Morris County Hospital [MCH] affiliated Rural Health Clinics

MCH Clinic – Chase County MCH Medical Clinic (Council Grove)
MCH Clinic – White City

Welcome Letter and Guide for Our Patients

Welcome to MCH clinics, and thank you for choosing us as your provider for primary medical care. Our goal is to provide quality medical care, which is easily accessible and responsive to you in your time of need.
Along with your provider, you are the most important person in managing your health. Having MCH clinics as your primary care provider has many benefits:

- ✓ Development of an ongoing relationship with you and your family to manage your healthcare needs.
- ✓ Coordination of care with other providers, specialist and community resources as needed.
- ✓ Access to all your health information through electronic records in order to effectively manage your care.

How You Can Help:

- ✓ Talk with your primary care provider and team about any questions you have.
- ✓ Keep in touch with your team if further questions arise about your health
- ✓ Take care of your health by following the plan recommended by your team
- ✓ Schedule a complete physical exam at least once a year
- ✓ Let us know how we're doing and how we can improve.

We look forward to serving your healthcare needs!
This packet contains information that will help you understand how our office works to best serve you, as well as patient forms, we need you to complete and bring to your first appointment.

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Please Bring all of the following to your first appointment:

- Identification Card (driver's license or ID)
- Insurance Card(s)
- Medication in original containers or list of medications from pharmacy
- Over the counter medications
- All completed forms from this packet.

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NO SHOW AND LATE POLICY

Patient Name (print): _____

Patient Date of Birth: _____

Dear Patient:

We have been experiencing a large number of patients who make appointments and then do not keep that appointment, sadly we are not notified of this and we in effect are denying other patients the opportunity to seek medical attention.

March 1, 2020 MCH Medical clinic's "No Show" policy went into effect. Patients will be notified to reschedule after each no-show event. A No show event is if you fail to check in for your scheduled appointment or cancel within 2 hours of your scheduled appointment. Once you have 3 no show events in a 12-month period you may be dismissed from the practice.

We also request that our patients be on time for their appointments. When a patient is late for their scheduled appointment, this causes other patients to wait longer and often past their scheduled appointment time. New patients who are 10 minutes late or greater for an appointment will be asked to reschedule. Established patients who are 10 minutes late or greater may be asked to reschedule or will be worked in if the schedule allows. If unable to be worked in, this will be considered a No Show.

Thank you. We look forward to caring for you.

_____ _____
Patient/Legal Guardian Signature Date

MCH Medical Clinic

604 N. Washington
Council Grove, KS 66846
620-767-5126
620-767-6910 (fax)

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's name_____ **Date of Birth** _____

Social Security# (Last 4 digits):_____ **Phone Number** _____ **Medical Record #:**_____

Address _____

Records To: _____ Phone # _____

Address _____ Fax # _____

Records From:_____ Phone # _____

Address _____ Fax #'s _____

The purpose of this release is to share written and verbal information sufficient to ensure continuity of care. I understand that eligibility, payment or treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I understand that fees may be charged for preparing and sending copies of records. I understand that requested 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 or mental health services, and treatment of alcohol and drug abuse (CFR 42).

Purpose for use or disclosure (check one):

- ❑ Continuity of Care
- ❑ Personal
- ❑ Litigation
- ❑ Insurance/Disability
- ❑ Other _____

❑ Medical Record Includes (last 2 years)	❑ Progress Notes	❑ HIV (Human immunodeficiency virus) results
❑ Emergency Room	❑ Lab Report (s)	❑ Tuberculosis Test Results
❑ History and Physical	❑ Imaging/Radiology Report (s)	❑ Immunization
❑ Consult Report (s)	❑ Rehab Services	❑ Cardiac Studies
❑ Operative Report (s)	❑ Discharge Summary	❑ Other

Disclosure Format (Paper is default if not marked). ____ Paper ____ CD _____ US Mail _____ Fax

Medical Records are being requested for the following dates of treatment:

- ❑ _____ to _____
- ❑ All past, present, and future periods.

The disclosure of all my Protected Health Information for the above time period except as noted below:

- ❑ Do not disclose psychiatric/psychological/mental health treatment records.
- ❑ Do not disclose alcohol/drug abuse treatment records.
- ❑ Do not disclose other records (identify below

_____

This consent shall expire on _____. (If left blank, expiration is 12 months from the date entered below).
I understand that I may revoke this authorization at any time (except to the extent that action has been taken and reliance upon it, by providing verbal or written notice of revocation to MCH Privacy Officer or designated staff.

_____ _____
Signature of Patient or Personal Representative **Date**

_____ _____
Signature of Parent or Personal Representative **Relationship to Patient**

Dept: _____ Completed by: _____ Date: _____

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

Please list current and previous physicians or providers you have seen within the last 5-7 years

Provider Name	Dates Seen	Provider Name	Dates Seen

	Date Last Completed	Order/Performing Provider & Facility Completed at
Date of Last Annual/Physical Exam:		
Bone Density Testing (DEXA)		
Colorectal Cancer Screening		
Pap Test./Cervical Cancer Screening		
Mammogram		

Women's Health Information (Please skip if not applicable)

Date of last Menstrual Cycle? _____
Heavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No
Are you currently pregnant or breastfeeding? ☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____
Have you had a D&C, hysterectomy, tubal ligation or Cesarean?
☐ Yes (*please list procedure & when)* _____ ☐ No

List all allergies and/or reactions to medications

Substance	Type of Reaction	Substance	Type of Reaction

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers (Use Back if need more space)

Name the Drug	Strength	Frequency Taken

List all surgeries and procedures (include last colonoscopy, EGD, etc)

Year	Name of Surgery and Side (right or left)	Hospital

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List all medical problems that other doctors have diagnosed (Use Back if need more space)			
Medical Issue/Problem	Date of Onset	Medical Issue/Problem	Date of Onset

Other hospitalizations (Use Back if need more space)		
Year	Reason	Hospital

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FAMILY MEDICAL HISTORY INFORMATION			
	Health Problems/Conditions		Health Problems/Conditions
Father		**Mother**	
Grandmother Paternal		**Grandfather Maternal**	
Grandfather Paternal		**Grandmother Maternal**	
Siblings		**Children**	
☐ M ☐ F		☐ M ☐ F	
☐ M ☐ F		☐ M ☐ F	
☐ M ☐ F		☐ M ☐ F	

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All questions contained in this questionnaire are optional and will be kept strictly confidential.

Thinking about your typical week, how often would you spend time exercising?
Duration (average of minutes): _____
Times per week: ☐1-2 times/week ☐ 3-4 times/week ☐ 5-6 times/week ☐ Daily
Exercise Type (select all that apply): ☐ Walking ☐Aerobics ☐Running ☐Swimming
☐ Weight lifting ☐Yoga ☐Other: _____.

Which of the following would best describe your typical diet/food plan?
☐ Regular ☐Calorie restricted ☐Diabetic ☐Vegetarian ☐Other: _____.

Which the following type of caffeine beverages do you routinely drink (select all that apply)? ?
☐ None ☐Coffee ☐Tea ☐Cola/Soda ☐Other: _____.
How many ounces do you drink per day? : _____.

Which of the following would best describe your experience with smoking tobacco?
☐ Currently smoke every day. *Please estimate #* _____per day .
☐ Currently smoke some days. *Please estimate #* _____per week.
☐ Previous smoke & have quit. *Started at age* _____. *Stopped age* _____.
☐ Never used

Which of the following would best describe your experience with using smokeless tobacco?
☐ Currently used within the last 30 days
☐ Previous smoke & have quit. *Started at age* _____. *Stopped age* _____.
☐ Never used

Which of the following would best describe your experience with using electronic cigarettes (vaping)
☐ Currently used within the last 90 days. *Please estimate #* _____per day .
☐ Previous use & quite more than 90 days ago. *Started at age* _____. *Stopped age* _____.
☐ Never used

Do you drink alcohol? ☐ Yes ☐ No
If yes, what type? ☐ Beer ☐ Wine ☐ Liquor ☐ Other
How often do you drink?? ☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 times per week ☐ 3-5 times per week
☐ Daily ☐ Several times per day

Do you currently use recreational or street drugs? ☐ Yes ☐No
If yes, what kind of drugs? : _____.
Have you ever given yourself street drugs with a needle? ☐ Yes ☐No

Are you sexually active? ☐ Yes ☐No
If yes, are you trying for a pregnancy? ☐ Yes ☐No
If not trying for a pregnancy list contraceptive or barrier method used: : _____.
Any discomfort with intercourse? ☐ Yes ☐No

Which of the following best describe your home environment (select all that apply)?
☐ Live alone ☐ Live w/ Children ☐ Live w/ Parent – select Father Mother Both
☐ Live w/ Siblings ☐ Live w/ Significant Other ☐ Live w/ Spouse ☐ Other _____.

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?
☐ Yes ☐No

Have you fallen in the past year (12 months)? ☐ Yes ☐ No
If yes, how many times _____ Were you injured? ☐ Yes ☐ No
Do you feel unsteady standing or walking? ☐ Yes ☐ No
Do you worry about falling? ☐ Yes ☐ No