WINDSONG
PRIMARY CARE

INSTRUCTIONS FOR PHYSICAL EXAM

Please bring with you the day of your appointment:

1. Completed demographic, needs to be update yearly, annual screening questionnaires, and Notice of Privacy and Consents acknowledgement.
2. Updated medication list. If you have questions about what you take, please bring all medication bottles with you to your appointment.
3. Stool test, if ordered, and provided in this packet. **(Return to our office)**
4. Copy of your living will, health care POA, and DNR, if applicable and not already shared previously.

On the day of your appointment:

You may have an EKG: Avoid using lotions on your skin to ensure proper contact of the electrodes. (If you see a cardiologist, or have had a normal EKG in the past, this may not be needed.)

Women: If you are due for a pap smear, DO NOT douche for 48 hours prior to your appointment.

Urinalysis: We will perform this in the office if needed. If diabetic, you may have a urinalysis at the lab and the office.

Fasting labs: Using the order provided, please complete the FASTING labs between 1 month and 1 week prior to your appointment.

Your appointment is scheduled for:

DAY:_____DATE:_____

ARRIVAL TIME:_____APPOINTMENT TIME:_____

3221 N WINDSONG DR PRESCOTT VALLEY, AZ 86314 - PHONE 928-910-7010 - FAX 928-910-7011

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If you need to reschedule, we ask that you notify us 24 hours in advance.

We ask that you check in 30 minutes prior to your

appointment time for clinical preparation.

Services that may be rendered during your Physical Exam and Annual Wellness Visit.

For Medicare patients:

1. Office visit – treatment of chronic or acute conditions, and possible head to toe exam. Codes that you **may** see: 99212, 99213, 99214, and 99215. Provider determines code based on treatment. These codes are subject to deductible and co-insurance responsibilities.
2. Medicare Welcome to Medicare or Annual Wellness Visit. Codes that you **may** see: G0402, G0438, G0439, 99397, G0403, G0442, and G0444 – these codes are covered completely by Medicare and cover only preventive portion of your physical. This exam is limited to basic vitals, review of health risks, update to your medical history and family history, update to your medical provider list, cognitive assessment, depression and alcohol use screening, review of functional status, update preventive service schedule, review of risk factors, and action required based on any findings.
3. 93000 for EKG, G0328 for stool card, and 81002 for urinalysis.
4. 99497 for living will discussion, if performed.

For Commercial patients:

1. Office visit – treatment of multiple extensive chronic or acute conditions. Codes that you **may** see: 99212, 99213, 99214, and 99215. Provider determines code based on treatment. These codes are subject to deductible and co-insurance responsibilities.
2. Annual Physical codes that you **may** see: 99395, 99396, 99397 (based on age). 93000 – EKG, 82274 – stool card, 81002 – urinalysis in office. 99408, 99420, & 99497 – Alcohol & Depression screening, and Living Will Discussion.

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Patient Information:

Last Name: _____ First Name: _____ MI: _____

Social Security #: ____ - ___ - ____ Maiden or any other name(s): _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

May we leave messages on your voicemail(s): _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Please specify: _____

Marital Status (circle one): Divorced / Married / Partner / Single / Unknown / Widowed / Legally Separated

Spouse/Partner name: _____

Employer Name: _____ Employer Phone #: _____

Additional information:

Mailing address (if different from above): _____

Email address: _____

Race: _____ ☐ Declined to specify

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to specify

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred Pharmacy Name and Location: _____

Permissions:

Who do we have permission to speak to regarding your health information, both medical and administrative?

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Patient Signature: _____ **Date:** _____

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Financial information:

Responsible Party Name: _____

Invoice address: _____

Responsibly Party Contact Phone Number: _____

*****If you have benefits under someone other than yourself, please make sure to complete.**

*****If you are the beneficiary and have provided copies of your cards, you may skip.**

Primary Insurance Company Name: _____Co-Pay? _____

Policy Holders Name (if not the patient): _____

Insurance Company ID number: _____

Secondary Insurance Company Name (if applies): _____Co-Pay? _____

Policy Holders Name (if not the patient): _____

Insurance Company ID number: _____

Please initial each box:

☐ I understand that it is my responsibility to update the Windsong Primary Care / Windsong Physical Therapy with any changes to all the above information.

☐ The information printed above regarding my demographic and financial information is correct to the best of my knowledge. I authorize Windsong Primary Care / Windsong Physical Therapy, which is a DBA entity of Davis Orthopaedics, LLC to bill my health insurance for all services rendered. I give permission to furnish my information to my insurance company regarding my treatment.

Patient Signature: _____ **Date:** _____

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

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Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our uses and Disclosures:

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

  Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:

  - Preventing disease • Helping with product recalls • Reporting adverse reactions to medications

  - Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

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• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

• We can use or share health information about you:

• For workers' compensation claims

• For law enforcement purposes or with a law enforcement official

• With health oversight agencies for activities authorized by law

• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

- Effective 04/20/2020
- Questions about this notice, please contact: Windsong Primary Care & Windsong Physical Therapy
  Attn: Practice Manager

  3221 N Windsong Drive

  Prescott Valley, AZ 86314

  (928) 910-7010

- Windsong Primary Care and Windsong Physical Therapy DBA's of Davis Orthopaedics, LLC will never market or sell your information.
- If you provide us with your personal email, we can provide access to our patient portal where you will have access to your chart, medication lists and be able to make changes to your demographic information.

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Acknowledgement and Consents (Please initial each box):

☐ I acknowledge that I have received a copy Notice of Privacy Practices.

☐ Windsong Primary Care / Windsong Physical Therapy, which is a DBA entity of Davis Orthopaedics, LLC is contracted with most major insurances. I acknowledge that it is my responsibility as the patient and the insured to know the provisions of my insurance, who is contracted, the plan coverage, my deductible, co-insurances, and co-pays. If we are contracted with your insurance, we must follow our contract and the requirements. If you have a co-pay, copays are due at the time of service and will be collected upon check in. If we are not contracted with your plan, we will follow the Windsong Primary Care / Windsong Physical Therapy Self Pay fee schedule and the fees will be collected at the time of service.

☐ I acknowledge that I am financially responsible for payment of any services that are not covered, including deductibles, co-pays, co-insurances, and uncovered services. Returned checks are subject to a $35 return check fee.

☐ I acknowledge that it is asked of me to provide at least 24 hours when cancelling an appointment. There are times that this cannot be done but if a pattern arises, we will discuss it with you. If it happens again, a no-show charge of $35.00 may be assessed. This same charge may be assessed if you continuously arrive late to an appointment. You may not be seen depending on the circumstances.

☐ I acknowledge that there is a $35.00 no show fee for missed appointments.

☐ I acknowledge that if I have an HMO health insurance plan and I need to see another medical provider, that it is my responsibility to contact Windsong Primary Care at least 3 business days in advance. This is to notify them and request them to obtain an online referral with the HMO insurance. If I have not been referred to this medical provider prior, I may need an appointment to discuss and have documentation for my insurance.

☐ I (or my authorized representative) give general consent to treatment. I authorize Windsong Primary Care & Windsong Physical therapy and the staff to conduct diagnostic examinations, test and procedures and to provide any medications or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my disease, illness or injuries. I acknowledge that I will be recommended that I have yearly physical examinations.

☐ In giving my general consent to treatment, I acknowledge that I retain the right to refuse any examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers.

☐ As a medical practice not only do we have a responsibility to care for you, our patient, to the best of our abilities, but we have a responsibility to create a work environment to where our employees are treated with courtesy and respect. As such, no verbal or physical violence, threats, or harassment towards any employee, by phone or in person will be tolerated and is grounds for immediate dismissal from the practice without other written notice than is here written.

☐ I acknowledge that Windsong Primary Care will not prescribe long term pain medications. Every patient will have a full medication review with their provider and a notification of prescriptions that will either be prescribed, or a referral will be given to an appropriate prescribing provider. Only a 30-day temporary fill may be given.

Patient Signature: _____ **Date:** _____

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

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Medication List and Renewal Sheet

Please fill in all information as detailed as possible

Name (Printed):_____Date of Birth:_____

Date: _____Provider (MD or NP) name:_____

Medication Allergies: _____

Other Allergies: _____

Prescribed Medications:

Medication Name	Dose	Directions	Name of Prescriber	Needs Refilled
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Local Pharmacy Name: _____

Address:_____ City: _____ St:___ Zip: _____

Phone Number: _____Fax Number: _____

Mail Order Pharmacy Name: _____

Address:_____ City: _____ St:_____ Zip: _____

Phone Number: _____Fax Number: _____

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Over the Counter Medications and Supplements

OTC & Supplements	Dose	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Other Information:

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IF YOU DON'T DRINK ALCOHOL CHECK HERE____SKIP TO PHQ-9

Alcohol Use Questionnaire

When talking with others, do you ever underestimate how much you drink?	Yes	No
After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?		
Does having a few drinks help decrease your shakiness or tremors?		
Does alcohol sometimes make it hard for you to remember parts of the day?		
Do you usually take a drink to relax or calm your nerves?		
Do you drink to take your mind off your problems?		
Have you ever increased your drinking after experiencing a loss in your life?		
Has a doctor or nurse ever said they were worried or concerned about your drinking?		
Have you ever made rules to manage your drinking?		
When you feel lonely, does having a drink help?		

Total Score_____

If you answered **"yes"** to two of the above questions, **please complete the audit questionnaire below.**

How often do you have a drink containing alcohol?		How many standard drinks containing alcohol do you have on a typical day?		How often do you have six or more drinks on one occasion?	
	Never (0 points)		None, I don't drink (0 points)		Never (0 points)
	Monthly or less (1 point)		1 or 2 (0 points)		Less than monthly (1 point)
	2-4 times a month (2 points)		3 or 4 (1 point)		Monthly (2 points)
	2-3 times a week (3 points)		5 or 6 (2 points)		Weekly (3 points)
	Four or more times a week (4 points)		7 to 9 (3 points)		Daily or almost daily (4 points)
			10 or more (4 points)		

Total Score _____

In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive.

PHQ-9

Low Mood	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things.				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling/staying asleep, sleeping too much				
4. Feeling tired or having little energy				
5. Feeling bad about yourself; that you are a failure or have let your family down				
6. Poor appetite or overeating				
7. Trouble concentrating on things, such as reading the newspaper or watching television				

NAME:_____**DOB:**_____**DATE::**_____

Low Mood	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety/restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
Total Score:				

0-4 Normal 5-9 Mild 10-14 Moderate 15-19 Moderate to Severe 20-27 Severe

GAD-7

Low Mood	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
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
Total Score:				

>/= 10 Probably diagnosis of GAD further examination needed - **5** Mild anxiety - **10** Moderate anxiety - **15** Severe Anxiety

Activities of Daily Living (ADL)

ADL Function	Independent	Needs Help	Dependent	Cannot Do
Bathing				
Grooming				
Mouth Care				
Toileting				
Transferring Bed/Chair				
Walking				
Climbing stairs				
Eating				
Shopping				
Cooking				
Managing medications				
Using the phone and looking up numbers				
Doing housework				
Driving or using public transportation				
Managing finances				

NAME:_____**DOB:**_____**DATE::**_____

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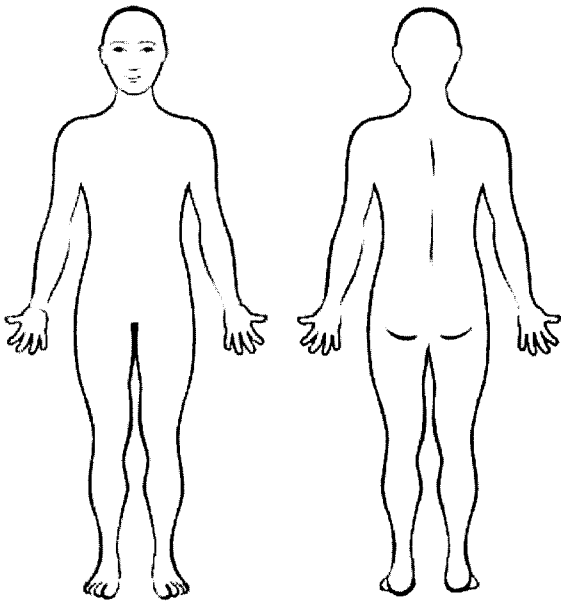
Pain Assessment

Do you have pain? Yes _____No_____ If your answer is No, then please disregard the rest of this questionnaire. If yes, please mark on the diagram where you feel pain.



1. Circle the number that best describes your pain at the **worst** in the past 24 hours.
   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Pain as bad as you can imagine

2. Circle the number that describes your pain at it's **least** in the past 24 hours.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Pain as bad as you can imagine

3. Circle the number that is your pain on **average.**

   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Pain as bad as you can imagine

5. Circle the number that is your pain **right now.**

   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Pain as bad as you can imagine

6. Circle the number that best describes your pain at **the worst in the past 24 hours.**
   0 1 2 3 4 5 6 7 8 9 10

   No Pain — Pain as bad as you can imagine

NAME:_____**DOB:**_____**DATE::**_____

7. What treatments or medications are you receiving for your pain?

_____
_____
_____
_____
_____

8. How much relief have the pain measures given you in the past 24 hours?

0 1 2 3 4 5 6 7 8 9 10

No relief — Complete relief

9. Circle the number that describes how pain has **interfered in your life in the last 24 hours.**

General Activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Normal work – outside the home and housework

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Fall History

Do you currently or have you had in the past any of the following?

Yes	No	
		Falls in the past year?
		Feel unsteady or worry about falling when standing or walking?
		Have you gone to the ER in the past year because of a fall?
		Do you take exercise classes or do any balance exercises?

Medical Conditions

Yes	No	
		Surgery on your back, knees, or feet?
		Pain in your back, knees, or feet?
		Cognitive impairment?
		Incontinence?
		Depression?
		Poor vision?
		Problems with heart rate and/or rhythm?
		An eye exam within the last year?

Medications

Yes	No	
		CNS or psychoactive medications? (sleeping, anxiety, or narcotic pain medications)
		Medications that can cause sedations or confusion?
		Medications that cause hypotension (low blood pressure)?

Additional information:_____

_____

_____

_____

_____

_____

_____

NAME:_____**DOB:**_____**DATE::**_____