cpacs.cosmo health center
center for pan asian community services

New Patient Intake Form

PATIENT INFORMATION

***Name*: _____ *Age*: _____**
(Last) (First) (Middle Initial)

Date of birth*:** (mm/dd/yyyy)**: _____/_____/_____ *SSN (*Optional*)**: _____**

***Street Address*: _____**

***City*: _____ *State*: _____ *Zip*: _____**

***Home phone*:** (_____)_____ ***Cell phone*:** (_____)_____

***E-mail*: _____@_____**

***Gender*:**
☐ Male
☐ Female
☐ Transgender
☐ Other,
Please Specify: _____
☐ Choose not to disclose

Sexual Orientation:
☐ Straight (Heterosexual)
☐ Bisexuality
☐ Homo Sexuality
☐ Something Else
☐ Do Not Know
☐ Choose not to disclose

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed

*Are you **Hispanic** or **Latino*?**
(Cuban, Mexican, Puerto Rican,
South or Central American,
other Spanish origin)
□ Yes □ No □ Refused to Report

***Are you a (check all that apply)*:**
□ Migrant worker
□ Seasonal worker
□ Veteran
□ Homeless
□ Public housing

***Race** (check all that apply)*
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian
□ White
□ Other Pacific Islander
□ Refused to Report

Monthly Household Income:
□ $0–1,000
□ $1,001–2,000
□ $2,001–3,000
□ $3,001–4,000
□ More than $4,000
□ Decline to answer

*What is your **primary language spoken at home?***

_____

*Including yourself, **how many people live in your household**?*

_____ people

PREFERRED PHARMACY

Pharmacy Name: _____ Phone: (_____)_____

Address: _____

EMERGENCY CONTACT

Name: _____
(Last) (First)

Relationship: _____ Phone: (_____)_____

Please check all that apply: ☐ Parent/guardian of patient ☐ Disclose patient health information

ADDITIONAL CONTACT(S)

Name: _____
(Last) (First)

Relationship: _____ Phone: (_____)_____

Please check all that apply: ☐ Parent/guardian of patient ☐ Disclose patient health information

---

Name: _____
(Last) (First)

Relationship: _____ Phone: (_____)_____

Please check all that apply: ☐ Parent/guardian of patient ☐ Disclose patient health information

INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No

Primary insurance: _____

Policy no.: _____

Group no.: _____

Phone: (_____)_____

Type: ☐ EPO ☐ HMO ☐ PPO ☐ POS ☐ DMO ☐ Other

Secondary insurance: _____
(If applicable)

Policy no.: _____

Group no.: _____

Phone: (_____)_____

Type: ☐ EPO ☐ HMO ☐ PPO ☐ POS ☐ DMO ☐ Other

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, including major medical benefits to which I entitled such as Medicare, private insurance, and any other health plan, to CPACS Cosmo Health Center/Dental Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as the original.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the assignee to release all information necessary to secure payment.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for CPACS Cosmo Health Center (Cosmo) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (CPACS Cosmo Health Center Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cosmo reserves the right to revise its Notice of Privacy Practices prior to signing this consent. Cosmo reserves the right to revise its Notice of Privacy practices at any time. A revised Notice of Privacy Practices may be obtained by a written request to:

Administrative Office	Service Site
Center for Pan Asian Community Services	**CPACS Cosmo Health Center**
3150 Shallowford Rd NE	6185 Buford Hwy Building A1&G
Atlanta, GA 30341	Norcross, GA 30071

With this consent, Cosmo may call my home or alternate location and leave a message in reference to any items that assist the health center in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Cosmo may mail to my home or other alternate locations any items that assist the practice in carrying out TPO, such as letters and patient statements.

With this consent, Cosmo may send mails to my home or other alternative locations utilizing *eClinicalWorks*, our electronic medical records system which assists the practice in carrying out TPO.

I understand that my PHI is protected under the federal regulations governing the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164; as well as under 42 CFR Part 2; and cannot be disclosed without my written consent unless otherwise provided for in federal regulations.

I have the right to request that Cosmo restrict how it uses or disclose my PHI to carry out TPO. However, the health center is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Cosmo 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 in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cosmo may decline to provide treatment to me.

I understand that I can receive Title X Family Planning services confidentially and voluntarily regardless of my ability to pay.

Restrictions on disclosure (OPTIONAL): _____

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

Prescription History & ePrescribing Consent Form

ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification** - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your health care provider at CPACS Cosmo Health Center as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

ePrescribe Program Consent

By signing this consent form you are agreeing that your provider at CPACS Cosmo Health Center may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to CPACS Cosmo Health Center to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name	Patient DOB
Signature of patient or guardian	Today's Date
Relationship to Patient	

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize: _____
_____
_____

To release copies of medical records compiled during office visits and/or hospital admissions.

Patient Name: _____ **DOB: _____**

Release medical records to: CPACS Cosmo Health Center:

Medical: 6185 Buford Hwy, Bldg G
Norcross, GA 30071
P)770-446-0929 Fax)770-446-6977

Dental: 6185 Buford Hwy, Bldg A1
Norcross, GA 30071
P) 770-674-7980 Fax) 470-545-2277

The type and amount of information to be used or disclosed is as follows:

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history and physicals
- ☐ Most recent discharge summary
- ☐ Laboratory results
- ☐ X-Ray and imaging reports
- ☐ Consultation reports
- ☐ Entire record
- ☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health or mental health services and treatment for alcohol and drug abuse.
I understand that my health information is protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2; and that re-disclosure is prohibited under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim or lawsuit.
I understand that authorizing the disclosure of this health information is voluntary; I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____

Signature of Patient or Legal Representative *Date*

cpacs.cosmo health center
center for pan asian community services

Patient Health Questionnaire (English)

Skip the form for children **under 12** years of age

Name: _____ **DOB:** _____ **Date:** _____

	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**	**Declined to specify**
1	*Little interest or pleasure in doing things*	☐	☐	☐	☐	☐
2	*Feeling down, depressed, or hopeless*	☐	☐	☐	☐	☐

If you answered "Not at all" or "Declined to specify" to BOTH 1 and 2,

STOP HERE.

	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** *0*	**Several days** *1*	**More than half the days** *2*	**Nearly every day** 3
3	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4	Feeling tired or having little energy	☐	☐	☐	☐
5	Poor appetite or overeating	☐	☐	☐	☐
6	Feeling bad about yourself--or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9	Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
	FOR OFFICE CODING	**0**	+_____	+_____	+_____
				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? (circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**