CHHABRA MEDICAL CORPORATION PC

Portage Health Center
6375 U S Hwy 6
Portage. IN 46368
219.762.3196 / 219.763.6438 Fax

Hobart Health Center
7835 Grand Blvd
Hobart, IN 46342
219.769.2258 / 219.769.2743 Fax

B. Chhabra, MD Family Practice
M. Geeta, MD Family Practice

S. Meeks, NP Family Nurse Practitioner
K. Kozub, NP Family Nurse Practitioner
S. Wojcik, NP Family Nurse Practitioner

ACCT: _____

PATIENT INFORMATION ***PLEASE PRINT***

LAST NAME_____ FIRST_____ MI_____

DOB: _____ SEX_____

ADDRESS: _____CITY_____STATE_____ZIP_____

EMPLOYED YES___NO___ EMPLOYER/SCHOOL _____ HOME PHONE: (__)_____ CELL PHONE: (__)_____ WORK PHONE: (__)_____

RACE_____ SOCIAL SECURITY#_____-_____-_____ MARITAL STATUS (M) (S) (W) (D) (O)

LANGUAGE SPOKEN_____EMAIL_____SMOKE Y/N

PARENT/INSURANCE POLICY HOLDER INFORMATION

LAST NAME FIRST MI SEX

_____

ADDRESS_____CITY_____STATE_____ZIP_____

DATE OF BIRTH ___/___/___ SOCIAL SECURITY# ___-___-___ EMPLOYED YES__NO___ EMPLOYER _____ HOME/CELL PHONE # _____

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

RESPONSIBILITY PARTY SIGNATURE **TODAY'S DATE**

X_____ _____/_____/_____

FOR EMERGENCIES-PLEASE NAME NEAREST RELATIVE NOT LIVING WITH YOU

LAST NAME_____FIRST NAME_____MI_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

HOME ( ) _____WORK PHONE ( ) _____
RELATIONSHIP_____

REFERRED BY – CHECK HERE IF REFERRED BY DOCTOR ( )

LAST NAME_____FIRST_____ADDRESS_____TELEPHONE_____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE NAMED INDIVIDUAL FOR PROFESSIONAL SERVICES RENDERED. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO CHHABRA MEDICAL CORP ON MY BEHALF FOR ANY SERVICES FURNISHED ME BY THEIR PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENT ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I REQUEST THAT PAYMENT OF MEDIGAP BENEFITS BE MADE ON MY BEHALF TO CHHABRA MEDICAL CORP FOR ANY SERVICES FURNISHED ME BY THEIR PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO _____ (MEDIGAP INSURANCE) ANY MEDICAL INFORMATION NEEDED TO DETERMINE THESE BENEIFTS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED: _____ DATE: _____

AUTHORIZATION AND ACKNOWLEDGEMENT

I RECOGNIZE AND ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL SERVICES RENDERED AND FUTHER AUTHORIZE THE INSURANCE COMPANY TO PAY BENEFITS DIRECTLY TO THE PHYSICIAN. ALL COSTS OF COLLECTION INCURRED FOR OVERDUE ACCOUNTS ARE AGREED TO BE PAID BY RESPONSIBLE PARTY; INCLUDING, BUT NOT LIMITED TO COURT COSTS, REASONABLE ATTORNEY FEES, AND ALL OTHER LITIGATION EXPENSES.

SIGNED: _____ DATE: _____

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Family Practice

S. Meeks, NP
Family Nurse Practitioner

Kozub, NP
Family Nurse Practitioner

S. Wojcik, NP
Family Nurse Practitioner

MEDICAL HISTORY

NAME: _____ DATE: _____
ADDRESS: _____
PHONE: _____ WORK: _____
EMAIL: _____
AGE: _____ SEX: _____ DOB: _____

PERSONAL HISTORY:

Please circle Yes or No- if YES, please explain		
Diabetes Mellitus Type 2 (NON-Insulin Dependent)	Yes	No
Diabetes Mellitus Type 1 (Insulin Dependent)	Yes	No
Hypertension (High Blood Pressure)	Yes	No
Hypotension (Low Blood Pressure)	Yes	No
Hypertensive Heart Disease	Yes	No
Renal Arterial Hypertension	Yes	No
Heart Disease (Coronary Artery Disease)	Yes	No
Heart Valve Disease	Yes	No
High Cholesterol	Yes	No
Conductive Disorder of the Heart (Irregular Heart Beat)	Yes	No
Peripheral Vascular Disease (Poor Circulation)	Yes	No
Obstructive Sleep Apnea	Yes	No
Cerebrovascular Disease (Stroke or Mini-Stroke)	Yes	No
Blood Clotting Disorder	Yes	No
Hypothyroidism (Low Thyroid Function)	Yes	No
Disease of the Parathyroid Gland (Disorder Calcium Metabolism)	Yes	No
Hepatitis A	Yes	No
Hepatitis B	Yes	No
Hepatitis C	Yes	No
Alcoholic Hepatitis	Yes	No
Chronic Diarrhea (Loose Stools)	Yes	No
Abdominal Pain	Yes	No
Hiatal Hernia	Yes	No
Stomach Ulcer	Yes	No
Osteoarthritis	Yes	No

Name: _____ DOB: _____

Cyst of Ovary	Yes	No
Tumor Producing Hormones	Yes	No
Upper Back Pain	Yes	No
Lower Back Pain	Yes	No
Basal Cell Carcinoma	Yes	No
Squamous Cell Carcinoma (Skin)	Yes	No
Melanocytic Nevus (Pigmented Moles)	Yes	No
Malignant Neoplasm (Cancer)	Yes	No
Weight Gain: _____ lbs in the last 3 months	Yes	No
Weight Loss: _____ lbs in the last 3 months	Yes	No
Prostatitis	Yes	No
Enlarged Prostate	Yes	No
Other Personal Medical History:		
SURGICAL HISTORY:		
Bariatric Surgery: Date/Year	Yes	No
Bladder Prolapse	Yes	No
Rectal Prolapse Repair	Yes	No
Vaginal Surgery	Yes	No
Removal of Ovary	Yes	No
Hysterectomy	Yes	No
Cesarean Section	Yes	No
Prostate Surgery	Yes	No
Male Sterilization	Yes	No
Hernia Repair	Yes	No
Circumcision	Yes	No
Heart Stent: Date/Year	Yes	No
Open Heart Surgery: Date/Year	Yes	No
Cardiac Catheterization: Date/Year	Yes	No
Esophagogastroduodenoscopy (EGD): Date/Year	Yes	No
Colonoscopy: Most Recent Date:	Yes	No
Cataract	Yes	No
Cryosurgery	Yes	No
Breast Surgery: Date/Year	Yes	No
Tonsillectomy	Yes	No
Adenoidectomy	Yes	No

Name: _____ DOB: _____

Colposcopy	Yes	No
Cholecystectomy (Gallbladder Removal)	Yes	No
Appendectomy: Date/Year	Yes	No
Other Surgical History:		
HABITS:		
Alcohol Use: Type: _____ How Much: _____ How Often: _____	Yes	No
Smoking: How Much: _____ How Often: _____ How Long: _____	Yes	No
Drug Usage: Type: _____ How: _____	Yes	No
Narcotic Drug Usage: Name: _____ Frequency: _____ How Long: _____	Yes	No
Exercise: Type: _____ How Often: _____ How Long:_____	Yes	No
Sleep Problems: How often: _____ How Long: _____ Symptoms (*i.e., snoring, apnea, daytime sleepiness, headaches, etc*):	Yes	No
Other Habits:		
SOCIAL HISTORY:		
Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Other: _____		
Living Situation: Alone _____ W/Spouse _____ W/Roommate _____ W/Family _____ Other: _____		
Additional Social History:		

Name: _____ DOB: _____

FAMILY HISTORY:

Please circle Yes or No- if YES, please state relationship *(i.e. mom, dad, sister, brother, etc)*		
Diabetes Mellitus 1 (Insulin Dependent)	Yes	No
Diabetes Mellitus 2 (Non-Insulin Dependent)	Yes	No
Hypertension (High Blood Pressure)	Yes	No
Aneurysm of Heart/Blood Vessels	Yes	No
Conductive Disorder of the Heart (Irregular Heart Beat)	Yes	No
Heart Failure	Yes	No
Ischemic Heart Disorder (Coronary Artery Disease)	Yes	No
Bleeding/Coagulation Disorder	Yes	No
High Cholesterol	Yes	No
Valvular Heart Disease (Heart Valve Disease)	Yes	No
Congenital Heart Disease	Yes	No
Sleep Apnea Syndrome	Yes	No
Hypothyroidism (Low Thyroid Function)	Yes	No
Kidney Disease	Yes	No
Polycystic Kidney Disease	Yes	No
Osteoporosis	Yes	No
Osteoarthritis	Yes	No
Basal Cell Carcinoma Skin	Yes	No
Malignant Neoplasm (Cancer, specify location)	Yes	No
Seizure Disorder (Specify Type)	Yes	No
Mental Disorder (Specify Type)	Yes	No
Other Family History:		

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MEDICATIONS

NAME: _____ DOB: _____

Pharmacy:_____ Pharmacy Phone Number: _____

Address: _____

ALT Pharmacy: _____

PRESCRIPTIONS:		
Name:	Dosage:	Frequency:
NON-PRESCRIPTIONS:		
Name:	Dosage:	Frequency:
ALLERGIES:		
Medications:		
Other:		

Medications List updated 08/01/2021

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NAME: _____ **D.O.B:** _____ **DATE:** _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by 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	0	1	2	3
Add columns		+	+	

TOTAL:

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

10. 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	_____

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**Over half the days**	**Nearly every day**
1. Feeling nervious, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med* 2006; 166:1092-1097

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The Alcohol Use Disorders Identification Test

Answer the following question regarding your use of alcoholic beverages during this past year. Examples of "alcoholic beverages" are beer, wine, vodka, etc.

1. How often do you have a drink containing alcohol?
   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 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 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 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

   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never [Skip to Qs 9-10]
   (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 from you because of drinking?
   (0) Never [Skip to Qs 9-10]
   (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 in the morning to get yourself going after a heavy drinking sessions?
   (0) Never
   (1) Less than Monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guild 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 y ear have you been unable to remember what happened the night before because you had been 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 a result of your drinking?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
    (0) No
    (1) Yes, but not in the last year
    (2) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual

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Tobacco Assessment Form

How soon after waking do you smoke your first cigarette?	Within 5 minutes 5-30 minutes 31-60 minutes	3 ❑ 2 ❑ 1 ❑
Do you find it difficult to refrain from smoking in the places where it is forbidden? *e.g. Church, Library, etc*	YES NO	1 ❑ 0 ❑
Which cigarette would you hate to give up?	The first in the morning Any other	1 ❑ 0 ❑
How many cigarettes a day do you smoke?	10 or less 11-20 21-30 31 or more	0 ❑ 1 ❑ 2 ❑ 3 ❑
Do you smoke even if you are sick in bed most of the day?	YES NO	1 ❑ 0 ❑
Do y ou smoke more frequently in the morning?	YES NO	1 ❑ 0 ❑

Score	1-2 = low dependence, 3-4 = low to mod dependence, 5-7 = moderate dependence, 8+ = high dependence

Previous smoker Y / N Years Quit _____ Never Smoked

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STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN A WEEK:
BEER OR COOLER	
12 oz.  ~5% alcohol	12 oz. = 1 16 oz. =1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz  ~12% alcohol	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz  ~12% alcohol	750 mL (25oz) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz  ~40% alcohol	Mixed drink = 1 or more* Pint (16oz) = 11 Fifth (25 oz) = 17 1.75 L (59 oz) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

CHHABRA MEDICAL CORPORATION

Acknowledgment of Receipt and/or Review of Privacy Policies

In effort to communicate with you more effectively and keep your Protected Health Information confidential, we are asking you to complete this form. This form lets you decide how we can release your information to-and for what reason. If you have any questions about this form, please ask.

I have received a paper copy of/have reviewed the office copy of Chhabra Medical Corporation's Notice of Privacy Policies.

_____(Initial)

Chhabra Medical Corporation staff may discuss or leave information about my Protected Health Information and/or financial matters to the following people:

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

Name_____Relation_____Phone_____

In addition to the above, how may we contact you regarding health issues or concerns which may be confidential? **PLEASE ANSWER EVERY QUESTION BELOW!**

Via Mail (sealed privacy mail only)	YES ( )	NO ( )
Home Phone_____	YES ( )	NO ( )
Cell Phone_____	YES ( )	NO ( )
Can we leave a message on your answering machine	YES ( )	NO ( )
Work Phone_____	YES ( )	NO ( )
Can we leave a voicemail at work	YES ( )	NO ( )

Other_____

_____

Patient /Responsible Party (PRINTED) Date **D.O.B.**

_____

Patient/Responsible Party (SIGNED) Date Relationship to Patient

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PATIENT OFFICE POLICIES

We welcome you to our medical offices. For your convenience we have two facilities to meet your healthcare needs. Some of our office policies are stated below for your information. Please read and sign at the bottom of the second page.

Office Hours:

Portage Health Center
Monday- 8 a.m. to 5 p.m.
Tuesday- 8 a.m. to 5 p.m.
Wednesday-8 a.m. to 5 p.m.
Thursday- 8 a.m. to 5 p.m.
Friday- 8 a.m. to 1 p.m.

Saturday- 8 a.m. to 12 p.m.
(Every 1st Saturday of the month)

Hobart Health Center
Monday- 8:30 a.m. To 4:30 p.m.
Tuesday- 9 a.m. to 5 p.m.
Wednesday- 8 a.m. to 4 p.m.
Thursday- 9 a.m. to 5 p.m.
Friday- 8:00 a.m. to 1 p.m.

The time of these hours are subject to change without notice. Please call the office to confirm appointments and location.

APPOINTMENTS: Appointments are scheduled in advance. In an emergency situation, we will be able to see you in either of our two offices or you may go to the emergency room at the nearest hospital. If it becomes necessary to cancel an appointment, please give our office a 24-48 hour notice so we may offer your appointment to another patient. If a 24-hour notice is not given there will be a failed appointment service charge added to the account. **1st occurrence $50.00, 2nd occurrence $75.00, and 3rd occurrence $100.00.** This charge shall be the responsibility of the patient and is not insurance billable.

TELEPHONE: In order to reduce interruptions to patients being examined, our receptionist and or nursing staff will handle the phone calls. Messages taken between, 8 a.m. and 1:00 p.m. shall be most likely handled within 12-24 hours. Most messages taken after 1 p.m. will be handled by the end of the next business day. The doctors or their associates will return your calls as soon as possible. This, on occasions, may take up to 48-72 hours. When the offices are closed, our answering service will take **urgent messages only** and transmit them to the doctor on call. All refill requests shall be accommodated only during business hours.

IN OFFICE TESTING: We are equipped to do some basic blood and urine tests in our office. An outside laboratory does more complicated testing. As a convenience to you, frequently will draw the blood for these tests in our office. When this is done, there is a nominal charge for drawing the blood and preparing the specimen. Any other tests done will be billed according to the test performed. Testing results shall be discussed at the time of your next follow-up visit.

X_____
Signature of Responsible Party/Guarantor/Patient

X_____
Print Name
D.O.B._____

HEALTH INSURANCE: Health insurance is designed to help the patient meet the cost of medical service, but the basic responsibility for payment is the patient's. Your insurance contract defines to what extent the company can reimburse you. We are prepared to help you recover the portion of your medical expenses that are covered by your contract by filling out the form from the patient before submitting the form to us for completion. There shall be a nominal charge for completion of disability forms, insurance forms and workman's compensation forms. It is your responsibility to familiarize yourself with your insurance policy. Your insurance dictates if you need referrals for diagnostic testing and specialty visits. If referrals are needed, please inform our offices before your diagnostic testing and/or for specialist visits. This could take up to 4-5 business days.

CREDIT AND GUARANTEE AGREEMENT: We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain the medical offices for our patients and the community. By signing below you signify your understanding and agreement to be responsible for any and all reasonable charges incurred for medical services provided to the patient. **Charges for medical services at our offices are due and payable at the time services are rendered.** All co-pays, deductibles, and co-insurance as dictated by your health policy, are payable at the time of service. For your convenience, we accept cash, check, or credit card. All Co-Pays not paid at time of office visit shall entail a $20 administrative and collection charge.

If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our billing manager. This will avoid misunderstandings and enable you to keep your account in good standing. Accounts 60 days past due are referred to our attorney, unless prior arrangements have been made with my office. If we must retain an attorney in order to collect and overdue amount owed by you, you will be responsible for not only the original debt, but also for all costs of collection incurred by this office, including court costs, attorney fees incurred, and any and all other costs reasonable and necessarily incurred in litigating the matter.

If you have health insurance, please understand that this is an agreement between you and your insurance company to pay your certain amounts for medical care. Our bill for medical services is an agreement between you and us. You are responsible for the payment of your bill regardless of the status of your insurance claim.
If you should have any questions regarding any of the above, please feel free to discuss it with my staff.

Sincerely,
CHHABRA MEDICAL CORPORATION, P.C.

This agreement also serves as a formal consent to treatment for myself and/or my dependents.

X_____
Signature of Responsible Party Guarantor/Patient

X_____
Witness Signature

X_____
Print Name

X _____
Witness Name

X_____
Date

X_____
Date

_____
D.O.B.

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, D.O.B_____HAVE BEEN OFFERED TO READ/VIEW A COPY OF CHHABRA MEDICAL CORPORATION'S PC NOTICE OF PRIVACY PRACTICES.

_____ _____
SIGNATURE OF PATIENT **DATE**

_____ _____
WITNESS NAME/SIGNATURE **DATE**