100 Indian Ridge Dr., Suite 1
Piketon, OH 45661
Office Phone (740) 947-6480
Office Fax (740) 289-3989

WELCOME TO OUR CLINIC!

We are pleased that you have chosen Adena Family Medicine – Piketon 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.

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 Family Medicine - Piketon
Providers & Staff

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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 Family Medicine - Piketon. We look forward to serving you.

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Patient Demographic Information

Name *(Last, First, M.I.):*			**DOB:**
Street Address:			**Social Security No.**
City:	**State:**	**Zip:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
Email:			**Would you like to be web enabled?** ☐ Yes ☐ No
What is your preferred method of contact? ☐ **Email** ☐ **Phone** ☐ **Cell Phone** ☐ **Web Portal** ☐ **Text**			**Do you have an Advanced Directive?** ☐ Yes ☐ No
Sex: ☐ M ☐ F ☐ Transgender	**Marital Status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Employer:			**Address:**
Emergency Contact:			**Relationship:**
Emergency Contact Address:			**Emergency Contact Phone:**
Responsible Party: ☐ Self ☐ Guarantor			**Guarantor Name:**
Insurance Name:			**Subscriber Number:**
Copay:	**Insured Name:**		**Relationship to Patient:**
Group Number:			**Group Name:**
Do you have separate prescription coverage? ☐ Yes ☐ No			*If yes, please bring card. If Mail order, bring member ID*
Local Pharmacy:			**Mail Order Pharmacy:**
Race:	**Ethnicity:**	**Language:**	*If you require a translator, please let us know 48 hours prior to your appointment.*

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:

☐ Photo ID scanned
☐ Insurance scanned
☐ Authorization of Information Complete
☐ Advance Directive
☐ PCP Identified
☐ MSPQ
☐ Default Facility to PCP
☐ PCMH Acknowledgement
☐ Consent
☐ Minor Consent
☐ Web Enable

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?	☐ Well Visit (preventive only) ☐ Establish (Existing Chronic/Acute Condition)
Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio
Immunizations and dates:	☐ Tetanus ☐ Pneumonia ☐ Influenza ☐ Hepatitis ☐ Chickenpox/Shingles ☐ MMR *Measles, Mumps, Rubella*

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 _____	☐	☐
Heart Failure	☐	☐
High Blood Pressure	☐	☐
Irregular Heart Beat (arrhythmias)	☐	☐
Other, Specify	☐	☐
Lung Problems	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Other, Specify:	☐	☐
Bone and Joint Problems	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Fracture of Hip, Wrist, Spine (circle which one)	☐	☐
Gout	☐	☐
Other, Specify:	☐	☐

Gland Problems	☐	☐
Diabetes	☐	☐
Thyroid, Overactive (High)	☐	☐
Thyroid, Underactive (Low)	☐	☐
Other, Specify:	☐	☐
Kidney and Urinary Tract Problems	☐	☐
Kidney Disease	☐	☐
Prostate Disease	☐	☐
Frequent Bladder or Kidney Infection	☐	☐
Urinary Incontinence	☐	☐
Other, Specify:	☐	☐

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	☐ M ☐ F			
Mother						☐ M ☐ F			
Sibling	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F				**Grandfather** *Paternal*				
	☐ M ☐ F				**Grandmother** *Paternal*				
	☐ M ☐ F				**Grandfather** *Maternal*				
	☐ M ☐ F				**Grandmother** *Maternal*				

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 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

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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.

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 office at (740) 947-6480 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 Family Medicine – Piketon now offers a new way to schedule appointments with your provider. You can now log onto www.adena.org/amgpiketon 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 office for an appointment at (740) 947-6480. 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 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 and may require 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 Family Medicine – Piketon 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 48 hours 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.

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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