat (arrhythmias)	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify:	<input type="checkbox"/>	<input type="checkbox"/>
Bone and Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Fracture of Hip, Wrist, Spine (circle which one)	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify:	<input type="checkbox"/>	<input type="checkbox"/>

Gland Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid, Overactive (High)	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid, Underactive (Low)	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify:	<input type="checkbox"/>	<input type="checkbox"/>
Kidney and Urinary Tract Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Disease	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Bladder or Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify:	<input type="checkbox"/>	<input type="checkbox"/>

Allergies to medications

Name the Drug	Reaction You Had

Surgical History

Year	Reason / Type of Surgery	Hospital

Other hospitalizations

Year	Reason / Diagnosis	Hospital

Family History

		STATUS (LIVING/DECEASED)	AGE	SIGNIFICANT HEALTH PROBLEMS			STATUS (LIVING/DECEASED)	AGE	SIGNIFICANT HEALTH PROBLEMS	
Father					Children	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F				
										Mother
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F									
	<input type="checkbox"/> M <input type="checkbox"/> F									
	<input type="checkbox"/> M <input type="checkbox"/> F						Grandfather <i>Paternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F						Grandmother <i>Paternal</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F				Grandfather <i>Maternal</i>					
	<input type="checkbox"/> M <input type="checkbox"/> F				Grandmother <i>Maternal</i>					

Social History

Adult Functional Questionnaire:

Support System

Do you have a support system? Yes No (Circle All that Apply) Family / Friends / Home Health / Work / Church / Other _____

Home Safety

Do you feel you move safely around the community?

Yes No

Do you make safe decisions?

Yes No

Do you safely use small appliances?

Yes No

Do you feel safe in your home?

Yes No

Fall History

Have you fallen in the last six months?

Yes No

Active Daily Living

Do you need assistance with any of the following? (Circle All that Apply) Bathing / Dressing / Using the toilet / Eating / Moving around

Diet and Physical Activity

Are you currently on a diet or exercise plan?

Yes No

Caffeine

None

Coffee

Tea

Cola

of cups/cans per day?

Drug and Alcohol History:

Have you used drugs other than those for medical reasons in the past 12 months?

Yes No

Have you had a drink that contained alcohol in the past year?

Yes No

Depression Screening:

Do you have little interest/pleasure in doing things?

Yes No

Do you feel down, depressed or hopeless?

Yes No

PCMH Social History:

Do you understand your medication regimen?

Yes No

Do you have any barriers in adhering to your treatment plan?

Yes No

Do you need additional help with your care?

Yes No

Are you able to manage your care at home?

Yes No

Are all of your Over the Counter Medications on the list?

Yes No

Do you see any other providers?

Yes No

Tobacco History:

Do you use tobacco?

Yes No

of years _____

Cigarettes – pks./day

E-Cigarettes

Chew - #/day

Pipe - #/day

Cigars - #/day

Former tobacco user? year quit _____

Mark all that apply

Cigarettes

E-Cigarettes

Chew tobacco

Pipe

Cigars

Review of Systems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Constitutional

Fatigue Fever Night Sweats Unexplained weight loss

Eyes

Double Vision Eye Pain Visual Changes

Ear, Nose, Throat

Nasal Congestion Difficulty Swallowing Ear Pain Sore Throat

Endocrine

Cold Intolerance Excessive thirst

Respiratory

Shortness of breath Cough Bloody Sputum

Cardiovascular

Chest pain Irregular heart beat Palpitations

Gastrointestinal

Abdominal Pain Constipation Diarrhea Heartburn Nausea
 Blood in stool Vomiting

Hematology

Anemia Easy Bruising Prolonged Bleeding

Women

Abnormal Uterine Bleeding Pelvic Pain Breast Pain Irregular menses

Urinary

Blood in urine Frequent urination Painful urination

Musculoskeletal

Back Pain Difficulty Walking Joint Pain Joint Swelling

Skin

Dry Skin Changing Moles Rashes

Neurologic

Fainting Headaches Muscle Weakness Numbness/Tingling

Psychiatric

Anxiety Depression Insomnia/Sleeping Difficulty

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

Period every ____ days

Heavy periods, irregularity, spotting, pain, or discharge?

Yes No

Number of pregnancies ____ Number of live births ____

Are you pregnant or breastfeeding?

Yes No

Have you had a D&C, hysterectomy, or Cesarean?

Yes No

Any urinary tract, bladder, or kidney infections within the last year?

Yes No

Any blood in your urine?

Yes No

Any problems with control of urination?

Yes No

Any hot flashes or sweating at night?

Yes No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?

Yes No

Experienced any recent breast tenderness, lumps, or nipple discharge?

Yes No

Date of last mammogram?

Date: _____

Date of last pap and rectal exam?

MEN ONLY

Do you usually get up to urinate during the night?

Yes No

If yes, # of times ____

Do you feel pain or burning with urination?

Yes No

Any blood in your urine?

Yes No

Do you feel burning discharge from penis?

Yes No

Has the force of your urination decreased?

Yes No

Have you had any kidney, bladder, or prostate infections within the last 12 months?

Yes No

Do you have any problems emptying your bladder completely?

Yes No

Any difficulty with erection or ejaculation?

Yes No

Any testicle pain or swelling?

Yes No

Date of last prostate and rectal exam?

Yes No



PATIENT CENTERED MEDICAL HOME PACT

WELCOME

Welcome to Adena Health System's Patient Centered Medical Home. Caring for you is the most important job of your Patient Centered Medical Home. Your primary provider leads your personal Care Team, which may include a nurse practitioner, nurse and medical assistants. Working together, the team makes certain you receive the care you need.

A pact is an agreement about the roles and responsibilities for you, the patient, and us, the providers. This pact recognizes that neither party can solve problems without the other. This pact represents our commitment to work together towards a common goal.

Clinic hours:

Monday 8:00 am – 7:00 pm

Tuesday through Friday 8:00 am – 5:00 pm

GUIDE FOR PATIENTS

In the case of an emergency, we recommend you call 911

After Hours Care: If you have an urgent need that does not require IMMEDIATE treatment, please call our clinic at (740) 779-4700 to speak with the answering service. If you feel it is necessary to seek after hours care and it is NOT an emergency, please go to Adena Urgent Care with locations in Waverly, Chillicothe and Washington Court House.

- Adena Waverly Urgent Care, 12340 St. Rte. 104, Waverly, OH 45690
Sunday- Saturday Hours 10:00 a.m. to 8:00 p.m. Phone: (740) 941-5150
- Adena Western Avenue Urgent Care, 55 Centennial Blvd., Chillicothe, OH 45601
Sunday-Saturday Hours 10:00 a.m. to 8:00 p.m. Phone: (740) 779-4000
- The Adena Clinic at Wal-Mart- Chillicothe, 85 River Trace Lane, Chillicothe, OH 45601
Monday through Friday: 10 a.m. to 8 p.m. Phone: (740) 779-8995
Saturday: 10 a.m. to 7 p.m.
Sunday: Noon to 5 p.m.

- The Adena Clinic at Wal-Mart- Washington Court House, 1397 Leesburg Ave., Washington Court House, OH 43160
Monday through Friday: 10 a.m. to 8 p.m. Phone: (740) 333-4976
Saturday: 10 a.m. to 7 p.m.
Sunday: Noon to 5 p.m.

MAKING AN APPOINTMENT: Adena Internal Medicine now offers a new way to schedule appointments with your provider. You can now log onto www.adena.org/AIM and schedule from the comfort of your own home at any time of day or night. Click on your provider's name and choose "Request an Appointment." You can also call the clinic for an appointment at (740) 779-4700. We offer a variety of appointment types. We have same day illness appointments, wellness visits, chronic illness visits and even appointments specifically for things that may require more time; for example, follow up hospitalization.

LATE ARRIVING PATIENTS: In response to feedback on our patient satisfaction surveys, Adena Medical Group has created a policy that will request patients arrive on time for their scheduled appointments. Any patients arriving late will be worked into the schedule provided openings are available. We encourage patients to arrive 15 minutes early to prevent delays to other patients. This time allows us to update all of your information and make sure it is accurate. When you come for your visit, we ask that you bring your insurance cards, co-pay (if required), and a current list of medications. It is very helpful to bring your medication bottles with you to the office as well. If you are unable to make your appointment please call the clinic at least 24 hours in advance. If you cancel your appointment the same day as your scheduled appointment it will be considered a "No Show".

CANCELLATIONS: If you cannot keep your appointment, you will need to cancel the appointment 24-hours in advance. A cancellation that is made less than 24 hours from your appointment time will be counted as a "no show" appointment. A "no show" appointment is not acceptable and three (3) no shows within 12 months may result in a dismissal from the practice. As a new patient, if you are a "no show" for your first appointment, then no other appointment will be scheduled.

WELLNESS VISITS: If you need to schedule a "Wellness Visit", please make sure you let us know when scheduling your appointment. Insurance companies require specific information for these visits and will only cover certain items; therefore, if you have other needs, you may need to schedule an additional appointment to address those concerns. If both concerns are addressed during the "Wellness Visit", it cannot be billed as a "Wellness Visit" and the insurance will not pay as a "Wellness Visit". Not all labs that are ordered are paid under a wellness code. It is the patient's responsibility to know and understand his/her benefits. Please check with your insurance to verify that each lab and diagnosis ordered are covered under the "Wellness Visit".

Prescription Refills:

- When refills are needed, you must first call your pharmacy and have your medication request sent to us for approval.

- You must plan ahead and give our providers **2 BUSINESS DAYS** notice to complete prescription requests.
- Please first contact your pharmacy after **2 BUSINESS DAYS** to see if your prescription refill is ready. Phone calls to the provider's office before the **2 BUSINESS DAYS** may result in a delay of your prescription refill being processed.
- If you have an appointment, please address the medication refill with the providers at that time.
- Narcotics will only be filled by your primary physician upon his or her discretion without an appointment.
- Narcotic refills will never be issued by the on-call physician after hours or on the weekends.
- Please do not call the answering service for prescription refills.
- All refills are subject to denial at the discretion of the provider without an appointment.

ADDITIONAL SERVICES: Adena Internal Medicine does offer a variety of services to make your visit easier for you. We can provide interpretive services for patients with limited English proficiency. Our interpreters can facilitate communication with healthcare providers through most foreign languages and American Sign Language. If these services are needed for scheduled visits, please notify us at least 2 business days in advance.

Wheelchairs are located near the entrance for anyone who needs to use them during his or her visit with us.

Please alert our staff if you have additional needs so we can better serve you, such as low-vision or hearing loss.

If you believe you qualify for financial assistance or wish to speak to a financial counselor, call (740) 779-8786 or (740) 779-7960 to make an appointment. We also have an extensive listing of local community resources that can help you with your non-medical needs.

SHARING INFORMATION

AS A PATIENT,

- I will write down a list of concerns and questions to talk about with my provider before each medical visit.
- I will report accurately on my problem, such as: How long has it been going on? How severe is it? How does it affect me?
- I will bring a list of all current medications and doses, including vitamins, supplements and other products.
- I will be ready to let my provider know if my medications are helping me or if I am having problems with them.
- I will ask questions when explanations and next steps are not clear before leaving my appointment.
- I will tell my provider when I get care somewhere else. For example, if I go to the emergency room or see a specialist that my provider did not refer me to, I will authorize those providers to share this information with my medical home provider.

AS A PROVIDER,

- We will specifically ask what the patient's concerns and questions are for the visit. We will respond to concerns and answer questions.
- We will provide a safe setting for talking about confidential concerns. We may ask about mental and physical symptoms, substance use, changes since last visit and progress in previous treatment plans.
- We will review your list of medications and ask how they are working. We will make a plan with you for refills, substitutions, and discontinuation.
- We will ask you to describe your understanding of what we have discussed or explained during the visit.
- We will ask you if you have consulted with other doctors or providers. We want to ensure that medical information is safely and appropriately shared with other providers and institutions when needed.
- We will discuss your health and family history.

SHARED DECISION MAKING

AS A PATIENT,

- I will ask about and consider information about how different treatments or tests might affect me.
- I will agree on a plan of care with my provider.
- I will follow-through on referral for treatment and testing.
- I will ask my provider to help me get other expert opinions on my condition, if needed, and to develop a plan of care before starting treatment.

AS A PROVIDER,

- We will describe the benefits and risks of treatments and tests.
- We will agree on a plan of care with you.
- We will explain our reasons for advising any treatments and tests.
- We will provide or direct you to resources for additional information and support.
- We will make and record referrals and provide contact information for them.
- We will discuss how you will monitor and revise your plan of care.
- We will provide guidance and referrals, if necessary, when other opinions are needed.

RESPONSIBILITY FOR CARE

AS A PATIENT,

- I will fill or refill prescriptions on time.
- I will use medications or devices as directed.
- I will monitor whether medications or devices are working and report any side effects.
- I will consult with my provider before I stop taking any prescribed medications or change the way I am taking them.
- I will discuss with my provider whether I should get immunizations (such as a flu shot) or screening tests (such as a mammogram or colonoscopy)

AS A PROVIDER,

- We will ensure that you receive the right medication at the right dose and that any new medications do not conflict with your current medications.
- We will ask you if your medications are working or if you are having any side-effects.
- We will make recommendations for immunizations.
- We will make recommendations for screening and early detection tests.



I acknowledge receipt of the Adena Patient Centered Medical Home (PCMH) information. I understand that there are responsibilities of me as a patient participating in the PCMH.

Signature

Date

Printed name