GERIATRIC & FAMILY MEDICINE

Drs. Fishman, Geller, & Associates
3885 Upham St., Suite 100 Wheat Ridge, CO 80033
Phone: (303) 742-0086 – Fax: (720-221-8994)
(Call or Text) Appointment Confirmation Number: (720) 446-9742

IMPORTANT - PLEASE READ PRIOR TO YOUR APPOINTMENT

The New Patient Packet must be completed and returned to our office prior to your appointment with our practitioners. In the event that the paperwork is not received two days prior to your appointment, our front-end staff will contact you to reschedule your visit.
To assist you in this process we encourage you to either:

1. Return paperwork to our office directly.
2. Mail paperwork in the stamped return envelope included with your packet.
3. Electronically, by emailing it to a member of our staff at: office@drfishman-drgeller.com
4. Submit the packet to a HIPAA secure fax: (720) 221-8994

Please bring the following items with you to your appointment:

1. Picture ID
2. Valid Insurance Card
3. All current medications (prescribed as well as over the counter)
4. Copay (We **only** accept **cash or check**)
5. Any medical records you may have in your possession

Even if your paperwork is already complete, please be sure to arrive at our clinic no later than 15 minutes before your scheduled appointment time. This will allow time to check-in and go over any additional paperwork.

Cancellation Policy:

Our staff will attempt to contact you to confirm your appointment at least 1 to 3 days in advance. We have an after-hours Appointment Confirmation Line for your convenience. **In the event that an appointment is not confirmed, it may be given to another patient on our waiting list.** It is your responsibility, as the patient, to contact our office a minimum of 24 hours prior to your appointment time, should you need to cancel or reschedule. ***Failing to do this will result in a fee of $50.00***. A new patient who is a "No Call / No Show" for their first appointment WILL NOT BE ALLOWED TO RESCHEDULE.

Reminder:

Please take it upon yourself to understand your insurance coverage and benefits, including re-certifications, referrals and prior authorization requirements. Be sure that the insurance information our office has on file is current. If you give incorrect insurance information, you will be responsible for the charges.

Specialized Care for Young Adults through Seniors

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New Patient Form

Patient Name:_____(first) _____(Middle) _____(Last)

Date of Birth:_____ **SSN:** _____-_____-_____ **Gender:** ▫ Male ▫ Female

Address: _____ **Unit :** _____

City: _____ **State:** _____ **Zipcode:** _____

Contact Info: Cell: _____ Home: _____ Work: _____

Email Address: _____@_____

(Optional) Ethnicity: ▫ Caucasian ▫ Amer. Indian/Alaskan Native ▫ Latino/Hispanic
▫ Black/African American ▫ Native Hawaiian/Pacific ▫ Asian

Emergency Contact Name:_____

Relationship to patient: _____

Contact Phone Number : _____

_____

Signature **Date**

_____

Print Name/ Relationship (if not patient)

I have reviewed Geriatric and Family Medicine Associates' policies regarding release of information and payment of services rendered. My signature below constitutes acknowledgment and acceptance

Name:_____ Date of Encounter:_____

Current Medications

Name or Brand	Dose	Route	Frequency	Est. Start Date

Medication Allergies

Name or Brand	Reaction

Pharmacy of Choice

Name of Pharmacy:	
Address with Zip Code:	
Phone Number:	

Turn Over

Name:_____ Date of Encounter:_____

Providers and Suppliers of Your Medical Care

This includes Primary Care Physicians, Speciality Physicians, Chiropractors, Herbalists and Therapists, etc.

Practitioners	Specialty	Phone Number

Surgical History (Major Events)

Surgery	Yes	No	Year
Appendectomy			
Brain Surgery			
Gallbladder Surgery (Cholecystectomy)			
Heart Bypass / Heart Valve Replacement			
Colon Surgery			
Cosmetic Surgery			
Eye surgery			
Fracture Surgery			
Hernia Repair			
Joint Replacement (Specify:_____)			
Small Intestine Surgery			
Spine Surgery			

** ANSWER IF FEMALE **

C-Section			
Tubal Ligation			
Hysterectomy			

** ANSWER IF MALE **

Prostate Surgery			
Vasectomy			

Turn Over

Name:_____ Date of Encounter:_____

Ongoing Medical Problems

Condition	Yes	No	Comments
Seasonal Allergies			
Anemia			
Anxiety			
Arthritis			
Asthma			
Blood Transfusion			
Cancer			Type:_____
Cataracts			
Heart Failure (CHF)			
Clotting Disorder			Specify:_____
Chronic Obstructive Lung Disease (COPD)			Currently wear Oxygen? ▫ Yes ▫ No
Depression			
Diabetes			
Emphysema			
Reflux, Heartburn (GERD)			
Glaucoma			
Heart Murmur			
HIV/AIDS			
High Blood Pressure/Hypertension			
Kidney Disease			
Meningitis			
Heart Attack (Myocardial infarction)			
Nerve/Muscle Disease			Specify:_____
Osteoporosis			
Seizures			
Sickle Cell Anemia			
Sleep Apnea			▫ CPAP or ▫ BiPAP
Stroke			
Substance Abuse			Specify:_____
Thyroid Disease			
Tuberculosis			
Gastrointestinal Ulcers			

Turn Over

Name:_____ Date of Encounter:_____

Family Health History

	Mother	Father	Sister	Brother	Daughter	Son
Alive						
Deceased						
Alcohol Abuse						
Arthritis						
Asthma						
Birth Defects						
Cancer						
COPD						
Depression						
Diabetes						
Drug Abuse						
Early Death						
Hearing Loss						
Heart Disease						
High Cholesterol						
Hypertension						
Kidney Disease						
Learning Disability						
Mental Illness						
Mental Retardation						
Miscarriage						
Stroke						
Vision Loss						

Turn Over

Name:_____ Date of Encounter:_____

Preventive Care

- Do you get vaccinated against the flu annually? ▫Yes ▫No
  - If so, when was your last shot? _____(year)

- Have you had a pneumococcal vaccine?
  Prevnar 13 ▫Yes ▫No
  Pneumovax 23 ▫Yes ▫No
  - If so, when was your last shot? _____(year)

- Have you ever been vaccinated against Chickenpox? ▫Yes ▫No
  - If so, at what age were you vaccinated? _____(age)

- If not, have you ever had the Chickenpox? ▫Yes ▫No

- Have you ever had the Shingles vaccine? ▫Yes ▫No
  - If so, when was your last shot? _____(year)

- Have you had a Tetanus shot in the last 10 years? ▫Yes ▫No
  - If so, when was your last shot? _____(year)

- Have you had a Colonoscopy in the past 10 years? ▫Yes ▫No
  - If so, when was your last procedure? _____(year)

ANSWER IF FEMALE:

- When was your last mammogram? _____(year)
- When was your last pap smear? _____(year)
- Are you currently on birth control? ▫Yes ▫No
- Have you ever had a Bone Density (DEXA) Scan? ▫Yes ▫No
  - If so, when? _____(year)

- How many pregnancies have you had? _____
- How many live births have you had? _____
- Have you gone through menopause? ▫Yes ▫No

Turn Over

Name:_____ Date of Encounter:_____

Physical Activity

How many days per week do you exercise?_____

How long do you typically exercise for?_____

How intense is your typical exercise?

▫ Light (stretching, slow walking) ▫Moderate (brisk walking)

▫Heavy (jogging or swimming) ▫Extreme (fast running or stair climbing)

Oral Health

How often do you brush your teeth?

▫ At least once daily ▫ Most days of the week ▫ Seldom ▫ Never

Do you visit the dentist regularly? ▫ **Yes** ▫ **No**

Nutrition

- How many serving of fruits and/or vegetables do you eat per day? _____ (1 serving = 1 cup of fresh vegetables, ½ cup cooked vegetables or 1 piece of medium fruit roughly the size of a baseball = 1 cup)
- How many servings of high fiber or whole grains do you eat per day? _____ (1 serving = 1 slice of 100% whole wheat bread, 1 cup whole grain or high fiber ready-to-eat cereal, ½ cooked cereal like Oatmeal, or ½ cup of cooked Brown rice or whole wheat pasta)
- How many servings of high fat foods do you eat per day? _____ (examples: fried foods, bacon, french fries, potato chips, and foods made with whole milk, cream, cheese or mayonnaise)

Motor Vehicle Safety

Do you wear you seatbelt in the car? ▫ **Yes** ▫ **No**

Do you ever drive or ride with a driver who is under the influence of alcohol? ▫ **Yes** ▫ **No**

Sun Exposure

Do you protect yourself from the sun when you're outdoors? ▫ **Yes** ▫ **No**

General Well-Being

In general would you say your health is?

▫ Excellent ▫ Very good ▫ Good ▫ Fair ▫ Poor

Social History

Tobacco Use

▫ **Yes** ▫ **No** If yes, are you a current everyday smoker? ▫

Number of cigarettes per day?_____ Number of Years? _____

Are you ready to quit? ▫ **Yes** ▫ **No**

If yes, would you like cessation resources? ▫ **Yes** ▫ **No**

Former smoker? ▫ **Yes** ▫ **No** Quit date:_______________

Do you use Smokeless Tobacco Products (Snuff/Pouches/Chew/E-Cigarettes)?

▫ **Yes** ▫ **No** ▫ **Never Used** If yes, what product? _____

Name:_____ Date of Encounter:_____

Sexual Activity

Are you sexually Active? ▫**Yes** ▫**No** ▫**Not currently**

How do you sexually identify? ▫ Lesbian/Gay (Homosexual) ▫ Straight (Heterosexual)

▫ BiSexual ▫ Transgender ▫ Prefer to discuss with practitioner

Alcohol Use

▫ **Yes** ▫ **No**

If Yes, how many drinks a week do you have? _____

Please list the type(s) of alcoholic beverage consumed: _____

_____

_

Drug Use

▫ **Yes** ▫ **No**

If Yes, how many times a week do you use them?_____

Please list the type(s) of illicit drugs consumed:_____

Marijuana Use

▫ **Yes** ▫ **No**

If Yes, how many times a week do you use them?_____

What form do you consume?

▫ Smoking(flower/oil) ▫ Edibles ▫ Topical(lotions/oils/patches, etc.)

Do you strictly use CBD's? ▫ **Yes** ▫ **No**

Why do you use marijuana? ▫ Medicinally ▫ Recreationally

Psychological Risk Factors

During the past 6 months, how often have you felt sad or depressed?

▫ Almost all of the time ▫ Most of the time ▫ Some of the time ▫ Almost Never

In general how satisfied are you with your life?

▫ Very Satisfied ▫ Satisfied ▫ Dissatisfied ▫ Very Dissatisfied

Stress/Anger

How often is stress or anger a problem for you?

▫ Never/Rarely ▫ Sometimes ▫ Often ▫ Always

Social/Emotional Support

How often do you get the social and emotional support you need?

▫ Never ▫ Rarely ▫ Sometimes ▫ Often ▫ Always

Pain/Fatigue

How many hours of sleep do you usually get a night? _____Hours

Do you have pain that interferes with performing desired activities? ▫ **Yes** ▫ **No**

▫Never/Rarely ▫Sometimes ▫ Often ▫ Always

GERIATRIC & FAMILY MEDICINE

Drs. Fishman, Geller, & Associates

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164)

1. I hereby authorize all medical services sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney named _____. (☐ Check if not applicable to you.)

2. Authorization for release of PHI covering the period of health care (check one)

   ☐ a. from _____(date) to _____ (date)

   -OR-

   ☐ b. All past, present and future periods.

3. I hereby authorize the release of PHI as follows:

   a. My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse)

   -OR-

   b. My complete health record with the exception of the following information (check as appropriate):

   ☐ Mental Health Records

   ☐ Communicable Diseases (including HIV and AIDS)

   ☐ Alcohol/Drug abuse treatment

   ☐ Other (Please specify): _____

4. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation as I may direct.

6. The authorization shall be in force indefinitely unless a new form is signed, dated and submitted as part of my medical record.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest this claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditional on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law.

_____ _____
Signature of patient Date signed

_____ _____
(Print Patient Name) Date of Birth

GERIATRIC & FAMILY MEDICINE ASSOCIATES, PC
CONTROLLED SUBSTANCE MEDICATION AGREEMENT

Patient Name: _____ DOB: _____

You have agreed to receive controlled substances for the treatment of your pain or anxiety. It is important that you have an understanding of the risks and responsibilities that go along with this treatment. Please read each statement and sign this agreement/contract below. If you have any questions regarding this information or the office policy regarding the prescribing of controlled substances, please request clarification.

I, _____, understand that:
Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand that the goal of using controlled substances is to decrease my pain or anxiety and increase my functional level. If my pain or anxiety does not significantly decrease and/or my function increases, the medication will be stopped.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief. The overuse of controlled substance medication can result in serious health risks including respiratory depression or even death. This medication will be strictly monitored and all of my medications must be filled at the same pharmacy. (Should the need arise to change pharmacies our office must be informed). The pharmacy that I have selected is:
Pharmacy: _____
Phone: _____

I cannot receive this medication by phone. I will not call the office to have a prescription called in. I am responsible for making and keeping scheduled appointments. Early refill requests will not be honored.

I will take the controlled substance medication only as prescribed. Any changes must first be discussed and agreed upon with my care provider. Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen and I complete a police report regarding the theft, an exception may be made. I agree that only my specified care provider will prescribe my controlled substance medication. I will not obtain or use controlled substances or other controlled substances from a source other than my specified provider. If it is brought to the attention of the clinic that other providers are prescribing medications for me, the Geriatric and Family Medicine reserves the right to discontinue prescribing medications and/or discharge me from the clinic.

Turn Over

I will not use any illegal "street drugs" while receiving medications from Geriatric and Family Medicine.

I will communicate fully and honestly with my physician about the character and intensity of my pain or anxiety, the effect of the pain or anxiety on my daily life, and how well the medicine is helping to relieve the pain or anxiety. Routine blood work and random drug screens will be a part of my treatment plan. I agree to have them done on the day the provider requests them.

The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to my records.
It is a felony to obtain controlled substance medications under false pretenses. This could include getting medication from more that one provider, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling).

I know that controlled substance medications will be stopped if any of the following occurs:
- I trade, sell, or misuse the medication
- The clinic finds that I have broken any part of this agreement
- I do not go for a blood or urine test when asked
- My blood or urine test shows the presence of medications that the staff are not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for
- I get controlled substances from sources other than Geriatric and Family Medicine
- Any member of the professional staff of Geriatric and Family Medicine feels that it is in my best interests that controlled substance treatment is stopped
- Any aggressive behavior toward physician or staff
- I consistently miss scheduled appointments

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no controlled substance prescriptions will be written) by Geriatric and Family Medicine providers. I have read the controlled substance Medication Agreement and without question understand all of this agreement. By signing this agreement I affirm that I have read, understand and accept all of the terms of this agreement.

Patient signature: _____Date:_____

Clinic Witness: _____Date: _____

Patient's Name: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

Reviewed by: _____ Total Score: _____

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**
☐	☐	☐	☐

Geriatric & Family Medicine Associates, P.C.

Patient Portal Sign-up Form

If you provide your email address to us, you can sign up for our Patient Portal, which allows you secure online access to the following information:

- **Vital signs**
- **Lab results**
- **Diagnoses**
- **Medications**
- **Allergies**
- **Dates of past visits**
- **Upcoming appointment dates**

Please indicate your preference by checking one of these boxes:

☐ **Yes, I would like to sign up for the Patient Portal.**

☐ **No, I would not like to sign up for the Patient Portal at this time.**

If you have chosen to sign up for the Patient Portal, please provide your personal email address here: _____

Patient Portal Terms of Use (Updated 1/11/2017):

1. The purpose of the Patient Portal is to provide you with better access to your health information. DO NOT use the Patient Portal to communicate with the practice, especially if there is a medical emergency. In the event of a medical emergency, call 911 immediately. For non-emergent communication, such as to schedule an appointment, contact us by phone at 303-742-0086 rather than using the Patient Portal.

2. Your secure personal email address is considered private. You will receive an email from "healthrecords@patientfusion.com" instructing you how to accessyour information securely on "Patient Fusion," the service we use as the Patient Portal. There are several steps involved, including establishing a username and password. DO NOT attempt to circumvent any safeguard meant to protect the security of the Patient Portal.

3. You may authorize other individuals access to your Patient Portal account at your discretion, understanding that our office assumes no responsibility or liability for doing so.

4. The Patient Portal Terms of Use are subject to change without prior notice. By signing below, you are indicating that you understand and will comply with these terms.

Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

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Phone: (303) 742-0086 - Fax: (720-221-8994)
email: office@drfishman-drgeller.com
Paul J. Fishman, M.D. I. B. Geller, M.D.

Authorization to Release Medical Records to Geriatric & Family Medicine Associates, PC

Patient's name: _____ DOB: _____

Name of Previous Doctor: _____

Previous Doctor's **Address:** _____

Previous Doctor's **City/State/Zip:** _____

Previous Doctor's **Phone:** _____ **Fax:** _____

I authorize the release of specific information regarding the following condition(s):	INITIALS	
	Yes	No
Drug abuse, if any		
Substance abuse, if any		
Psychological/psychiatric conditions, if any		
AIDS/HIV, if any		

Release the following records: (Initials)

- Years Requested (specify): _____
- Only records generated by this facility (excluding records received from other sources) _____

I understand that I may revoke this authorization if I write a letter to this office. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I hereby release the above-named sender from all legal liability which might in any way result from the release of said records requested.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name if signed on behalf of the patient/Relationship Date

_____ _____
Witness Date