

# Authorization for Disclosure of Health Information

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law.

Examples of some instances in which we are required to disclose your PHI include:

Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation. Progressive Medical Center will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Guardian/ Parent name: \_\_\_\_\_ Signature: \_\_\_\_\_

## ***My health information may be disclosed to and used by the following individual:***

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I understand that I have a 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 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.

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 that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: Progressive Medical Center.

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 or mental health services and treatment for alcohol and drug abuse.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Date

**PLEASE NOTE:** This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.



**Georgia Department of Public Health  
Georgia Volunteer Health Care Program (GVHCP)  
Patient Financial Eligibility Form**



Clinic/Program/Provider: Community Whole Health Clinic

**SECTION I – PATIENT DEMOGRAPHIC INFORMATION**

**Patient Name:**

(Last Name) (First Name) (Middle Initial) (Nickname or Preferred Name)

**Address: \***

(Street) (City/State) (Zip Code) (County)

**Telephone Number: \*** \_\_\_\_\_ **Secondary Telephone Number:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:**  Male  Female **Race/Ethnicity:** \_\_\_\_\_

**SECTION II - INSURANCE INFORMATION/FINANCIAL ELIGIBILITY**

**Do you have insurance that covers? \***  Health  Vision  Dental  No Insurance

If so, what services/specialty does your insurance exclude? \_\_\_\_\_

**Do you currently have Georgia Medicaid?**  Yes  No **Medicare Part B?**  Yes  No

**I am: \***  Uninsured (No insurance)  Underinsured (Do not have coverage for services being sought)

Your income must be at or below 200% of the Federal Poverty Level to be eligible to receive services under the GVHCP.

**Please provide the number of dependents in your household (include self/spouse):** \_\_\_\_\_

**Please provide gross family monthly income from all sources: \$** \_\_\_\_\_

**SECTION III – LEGAL ACKNOWLEDGEMENTS**

I understand that I am being referred to a volunteer health care provider who will provide care to me or to someone for whom I am legally responsible. My participation in this referral process is voluntary. The care I receive from the volunteer health care professional will be provided at no charge. I understand that the Volunteer is acting as an employee of the State of Georgia by treating me pursuant to the "Georgia Volunteer Health Care Program." I acknowledge that the exclusive remedy for any injury or damage suffered as a result of any act or omission of a health care provider acting within the scope of duties pursuant to that Program is a lawsuit under the State Tort Claims Act, O.C.G.A. § 50-21-20 *et seq.*

The information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge. I understand that any failure to update this information to the Department upon change in my financial or health insurance status may disqualify me from receiving health or dental care under the GVHCP. I further understand that making false statements or representations on this form may be punishable under O.C.G.A. Section 16-10-20 by a fine of not more than \$1,000 or by imprisonment for not less than one or more than five years, or both.

**"Please sign here stating you provided truthful information about your income and insurance statuses."**

**X**  
\_\_\_\_\_  
**Signature of Patient/Parent or Guardian**

\_\_\_\_\_  
**Printed Name of Person Signing**

\_\_\_\_\_  
**Relationship to Minor  
(If applicable)**

**X**  
\_\_\_\_\_  
**Signature of Eligibility Specialist**

\_\_\_\_\_  
**Printed Name of Eligibility Specialist**

\_\_\_\_\_  
**Date**



**Today's Date:**

Patient's Name: Mr. / Mrs. / Ms. (circle one) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home/Cell Phone number: \_\_\_\_\_

Email address: \_\_\_\_\_

Occupation: \_\_\_\_\_

What is the BEST way to communicate with you in between office visits?

- Home phone    Cell phone    Email

Is there any place you DO NOT want us to leave a message? \_\_\_\_\_

Emergency Contact Name / Relation: \_\_\_\_\_

Previous Physician's Name/number: \_\_\_\_\_

Please circle those that apply:   Single   Married   Divorced

Number of Children: \_\_\_\_\_

My overall health goals:

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**Chief Complaint/Past Medical History:**

What is the main problem that brought you in today? \_\_\_\_\_

How long have you been having symptoms? \_\_\_\_\_

**Allergies:**

Drug/Medication allergies:

Food allergies:

Environmental allergies (pollen etc.):

**Past Medical History:**

**Have you had any of the following medical issues?**

Condition	Yes	No	Current treatment	Date began	Date Resolved
ADD/ADHD					
Alcoholism/Drug addiction					
Allergies					
Anemia					
Anxiety					
Arthritis					
Asthma					
Autoimmune					
Cancer					
Chemical Sensitivities					
Chronic Fatigue					
Depression					
Diabetes					
Eczema					
Fibromyalgia					
GERD/reflux					
Headaches/migraines					
Heart Disease					
High Blood Pressure					
High Cholesterol					

Irritable Bowel Syndrome					
Lyme Disease					
Mononucleosis					
Menopause					
Mental Illness					
Irritable Bowel					
Obesity					
Ovarian Cysts (PCOS)					
Psoriasis					
Prostate Disease					
Recurrent Strep Infections					
Thyroid Disease					
Other					

**Hospitalizations:**

**If female:** Do you have any of the following:

Irregular menstrual cycles? Yes / No

Extreme heavy bleeding or cramping with menstrual cycles?

Extremely light bleeding with cycles?

Breast tenderness as part of PMS symptoms?

Sugar cravings or mood swings as part of PMS symptoms?

Have you been pregnant? Yes/ No If yes, ages: \_\_\_\_\_ If no, have you tried to get pregnant without success?

Date of your last Menstrual Cycle:

Date of last: Pap \_\_\_\_\_ Mammogram: \_\_\_\_\_

Have you used birth control pills? Yes /No If yes, how long \_\_\_\_\_

**If male:** Do you have any of the following:

Problems attaining/maintaining an erection Yes /No

Difficulty with urination including decreased stream or increased frequency?

**Family Medical History:**

Mother's age (at death if deceased): \_\_\_\_\_

Any medical conditions: \_\_\_\_\_

Father's age (at death if deceased): \_\_\_\_\_

Any medical conditions: \_\_\_\_\_

Siblings' ages and medical conditions: \_\_\_\_\_

Other family members with chronic health conditions (e.g.-diabetes, heart disease, thyroid disease):

List any vitamins or other dietary supplements that you take:

Type of Supplement (e.g. vitamin D, fish oil etc.)	Brand (e.g. Nature's way)	Dose (e.g. 1000 IU)	How often? (e.g. 1 x day, 1 x week)

Please list the medications you are currently taking (prescription and/or over the counter):

Name of Medication	Dose	Frequency

**Weight History**

Have you had any recent changes in your weight that you are concerned about? Yes/No

If yes, please explain: \_\_\_\_\_

Has your weight changed in the last year? Yes/No

Patient/Authorized Person Initials      Date      Provider's Initials      Date  
\_\_\_\_\_  
\_\_\_\_\_

# Lifestyle Medicine

## Short Assessment Form



The following questions comprise the core metrics we propose using to capture readiness, willingness and confidence to change, as well as health behaviors that are aligned with the six pillars of lifestyle medicine. This assessment tool was adapted from the original Loma Linda University/American College of Lifestyle Medicine short form published in 2019 and updated in 2024.

### Readiness to Change

On a scale of 0-10, with 0 being least and 10 being most, how important is it that you make or maintain lifestyle changes to improve your health?

0 1 2 3 4 5 6 7 8 9 10  
 Not Ready                      Somewhat Ready                      Very Ready

On a scale of 0-10, with 0 being least and 10 being most, how confident are you to make or maintain lifestyle changes to improve your health?

0 1 2 3 4 5 6 7 8 9 10  
 Not Confident      Somewhat Confident      Very Confident

### Motivation

Please rank the top 3 areas you are most motivated to change in order to improve your current overall LEVEL OF HEALTH (1 being most motivated).

- \_\_\_ Avoidance of Risky Substances      \_\_\_ Sleep
- \_\_\_ Nutrition                                      \_\_\_ Social Connectedness
- \_\_\_ Physical Activity                              \_\_\_ Stress Management

### Nutrition: ACLM Diet Screener 9

This brief questionnaire will ask about your usual diet over the last 4 weeks. Please try to answer as accurately as possible – there are no right or wrong answers. Your best guess is better than leaving a blank. It's ok if something that you eat falls into more than one category.

Over the last 4 weeks, how often did you eat or drink the following items?

Fruit (Apples, bananas, oranges, melon, berries, or any other fruit)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day



## Nutrition: ACLM Diet Screener 9

Vegetables (Cooked and raw leafy greens, tomatoes, carrots, potatoes, peas, or any other vegetables or dishes that are mostly made from vegetables)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Whole Grains (Oats, brown rice, whole grain bread or whole grain cereal, or any other 100% whole grain products)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Refined Grains or Refined Grain Products (Any items made from white flour or white rice, like bread, tortillas, baked goods or snacks, pasta, or other foods)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Packaged/Prepared, Restaurant, Takeout, or Fast Food Meals (Any store-bought dishes or meals, refrigerated or frozen, or any kind of ready-to-eat meals or dishes, take-out, or meals from a restaurant)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Sugary Foods and Beverages (Sweetened (sugar added) breakfast cereals, sweetened yogurts, candy, other desserts, or other foods with added sugar, or any sweetened beverages including soda/pop, sweetened tea or coffee drinks, energy drinks, etc.)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Salty Foods (Chips, crackers, or other salty snacks; canned soups, sauces, salad dressings, or other foods with added salt)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day

Fried Foods (Fried foods such as French fries, onion rings, fried chicken or other meat, fried potatoes, fry bread, tempura, or other fried foods)

Never	Less than 1x/week	1-3x/week	4-6x/week	1-2x/day	More than 3x/day



## Nutrition: ACLM Diet Screener 9

Which sources of protein do you eat frequently (at least a few times a week)?

Please select all that apply.

- Beef, pork, or lamb
- Lunchmeat, bacon, or sausage
- Poultry or poultry-based dishes
- Wild game (venison, elk)
- Nuts and seeds

- Fish or shellfish or seafood-based dishes
- Beans/legumes, or products made from them
- Dairy and dairy products
- Eggs or egg-based dishes

## Physical Activity: Physical Activity Vital Sign<sup>1</sup>

For an average week in the last 30 days, how many days per week did you engage in moderate to vigorous physical activity (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?

\_\_\_\_\_ days

On those days that you engage in moderate to vigorous physical activity, how many minutes, on average, do you exercise?

\_\_\_\_\_ minutes

During the past month, how many times per week did you do physical activities or exercises to strengthen your muscles?

\_\_\_\_\_ times per week

## Sleep

Over the last 2 weeks, how many hours of sleep did you average in a 24-hour period?

Less than 4 hrs	4-5 hrs	5-6 hrs	6-7 hrs	7-8 hrs	8-9 hrs	9 or more hrs

Over the last 2 weeks, how often did you feel tired or have difficulty staying awake during routine tasks in the day?

Not at all	Several days	More than half the days	Nearly every day

## Mood - PHQ-2<sup>2</sup> *(if not already present in electronic health record)*

Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things

Feeling down, depressed, or hopeless

Not at all	Several days	More than half the days	Nearly every day

\*Note that a recent study was done on accuracy of using the PHQ-2 for detecting depression and frequency of completing the survey. We recommend users consider the findings when determining how to screen for depression in primary care settings.<sup>3</sup>

## Meaning and Connectedness

Over the last 2 weeks, how often have you felt like your life had purpose or meaning?

Not at all	Several days	More than half the days	Nearly every day

Over the last 2 weeks, how often have you felt connected with any support network (e.g. community, spiritual, friends/family, nature, yoga, or meditation)?

Not at all	Several days	More than half the days	Nearly every day

## Substance Use

*In the case that something in the electronic medical record already exists to assess for the following substances, we recommend you use those assessment tools.*

Have you used NICOTINE (cigarettes, e-cigarettes/vaping, chewing tobacco pouches, cigars) in the past year?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If you marked "YES", how many (cigarettes, e-cigarettes/vaping, chewing tobacco pouches, cigars) do you usually use a week?

\_\_\_\_\_ per week

Are you currently using any over-the-counter or prescription nicotine replacement products?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Are you interested in quitting?

\_\_\_\_\_ Yes \_\_\_\_\_ No

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your nicotine use?

0 1 2 3 4 5 6 7 8 9 10  
Not Concerned Somewhat Concerned Very Concerned

Have you used ALCOHOL (12 oz beer, 5 oz wine, 1.5 oz liquor) in the past year?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If you marked "YES", how much alcohol do you usually use a week?

\_\_\_\_\_ per week

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your alcohol use?

0 1 2 3 4 5 6 7 8 9 10  
Not Concerned Somewhat Concerned Very Concerned

Have you used MARIJUANA / THC / CBD in the past year?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If you marked "YES", is this marijuana prescribed by a healthcare professional?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If you marked "YES", how much marijuana do you usually use a week?

\_\_\_\_\_ per week

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your marijuana use?

0 1 2 3 4 5 6 7 8 9 10  
Not Concerned Somewhat Concerned Very Concerned

## Substance Use Cont.

Have you used Other DRUGS (cocaine, heroin, meth, opioids etc.) in the past year? \_\_\_\_\_ Yes \_\_\_\_\_ No

If you marked "YES", how much do you usually use a week? \_\_\_\_\_ per week

On a scale of 1-10, with 1 being least and 10 being most, how concerned are you about your recreational drug use?

0 1 2 3 4 5 6 7 8 9 10  
Not Concerned Somewhat Concerned Very Concerned

### References:

1. Golightly YM, Allen KD, Ambrose KR, Stiller JL, Evenson KR, Voisin C, Hootman JM, Callahan LF. Physical Activity as a Vital Sign: A Systematic Review. *Prev Chronic Dis*. 2017 Nov 30;14:E123. doi: 10.5888/pcd14.170030. PMID: 29191260; PMCID: PMC5716811.
2. Gilbody, S., Richards, D., Brealey, S., & Hewitt, C. (2007). Screening for depression in medical settings with the Patient Health Questionnaire (PHQ): A diagnostic meta-analysis. *Journal of General Internal Medicine*, 22(11), 1596-1602. 10.1007/s11606-007-0333-y
3. 1. Simon J, Panzer J, Wright KM, et al. Reduced accuracy of intake screening questionnaires tied to Quality Metrics. *Annals of Family Medicine*. September 1, 2023. Accessed September 19, 2024. <https://www.annfammed.org/content/21/5/444>.