Snow Family Medicine, LLC

Dear new patients,

Welcome! We are happy to be your new primary care practice. Before we see you for your first appointment, we will need to know a little bit more about you. Please complete this packet and bring it in on the day of your New Patient visit.

Our Practice Mission Statement:

At Snow Family Medicine, we believe that the mind, body and soul of the individual should be the focus of all patient-provider relationships. As healthcare professionals, we strive to provide patient-centered, quality care, in a convenient, and calming environment, while maintaining the privacy, respect, and collaborative rapport with patients and families.

We treat patients of any age, ranging from newborn to elderly. We want families to have the convenience of having one primary care provider from childhood to adulthood.

We believe that mental health is as important as physical health. We have a team of behavioral health counselors connected with our office so that we can better treat our patients mind and body.

We understand that healthcare system costs are constantly evolving. Our staff is committed to provide a professional and pleasant experience for our patients during these changes, while striving to keep a cost-efficient approach

Feel free to make note of any questions that you may have for us!

_____
_____
_____
_____

Patient Registration:

First name: _____ Last name: _____ MI:_____

DOB: _____ Gender: M / F Gender Identity: _____ SSN: _____

Cell: _____ Home: _____ Email: _____

Snow Family Medicine, LLC

Address: _____ City: _____ State: _____ Zip: _____

Preferred Pharmacy: _____ City: _____ State: ____ Zip: _____

Emergency Contacts:

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Insurance Information:

Primary Insurance:

Plan Name: _____

Policy Number: _____

Insured's Name: _____

Insured's DOB: _____

Plan Phone No.: _____

Secondary Insurance:

Plan Name: _____

Policy Number: _____

Insured's Name: _____

Insured's DOB: _____

Plan Phone No.: _____

Guarantor Information:

Relationship to Patient: Self __ Spouse __ Parent __ Other__

First Name: _____ Last Name: _____ M.I: _____

DOB: _____ Phone number: _____

Address: _____ City: _____ State: ___ Zip: _____

Notice of PCP selection -

If your insurance plan requires a Primary Care Provider to be listed, please make sure you have Kristen Snow, FNP-BC listed on your card. If Kristen Snow is not listed as your PCP, your claim may be denied, and you will be responsible for the full amount of the visit

No-Shows, Missed Appointments and Late Check-in Office Policy

Please be advised that patients arriving more than 15 minutes late for their appointment will be considered a no-show, and will need to be rescheduled.

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call *at least* **24 hours** in advance to your missed appointment. If for any reason you need to cancel an appointment, please notify our office as soon as possible.

After **3 consecutive** no-show occurrences, the practice may elect to discontinue your care with our providers, and you may need to seek care elsewhere.

FOLLOW-UPS, SICK VISITS, SAME DAY APPOINTMENTS	$30.00
PHYSICAL EXAMINATIONS AND WELL-CHILD VISITS	$50.00

I understand that if I do not call and cancel my appointment at least **24 hours** in advance to my appointment, I will be charged the above fees.

Print name: _____

Signature: _____ Date: _____

Authorization for Release of Medical Record Information

Patient Name: _____ DOB: _____

Phone: _____ Address: _____

City: _____ State: ____ Zip code: _____

Records Requested From:	**Requested to be sent to:**
Facility Name: _____	*Snow Family Medicine, LLC*
Address: _____	2220 Plainfield Pike, Cranston, RI, 02921
City/State/Zip: _____	P: 401-585-8500
P: _____ F: _____	F: 401-942-2200

Please Review the following information (Check One)

- ☐ All records, including those pertaining to substance abuse, HIV, AIDS, and mental health if applicable.
- ☐ All records, not including those pertaining to substance abuse, HIV, AIDS, and mental health if applicable.
- ☐ Immunization records only

Note: If the patient is a minor, the parent or guardian must sign. If the patient is an adult and does not sign this consent form, the party must provide legal documentation providing authority to do so.

This information will not be given, sold, transferred, or relayed to any other person not specified in this authorization without first obtaining my written consent which states the need for the proposed new use of this information, or the need for its being transferred to another person.

Understand that you, the patient will be liable for the reasonable transfer cost of $15.00 per patient if requesting your own private copy of your medical records.

Reason for Transfer: (Circle One)

Relocation Change of Provider Continuity of Care Change of Insurance Legal/Other

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Printed Name:_____ Date: _____

Signature: _____ Relation to Patient: _____

Controlled Substances Agreement

Controlled substance abuse has been and continues to be a major problem in healthcare. Due to this, Snow Family Medicine, LLC will not continue prescriptions of any controlled substances/opioids/narcotics previously prescribed to you by another provider. This policy is to protect you as the patient as well as the practice. If you are injured or are diagnosed with a condition that indicates the use of these medications, the provider may elect to do so. In case of this situation, we require a signed controlled substances agreement from the patient or guardian to keep in the patient's record.

Controlled medications are potentially dangerous. – Side effects and dangers include constipation, fatigue, drowsiness, mood changes, nausea, vomiting and anxiety. There is a risk of addiction, respiratory depression, and death. You understand that you cannot mix narcotics, benzodiazepines & stimulants with alcohol, and should use extreme caution when operating a motor vehicle.

You must take your medication exactly as prescribed. – You cannot increase medication without permission from me. All adjustments must be authorized and documented by the provider. If you increase your medication without approval, you will run out early and I can not prescribe additional medication.

This practice is the only office who can prescribe controlled medication to you. – You cannot obtain controlled medication from anyone else. If two different doctors are prescribing, the combination of these medications may cause death. This includes any other specialist, and/or emergency rooms or walk-in clinics. It is strongly recommended that you only use one pharmacy – We may require a printout from your pharmacy to confirm you are taking your medication as prescribed.

You are responsible for keeping your appointments for renewing your medication. – Controlled medications can only be prescribed monthly, in a 30 day supply or less. I cannot and will not renew controlled medication early, or if you missed your last controlled medication check appointment. These appointments will be required every 90 days in order to continue the prescription.

If you call the office repeatedly regarding your refill or a medication check - you will be in violation of this agreement. You may not ask a covering provider for a refill of this prescription.

You must have a urine toxicology screen at least once a year to confirm that you are using your medication properly. We are able to screen you at any time. You agree to take this medication only for the indicated condition, and not for any other purpose.

Do not throw out medications. If you need to change medications, you will be required to return the unused medication before I can provide you with a different medication.

Lost / Stolen medication. – You will be required to fill out a police report if you suspect someone has stolen your med. If you lose your med, or believe it to be stolen twice, we are unable to treat you with controlled medications.

The abuse and diversion of controlled substances is a criminal offense. - If criminal activity is suspected, I am obligated to report you to the authorities. I reserve the right to discontinue your controlled medications and/or discharge you from my practice for any violation of this agreement.

Printed Name: _____ Date: _____

Signature: _____

Relationship to patient: _____

Phone Contact Consent and Authorization

I, with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize Kristen Snow FNP-BC ("Healthcare Provider") or any of her automated systems to contact me via phone (including to my cellular phone by way of phone call or text message) in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items or appointment reminders).

If this Consent and Authorization applies to someone for whom you are a legal representative, please print their name below, if not please indicate so by populating the blank with N/A.

Relationship to Patient: _____ Date: _____

Signature: _____

Authorization and Consent to Participate in Telemedicine Consultation

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with Snow Family Medicine, LLC.

1) **Purpose & Benefits.** The purpose of this program is to use telemedicine to enable patients to access medical care by Snow Family Medicine providers without the inconvenience and expense of travel.
2) **Nature of Telemedicine.** During the telemedicine consultation:
    a. Details of you/your child's medical history, examinations, x-rays, and tests will be discussed with your provider using interactive video, audio, and telecommunications technology.
    b. Abbreviated physical exam of you/your child may take place.
    c. Non-medical technical personal may be present in the telemedicine studio to aid in video transmission.
    d. Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.
3) **Medical information and Records.** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers and other entities shall not occur without your consent, unless authorized under existing confidentiality laws.
4) **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Rhode Island state law apply to information disclosed during this telemedicine consultation.
5) **Risks and Consequences.** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate wit ha provider at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and education services is a new technology and may not be equivalent to direct patient to provider contact. Following the telemedicine, your provider may recommend a visit to a hospital or other healthcare facility for further evaluation. It is your responsibility to follow up with this recommendation.
6) **Rights.** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with you provider in person if you travel to his or her location at another time.
7) **Financial Agreement.** This telemedicine consultation will be billed to your insurance carrier as if it were an in-person visit, with the patient being responsible for the co-payment as usual. This is what the process has been in RI since the start of the 2020 COVID-19 pandemic. This is subject to change at any time under federal regulations.

I have been advised of all the potential risks, consequences and benefits of telemedicine. My health care practitioner has discussed with me the information provided above. I have had the opportunity to ask questions about this information and all of my questions have been answered. I understand the written information.

Printed Name: _____

Signature: _____ Date:_____

If signed by someone other than the patient, provide relationship to patient: _____

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from
my pharmacy, my health plans, and my other healthcare providers.

Relationship to Patient: _____ Date: _____

Signature: _____

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Notice of Primary Care Physician Selection

If your insurance requires you to select a Primary Care Physician, you must have Kristen Snow FNP-BC listed on your insurance card as your PCP.

Failure to do so could result in your claim being denied and you will be responsible for the full amount of the visit.

Please contact your insurance to ensure they have Kristen Snow listed as your Primary Care Physician.

If you need to re-schedule your appointment to avoid receiving a bill, we will be happy to do so for you.

Patient name: _____ Date: _____

Signature: _____

Relationship to patient: _____

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:
a basis for planning my care and treatment;
a means of communication among the health professionals who may contribute to my health care;

a source of information for applying my diagnosis and surgical information to my bill;

a means by which a third-party payer can verify that services billed were provided;

a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.
I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:
I have the right to review this Practice's Notice of Information practices prior to signing this consent; that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;

I have the right to object to the use of my health information for directory purposes;

I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;

I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Signature: Date: Relationship to Patient:

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Snow Family Medicine, LLC (the Practice) to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked “Personal and Confidential.”

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Relationship to Patient: _____ Date: _____

Signature: _____

Please list any specialists that you have seen *(Ex: Urology, Physical Therapy, Gastro.)*:

_____
_____
_____
_____
_____
_____

Please list any allergies to medications and/or food, including reactions/side effects:

_____
_____
_____
_____

Medication History *(please specify strength and directions for med)*

_____
_____
_____
_____
_____

Surgical History: *(be sure to include facility and date of procedures.)*

_____
_____
_____
_____
_____

Social History:

Are you a smoker? Y / N

Other tobacco user? Y / N if so, specify product: _____

Recreational Marijuana use? Y / N

Medicinal Marijuana use? Y / N if so, diagnosis: _____

Have you ever used illegal drugs? Y / N

Do you drink alcohol? Y / N if so, how often?

Are you sexually active? Y / N Sexual Orientation: _____

Have you ever been a victim of verbal/sexual/domestic abuse? Y / N

Medical History & Family Medical History

If you have been diagnosed with, or experienced any of the health conditions listed below, please check off the corresponding box.

If any of these conditions apply to any of your family members, please write an X next to the condition, along with what your relation is to that family member.

ADD	Lung cancer
ADHD	Lymphoma
Alcoholism	Migraines
Alzheimer's	Multiple sclerosis
Asthma	Muscular dystrophy
Autism	OCD
Bipolar disorder	Other:
Birth defects	Ovarian cancer
Blood clots	Parkinson's disease
Breast cancer	Physical abuse
Celiac disease	Prostate cancer
Cerebral palsy	Schizophrenia
Childhood trauma	Sexual abuse
Colon cancer	Sickle cell anemia
Depression	Speech/language delay
Eating disorder	Stroke
Epilepsy/Seizures	Substance abuse
Food allergies	Tics/Tourette's
Glaucoma	Verbal abuse
Hearing loss	Vision loss
Heart attack	
Heart disease	
High blood pressure	
High cholesterol	
Huntington's chorea	
Immune disorder	
Infertility	
Kidney disease	
Leukemia	

Additional Notes / Concerns:

_____

_____

_____

_____

Patient name: _____ Date: _____

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

(Form Last updated 03/30/2021)

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 nervous, 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 its 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 here) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of thigs at home, or get along with other people?

- ☐ Not difficult at all
- ☐ Somewhat Difficult
- ☐ Very Difficult
- ☐ Extremely Difficult

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	*Not at All*	*Several Days*	*More than Half the Days*	*Nearly Every Day*
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble Concentrating on things such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
(Add columns)	+	+	+	+
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 difficul