Broad Top Health & Wellness
BTAMC Inc.

NEW PATIENT REGISTRATION & MEDICAL HISTORY FORM

****

As a Federally Qualified Health Center (FQHC), we are required to collect the following information from every patients we serve.
Per federal privacy rules, (HIPAA) this protected information is kept confidential and is not disclosed, unless authorized by the patient.
Thank you for your cooperation and choosing BTAMC as your health care provider.
(PLEASE PRINT THE INFORMATION BELOW)

TODAY'S DATE: _____ **DATE OF BIRTH:** _____ **SEX:** ☐ M ☐ F

PATIENT FULL NAME: _____ **SOCIAL SECURITY #:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____

EMAIL: _____ ☐ **I DO** ☐ **I DON'T** authorize BTAMC to leave a detailed message

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED
PRIMARY LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ SIGN LANGUAGE ☐ OTHER: _____
ETHNICITY: ☐ NOT HISPANIC ☐ HISPANIC ☐ LATINO/LATINA ☐ SPANISH ☐ DECLINED/REFUSED
☐ OTHER: _____(please describe)
RACE: ☐ CAUCASIAN ☐ AFRICAN AMERICAN ☐ ASIAN ☐ AMERICAN INDIAN/ALASKA NATIVE
☐ HAWIIAN/PACIFIC NATIVE *MORE THAN ONE RACE – please select all that apply or describe: _____

FINANCIAL RESPONSIBILITY (Please provide insurance cards)

Guarantor Information – List person or insured name responsible for bill **(If different than patient)**

Relationship to Patient: ☐ Self/Same as Patient ☐ Spouse/Partner ☐ Parent ☐ Other: _____

Guarantor's Name: _____ **SEX:** ☐ M ☐ F

Guarantor's Address: _____

Guarantor's Primary Phone: _____ **Employer:** _____

Patient's Insurance: _____ **Insurance ID#:** _____

Guarantor/Policy Holder: _____ **Insurance Group#:** _____

Guarantor's Date of Birth: _____ **Subscriber's Social Security#:** _____

PREFERRED PHARMACY

Local Pharmacy: _____ **Mail Order Pharmacy**: _____

ON THE TABLE BELOW PLEASE CIRCLE FAMILY SIZE & ESTIMATE ANNUAL HOUSEHOLD INCOME FOR 2024

We ask every patient to share their annual household income. We only collect aggregate information because BTAMC receives federal funding for assistance programs that benefit patients with lower incomes. Your information is confidential. Thank you!

Family Size	(<=100%)	(101% - 125%)	(126% - 150%)	(151% - 175%)	(176% - 200%)	Above 200% FPL
1	$0 - $15,060	$15,061 - $18,825	$18,826 - $22,590	$22,591 - $26,355	$26,356 - $30,120	$30,121 +
2	$0 - $20,440	$20,441 - $25,550	$25,551 - $30,660	$30,661 - $35,770	$35,771 - $40,880	$40,881 +
3	$0 - $25,820	$25,821 - $32,275	$32,276 - $38,730	$38,731 - $45,185	$45,186 - $51,640	$51,641 +
4	$0 - $31,200	$31,201 - $39,000	$39,001 - $46,800	$46,801 - $54,600	$54,601 - $62,400	$62,401 +
5	$0 - $36,580	$36,581 - $45,725	$45,726 - $54,870	$54,871 - $64,015	$64,016 - $73,160	$73,161 +
6	$0 - $41,960	$41,961 - $52,450	$52,451 - $62,940	$62,941 - $73,430	$73,431 - $83,920	$83,921 +
7	$0 - $47,340	$47,341 - $59,175	$59,176 - $71,010	$71,011 - $82,845	$82,846 - $94,680	$94,681 +
8	$0 - $52,720	$52,721 - $65,900	$65,901 - $79,080	$79,081 - $92,260	$92,261 - $105,440	$105,441 +

"The mission of Broad Top Area Medical Center, Inc. is to provide access to affordable, high-quality care without discrimination."

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As a Federally Qualified Health Center (FQHC), we are required to collect the following information from every patient we serve. The data you provide is for continued grant funding and your personal information is not reported. You may choose not to disclose some information, below. Please select "Declined/Refused". Thank you for your cooperation and choosing BTAMC as your health care provider.

Employment Status: ☐ Full-time ☐ Part-time **Employer Name:** _____ **Phone #**_____
☐ Self Employed ☐ Military Veteran ☐ Retired ☐ Disabled ☐ Student
☐ Seasonal Worker without a Residence ☐ Migratory Worker with a Residence

Shelter Status: ☐ Houseless-Street ☐ Houseless-Shelter ☐Doubling-up ☐ Public Housing ☐ N/A

Gender Identity: (How do you identify yourself today?)
☐ Male ☐ Transgender Male/Female-to-Male ☐ Declined/Refused
☐ Female ☐ Transgender Female/Male-to-Female ☐ Non-binary

Sexual Orientation: ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual
☐ Other: _____ ☐ Declined/Refused ☐ Uncertain/Don't Know

EMERGENCY & NON-EMERGENCY CONTACTS & CONSENT TO SHARE PERSONAL HEALTH INFORMATION

I authorize BTAMC to share personal health information with the named persons, as designated below.

Name: _____ **PHONE:** _____ **Relationship:** _____
☐ **Emergency Contact** ☐ Medical ☐ Billing ☐ Scheduling

Name: _____ **PHONE:** _____ **Relationship:** _____
☐ **Emergency Contact** ☐ Medical ☐ Billing ☐ Scheduling

Name: _____ **PHONE:** _____ **Relationship:** _____
☐ **Emergency Contact** ☐ Medical ☐ Billing ☐ Scheduling

Name: _____ **PHONE:** _____ **Relationship:** _____
☐ **Emergency Contact** ☐ Medical ☐ Billing ☐ Scheduling

TREATMENT & PAYMENT AUTHORIZATION

As a patient of BTAMC, I authorize treatment for myself, or the identified minor. I consent to clinical assessment, treatment, testing or tele-health services, including audio/visual or audio only encounter. I understand BTAMC uses an integrated, team-based approach to evaluation and management. Services may include primary medical care, integrated behavioral health services, preventative or additional dental services, patient outreach support and assistance, care management services, and/or some specialty services. Additionally, our integrated care specialists may provide consultation, behavioral health assessments, counseling interventions or support services, as you and your BTAMC provider decide are appropriate. I authorize BTAMC to release my medical information for the continuum of care with other medical providers and facilities, or with insurance payors to seek reimbursement for services provided.

I understand that I am financially responsible for all service charges for myself or identified minor, whether or not the service(s) are covered by insurance. BTAMC will submit claims to my insurance company to secure payment for all services provided. I understand charges not covered by insurance such as, co-pays, co-insurance, deductibles or sliding fees are my responsibility. I understand that I may apply for Sliding Fee Discounts or set up payment arrangements with the BTAMC Billing Department. I understand any checks returned by my financial institution will incur a $25.00 charge.

PATIENT / GUARDIAN SIGNATURE: _____ **DATE:** _____

Data Entry- Staff Initials: _____**Date:** _____ **Scanned – Staff Initials:**_____**Date:** _____

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Broad Top Health & Wellness
BTAMC Inc.

NEW PATIENT REGISTRATION & MEDICAL HISTORY FORM

****

We would like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health care needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA).

PATIENT NAME: _____ **DATE OF BIRTH:** _____

◆ Please briefly state in the box below the reason for your visit ◆

How did you hear about our practice?

◆ Review of Systems ◆

Please review the following symptoms and circle those items that are a problem for you.

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

◆ Past Medical History ◆

Condition / Disease	Year Began	Condition / Disease	Year Began
❑ Usual Childhood Disease (Mumps, Measles, Chicken Pox)		❑ Cancer Type: Location:	
❑ **Covid-19 / SARS-CoV-2**		❑ Bleeding Problems / Hemophilia / Anemia	
❑ Hypertension		❑ Brain Injury / Brain Malformation	
❑ High Cholesterol		❑ Epilepsy / Seizures	
❑ Hypothyroid (low) or Hyperthyroid (high)		❑ Depression / Anxiety / Nervousness	
❑ COPD, Emphysema or Asthma		❑ Mental Disorder / Behavioral Problem	
❑ Respiratory Disease / TB		❑ Dementia / Alzheimer's Disease	
❑ Diabetes		❑ MS / ALS / Parkinson's Disease	
❑ GERD / Ulcers / Stomach Problems		❑ Arthritis / RA / Lupus	
❑ Heart Disease / Mitral Valve Prolapse		❑ Hepatitis / Liver Disease	
❑ Blood Clot / DVT / Pulmonary Embolus		❑ Kidney Disease	

◆ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ◆

Operation / Hospitalization / Injury	Month / Yr.	Operation / Hospitalization / Injury	Month / Yr.

◆ Other Physicians and Specialists ◆

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc.)

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NEW PATIENT REGISTRATION & MEDICAL HISTORY FORM

****

◆ Medication or Food Allergies or Intolerances ◆

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	Reaction	Medication / Food	Reaction

◆ Medications, Vitamins and Herbal Supplements ◆

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency

◆ Disease Prevention and Health Maintenance ◆

Please list below the most recent dates of your vaccines and health screening tests

	Month / Yr.		Month / Yr.		Month / Yr.
COVID-19 Vaccine		Mammogram		Endoscopy (EGD)	
Flu Vaccine		Pap Smear		Stent Placement	
Pneumonia Vaccine		Prostate Exam		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Heart Stress Test	
Hepatitis B Vaccine		Bone Density		Echocardiogram	
Shingles Vaccine		Eye Exam		EKG	
Gardasil Vaccine		Foot Exam		**Most Recent Lab Work**	

◆ Family Health History ◆

Please list below the health history of your genetic (blood) relatives

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Problems
Paternal Grandfather:				
Paternal Grandmother:				
Maternal Grandfather:				
Maternal Grandmother:				
Father:				
Mother:				
Sibling:				
Sibling:				
Children:				

◆ Social History ◆

What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?	Do/Did you use other nicotine products?	
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

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Due to the complexity of the medical insurance industry, it is important that we know whether you have an existing doctor. These physicians are often referred to as your PCP Primary Care Provider. For many insurance plans, he or she is the only provider who can approve of you receiving non-emergency care for things such as office visits, X-rays, lab tests, cardiac stress tests, colonoscopy, and referrals to specialists, etc. If we see you for non-emergency care and order such things without PCP approval, you would then be billed personally for the costs. By signing this statement, you acknowledge this responsibility. Your signature also indicates that you have no other PCP.

Clinical Intake Information

Broad Top Area Medical Center, Inc. utilizes physician, nurse practitioner, and physician assistant providers. When scheduling your new patient appointment, we must know your past medical history, medications, and current problem to determine which type of provider can best meet your needs. For this reason, we ask you to provide the following information. Be advised, there is no guarantee or assurance that our provider will determine the continued need for or initiation of a controlled substances as part of your management plan.

List All Prior Medical Providers: _____

_____

List Current Medical Problem: _____

Medical Problems – Past & Present

Problem	Yes	No	Problem	Yes	No
Back Pain			*Cancer*		
Nerve Pain			*Migraine/Headaches*		
Muscle Aches and Pain			*Other Cause of Chronic Pain*		
Arthritis/Joint Problems			*Learning or Attention Problem*		
High Blood Pressure			Heart Problem		
Strokes			High Cholesterol		
Diabetes/Sugar			Seizure/Convulsion		
Asthma			Lung Problem		
Liver Problem			Reflux or Stomach Problem		
Thyroid Problem			Kidney Problem		
Eye Problem					

List All Prior Surgeries: _____

_____

List All medications, both prescription and over the counter drugs: (add pages if needed)

_____

_____

_____

PRINT NAME: BIRTH DATE:

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

PATIENT SIGNATURE: **DATE:**

Broad Top Health & Wellness
BTAMC Inc.

Broad Top Area Medical Center, Inc.

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

PATIENT NAME: _____ DOB: _____
ADDRESS: _____ SS#: _____ - _____ - _____
_____
PHONE#: _____ EMAIL ADDRESS: _____

I, HEREBY AUTHORIZED THE FOLLOWING:

Name of Practitioner/Facility:_____

Address: _____

Phone & Fax: _____

To RELEASE information TO and OR Exchange records with: Broad Top Area Medical Center, Inc.
****CIRCLE Office of choice and direct all records to this office****

☐ **Broad Top Medical Center**
4133 Medical Center Drive, PO Box 127
Broad Top, PA 16621-9001
Phone: 814-635-2916
Fax: (814) 635-2918

☐ **Trough Creek Medical Center**
358 Seminary Street, PO Box 158
Cassville, PA 16623-6203
Phone: 814-448-9226
Fax: 814-448-2068

☐ **Primary Care Center**
790 Bryan Street, Suite 2
Huntingdon, PA 16652-2410
Phone: 814-643-8300
Fax: 814-643-8299 or 814-643-8660

☐ **Belleville Wellness Center**
375 S. Kishacoquillas Street
Belleville, PA 17004-8620
Phone: 717-935-2065
Fax: 717-935-5560

☐ **Huntingdon Family Care Center**
835 Washington Street, PO Box 185
Huntingdon, PA 16652-1725
Phone: 814-506-8114
Fax: 814-506-8553 or 814-506-8623

☐ **Family Wellness Center**
814 Washington Street
Huntingdon, PA 16652-1726
Phone: 814-506-8463
Fax: 814-506-8324

☐ **Mount Union Medical Center**
95 S. Park Street
Mount Union, PA 17066-1334
Phone: 814-542-8627
Fax: 814-542-5444

☐ **Pediatric & Family Healthcare**
6311 Margy Drive, Suite 2
Huntingdon, PA 16652-6934
Phone: 814-506-8490
Fax: 814-506-8493

☐ **Walk-In Clinic**
6678 Towne Center Blvd.
Huntingdon, PA 16652-6934
Phone: 814-643-1232
Fax: 814-643-4267

☐ **Juniata Valley BTAMC Clinic**
846 Medical Center Drive, PO Box 355
Alexandria, PA 16611-2936
Telephone: 814-667-7400
Fax: 814-667-7395

☐ **Southern Huntingdon County Medical Center**
626 Water Street, Suite 1, PO Box 40
Orbisonia, PA 17243-9432
Phone: 814-447-5556
Fax: 814-584-5741

☐ **Southern Huntingdon County Dental Clinic**
626 Water Street, Suite 2, PO BOX 146
Orbisonia, PA 17243-9432
Phone: 814-447-3159
Fax: 814-447-3195

The extent or nature of information to be released is indicated below:

_____ COMPLETE DENTAL RECORDS
_____ COMPLETE MEDICAL RECORDS
_____ OFFICE NOTES (DATES) _____
_____ OPERATIVE REPORT
_____ DISCHARGE SUMMARY
_____ INPATIENT CARE (DATES OF SERVICE) _____
_____ EMERGENCY CARE (DATES OF SERVICE) _____

_____ X-RAYS
_____ LABORATORY
_____ MEDICATION LISTS
_____ HISTORY & PHYSICAL
_____ OTHER: _____

Broad Top Health & Wellness
BTAMC Inc.

Broad Top Area Medical Center, Inc.

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

The purpose for release of the above information is indicated below:

_____ CONTINUED CARE _____TRANSFER _____ INSURANCE _____ LEGAL _____ OTHER

If other is checked, please specify reason needed:
_____

I _____ GIVE CONSENT TO THE RELEASE OF THESE RECORDS, WHICH I UNDERSTAND MAY INCLUDE PSYCHIATRIC INFORMATION, DRUG AND ALCOHOL INFORMATION, AND/OR HIV/AIDS INFORMATION.

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated, and signed communication to the facility. This consent will expire in one year from the date signed, unless otherwise stated as follows: _____.
I understand that I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected.

X_____ DATE SIGNED: _____
(Signature of PATIENT)

X_____ WITNESS: _____
(Signature of Parent, Guardian, or Legal Representative)

If signed by other than the patient, state relationship and reason for patient's inability to sign:

_____

Verbal consent requires the signature of two witnesses:

_____ _____
Signature of Witness (1) Date Signature of Witness (2) Date

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer will be protected by the Health Insurance Portability and Accountability Act.

A copy of this authorization has been ___ **Accepted** ___ **Rejected** by the Patient/Representative.

Broad Top Area Medical Center, Inc.

2024 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION & INTEREST FORM

FEDERAL POVERTY GUIDELINES

Broad Top Area Medical Center Inc., (BTAMC) is a non-profit Federally Qualified Health Center, our Mission is to provide access to affordable, high-quality healthcare without discrimination based on one's race, color, sex, disability, age, creed, or national origin. BTAMC will provide in-scope services to all patients, regardless of their insurance status or ability to pay. Every patient may apply for our Sliding Fee Scale Discount Program (SFS) to determine qualification. Patients may choose to decline the benefit program.

Eligibility for Sliding Fee Discounts is based on the federal poverty level (FPL) income guidelines which are adjusted annually and operate in accordance with other federal program regulations. **ALL** patients are encouraged to apply. Uninsured and under-insured patients may qualify for the program based on their household size and their family's income. Sliding Fee Scale Discount Program applications are available at every BTAMC reception desk and on-line – visit **www.broadtopmedical.com**

Important discount program points are:

- The Sliding Fee Scale provides significant discounts for **Medical** and **Dental** services at every BTAMC location.
- The Sliding Fee Scale **is not** an insurance program – it is a benefit offered to ALL patients.
- The Sliding Fee Scale benefit year is from **March 1st to the last day of February**.
- Your eligibility is based only on your household size and the gross income for your household.
- You may qualify for the program, even if you have third-party insurance coverage.
- You must apply for the program to determine eligibility for Sliding Fee Scale Discounts.
- You must provide documentation for proof of income to complete the application and assessment process.
- You will qualify if your household income is below and/or up to **200 %** of the federal poverty level.
- You are encouraged to re-apply anytime your household income or household size changes, such as when someone becomes unemployed, or you add **or** lose a family member – even then the change is temporary.
- **You must renew applications and submit proof of income annually for approved Sliding Fee Scale Discounts.**
- Applications & questions can be submitted to the office in person, by mail or via secure Email to: **enrollment@broadtopmedical.com**

2024 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA
* For families/households with more than 8 persons, add **$5,380** for each additional person.

ON THE TABLE BELOW PLEASE CIRCLE FAMILY SIZE & ESTIMATED ANNUAL HOUSEHOLD INCOME FOR 2024

We ask every patient to share their annual household income. We only collect aggregate information because BTAMC receives federal funding for assistance programs that benefit patients with lower incomes. Your information is confidential. Thank you!

Family Size	Slide A (<=100%)	Slide B (101% - 125%)	Slide C (126% - 150%)	Slide D (151% - 175%)	Slide E (176% - 200%)	Above 200% FPL
1	$0 - $15,060	$15,061 - $18,825	$18,826 - $22,590	$22,591 - $26,355	$26,356 - $30,120	$30,121 +
2	$0 - $20,440	$20,441 - $25,550	$25,551 - $30,660	$30,661 - $35,770	$35,771 - $40,880	$40,881 +
3	$0 - $25,820	$25,821 - $32,275	$32,276 - $38,730	$38,731 - $45,185	$45,186 - $51,640	$51,641 +
4	$0 - $31,200	$31,201 - $39,000	$39,001 - $46,800	$46,801 - $54,600	$54,601 - $62,400	$62,401 +
5	$0 - $36,580	$36,581 - $45,725	$45,726 - $54,870	$54,871 - $64,015	$64,016 - $73,160	$73,161 +
6	$0 - $41,960	$41,961 - $52,450	$52,451 - $62,940	$62,941 - $73,430	$73,431 - $83,920	$83,921 +
7	$0 - $47,340	$47,341 - $59,175	$59,176 - $71,010	$71,011 - $82,845	$82,846 - $94,680	$94,681 +
8	$0 - $52,720	$52,721 - $65,900	$65,901 - $79,080	$79,081 - $92,260	$92,261 - $105,440	$105,441 +

☐ **I understand that I may qualify for the Sliding Fee Discount Program but at this time, I choose to decline.**

☐ **Yes, I would like to apply for the sliding fee discount program, please contact me at this Phone Number: _____**

_____ _____

Print Name of Patient/Applicant **or** Parent/Guardian Signature of Patient Date

_____ _____

Patient/Applicant's Date of Birth Signature of Staff/Witness Date

2024/rah – CAC

Broad Top Health & Wellness
BTAMC Inc.

Broad Top Area Medical Center, Inc. will strictly prohibit video and voice recording of consultations and will not be tolerated at any time.

Privileged communication between the patient's and the physician's relationship is private and should remain confidential. The patient has an obligation to be honest with their provider; just as it is the physician's duty to be fair and honest in their patient's care. Informed consent must be expressed, mutually to disclose Protected Health Information (PHI) at any time.

Potential Adverse Outcomes of Recording:

Recording may inhibit free and trustful information exchange.

Recording may hinder a patient's acknowledgment of recent events or problems that they perceive, might affect their independence if they know family members may access the information.

Recording might create fear for a patient about physical conditions being revealed when found on physical examination.

Recording may prompt providers to become guarded and introduce defensive medicine in a previously, trusting relationship.

Recording may mutually affect the patient's reciprocal sense of trust.

Recording could inadvertently, record Protected Health Information (PHI) about other, unrelated parties within the office.

Implementation:

To insure confidentiality and privacy of patients, their family & caregivers, our employees and **ALL** Protected Health Information (PHI) electronic recording is strictly prohibited. As a patient, family member, or caregiver, I agree to adhere to this policy by signing below.

Your provider will create a printed record of your visit or a copy of the visit summary with a signed authorization to release information.

Patient(print): Signature: Date:

_____

Witness(print): Signature: Date:

_____

TH/rah – 2021

Broad Top Health & Wellness
BTAMC Inc.

CONTROLLED SUBSTANCE AGREEMENT

Patient's Name: _____ Date of Birth: _____

Controlled substance medications (i.e. narcotics, tranquilizers, stimulants, benzodiazepines and barbiturates) are useful, but have a high potential for misuse. They are closely controlled by local, state, and federal governments. They are intended to reduce pain, improve functions, and/or ability to work; manage anxiety, reduce distractibility and improve attention.

Management of Attention Deficit Disorder with or without hyperactivity may involve the use of controlled substances. The ADD management plan includes assessment and reassessment of your need for therapy. The plan may also include behavioral therapy, educational support, counseling, or other therapies established between the patient and a single provider.

Management of anxiety may involve the use of a controlled substance. Anxiety management includes assessment and reassessment of your need for therapy. The use of a benzodiazepine is intended for short term use in the management of anxiety. The use of a long-acting medication for generalized anxiety disorder may be warranted. The plan may also include behavioral therapy, educational support, counseling, or other therapies established between the patient and a single provider.

Pain management involves a thorough history and physical for the cause of the pain. A plan of management will be established between the patient and a single provider. The pain management plan often involves multiple therapies that include but are not limited to physical therapy, regular exercise, yoga, osteopathic manipulative therapy, and massage therapy. Pain management may also include specific pain medications prescribed based on the types of pain present. It is mandatory that all aspects of the plan are adhered to.

If a controlled substance is determined by my provider to be appropriate for the management of my pain, anxiety, distractibility, or other medical condition, I agree to the following: **(Please initial to acknowledge your responsibility)**

_____ **1.** I am responsible for the controlled substance medications prescribed to me. If my prescriptions are misplaced, stolen, or if "I run out early", I understand that this medication will not be replaced regardless of the circumstances.

_____**2.** I am responsible for the storage of my medications in a safe place. I understand if someone besides myself takes this controlled medication, it can cause harm which includes but not limited to, drowsiness, fatigue, altered mental status, respiratory depression or death.

_____ **3.** Refills of controlled substance medications:

_____**a)** will be made only during regular office hours Monday through Friday, during face to face or formal telehealth visit, at the interval determined by your provider and during a scheduled office visit. Refills will not be made at night, weekends, or during holidays.

_____**b)** will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

_____**c)** I understand that I must call at least 72-hours ahead to schedule an appointment.

_____ **4.** It may be deemed necessary by my doctor that I see a medication-use specialist (pain management), or I am already seeing one and receive my controlled substance medications from that specialist who is _____. I understand that if I do not attend such an appointment, or I am dismissed due to non-compliance, BTAMC will not assume my medication management. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be filled. This management is exclusive; I will not seek controlled substance medications from any other organization, practice, or provider.

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_____**5.** I agree to comply with random medication testing and pill counts on demand. I will be held accountable for the proper documentations and use of any medications.

_____**6.** I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately and I may be dismissed as a patient. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

_____**7.** I understand that the main treatment goal is to improve my ability to function and/or work and reduce, not eliminate my pain. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I agree to follow the entire treatment plan as developed by myself and my physician. I will meet with my physician to discuss any changes that I want to make to my plan before making any changes on my own.

_____**8.** I do understand that taking a controlled medication does have risks which may or may not happen. These risks include tolerance, dependency, addiction and hyperalgesia (elevated sensitivity). There are side effects to controlled medications and by taking these medications, I understand that I may experience nausea, constipation, drowsiness, itching, vomiting, respiratory depression and/or fatigue included but not limited to these signs and symptoms.

_____**9.** I understand the long-term use of controlled substances may have unknown risks associated with chronic opioid use. My physician will advise me of advances in the field and will make necessary treatment changes.

_____**10.** I further understand that if I violate this controlled substance agreement due to non-adherence to medical directions, such as, failing to take medications as prescribed, utilizing other illicit drugs, abuse of controlled medications, or failure to follow the entire treatment plan, I may be subject to dismissal from this facility.

I also understand that not following my prescriber's directions on when and how to take my medication can cause serious complications which include but not limited to altered mental status/confusion, respiratory depression or death. I further understand that when my controlled medication is taken with other medications/substances which include but not limited to benzodiazepines, sleeping agents, narcotics, alcohol, and other illicit drugs, serious complications can occur such as altered mental, status confusion, lightheadedness, respiratory depression and even death.

_____**11.** If I display disruptive behaviors such as: Yelling, Foul and Abusive Language, Threatening Gestures, Public Criticism of Staff, Insults and Shaming Staff, Intimidation, Invading One's Space, Slamming Down Objects, Physically Aggressive or Assaultive Behavior, or Assaultive Behavior or being Uncooperative with Office Staff; such as, refusing to complete requested documents or providing requested samples. Dependent on severity, I may first be asked to leave the office without being seen. If I refuse to give a sample or I am repeatedly disruptive or uncooperative, my care may be terminated.

_____**12.** I agree to use only one pharmacy for narcotic medications. If I choose to change pharmacies, I will notify BTAMC before going to a new pharmacy.

My pharmacy is: _____

My pharmacy's phone number: _____

_____**13.** If I am unable to pick up a controlled medication myself, I delegate:

Name: _____

Relation: _____

Phone number: _____

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_____**14.** I do understand if my delegate misplaces my prescription, the controlled medication will not be filled early.

_____**15.** If I chose to change my delegate, I will notify the office of the new delegate and their information.

I certify the following:

_____ **1.** I have fully informed my prescriber of any past or present substance use (including alcohol, prescription medications, or illicit substances) so that we can discuss the benefits and risks of using a controlled substance in my treatment.

_____ **2.** I will not share, trade, or sell a prescribed controlled substance, as this would be considered diversion and is a crime.

_____ **3.** I understand that drug testing/screening is a routine part of the care of patients being prescribed controlled substances. I understand that I may be responsible for the costs of testing or screening, if it is not covered by my insurance. The cost of drug testing/screening is not covered by the Sliding Fee Scale Discount, and I will be responsible for payment, up front.

_____ **4.** I will notify the office if I will be out of town. This allows for the occurrence of a random pill count and a required 4-hour response time.

This treatment agreement may be discontinued if I do not meet the conditions described above. Violation of the above guidelines may lead to termination of my care with Broad Top Area Medical Center, Inc.

I have been fully informed by _____ regarding the warning signs and symptoms of a substance use disorder with regard to this medication. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve a desired effect; and in doing so, increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, When I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms.

Patient Signature: _____Date: _____

Witness Signature: _____Date:_____

Witness Signature: _____Date: _____

_____ By initialing, I have been given a copy of the controlled medication agreement.

Approved 01-20-2020, JBH/rah
Approved 01/15/2023, JBH/amw

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Patient Learning Assessment Form

PATIENT LEARNING ASSESSMENT

As a part of the Broad Top Area Medical Center, we strive to meet the diverse needs of our patients. Please complete the following questionnaire to assist us in making every attempt to meet your learning needs. Please let us know if you need help in completing this form. Thank you.

1. Are you able to read? ☐ Yes ☐ No

2 Are you able to write? ☐ Yes ☐ No

3 Do you want to learn about your health needs? ☐ Yes ☐ No

4 Please indicate your highest level of education (last grade of school completed)? _____

5 Please indicate your dominant language: ☐ English ☐ Spanish ☐ Other (Specify)

6 Do you need a translator? ☐ Yes ☐ No

7 Do you use a hearing aid? ☐ Yes ☐ No

8 Do you use any other device (s) to aid in communication? ☐ Yes ☐ No
If yes, please explain: _____

9 Please indicate any possible barriers to education:

☐ None ☐ Cultural ☐ Emotional ☐ Limited Learning Ability ☐ Learning Deficit ☐ Physical Limitations ☐ Religious ☐ Visual/Hearing Limitations

10 Please check preferred learning style (s). Please check all that apply.

☐ Reading a handout or pamphlet

☐ Watching a demonstration and then doing the task

☐ Listening to someone provide explanation of the topic

☐ Watching the topic on video

Patient Signature: _____ Date of Birth: _____

If patient is unable to sign, name of person completing form: _____
Relationship to patient: _____

Staff Signature: _____ Date: _____