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THE SOURCE FOR WELLNESS

HEALTH CENTERS

5707 N. 22ND ST. TAMPA, FL 33610

Hours and Days of Operation: 8:30AM – 4:00PM, Monday – Friday
Phone Number: 813-272-2244
Fax Number: 813-272-3466
After hours Emergency: 813-272-2244 For medical emergencies, contact 911.
Pharmacy Hours and Days of Operation: 8:00AM – 4:30PM, Monday – Friday

Gracepoint's Health Centers provides a variety of medical services as well as an on-site pharmacy, behavioral health medication services, and counseling services. These services are available to most patients.

Gracepoint's Health Centers is intended to help you regain your role and independence in the community so that you may live a meaningful and purposeful life reflective of the person you are and not the diagnosis you are given. Our treatment team will work in partnership with you (including counselors and psychiatrists if you wish) to guide your care to assist you with successfully achieving your health care goals.

Please know all payments must be paid prior to seeing the doctor.

Please inform our staff of any insurance, address, and phone number changes as they occur.

If you are interested in behavioral **VirtualHealth** (accessing a psychiatrist and/or licensed therapist from your cell phone or computer), please see reception staff for more information.

As part of our policy, Gracepoint's medical doctors, psychiatrists, and ARNPs do not routinely prescribe benzodiazepines (anti-anxiety agents such as Xanax, Librium, Klonopin, Valium, etc.) or any type of opioid pain medications for the treatment of chronic pain.

In accordance with our safety policies, individuals are not permitted to bring items that may be used as weapons into our Centers.

Please arrive 10 minutes early to all scheduled appointments. Should you arrive late to your scheduled appointment, you may not be seen by the doctor if he/she is heavily booked. If you cannot be seen, we will gladly reschedule you for an appointment that is most convenient for you.

The program welcomes individuals who may have a co-occurring mental health and/or substance use disorder and we understand this may be a difficult issue to discuss. Please know we are here to give you hope for recovery and help you receive the integrated treatment you need.

You have the right to report complaints, neglectful practices, and Medicaid fraud.
Gracepoint Complaint Line: 813-239-8207
Agency for Health Care Administration: 1-888-419-3456 Florida Relay Service (1-800-222-3448).
Abuse Hotline: 1-800-96-ABUSE (1-800-962-2873) TTY 1-800-955-8771.
Medicaid Fraud: 1-800-HHS-TIPS (1-800-447-8477). TTY number is 1-800-377-4950.

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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 difficult
	☐	☐	☐	☐

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Cage Screening

Name (Print): _____ **DOB:** ____/_____/_____

Please check Yes or No to each of the following questions.

1. **Have you ever felt that you should cut down on your drinking?**

   ☐ Yes

   ☐ No

2. **Have people annoyed you by criticizing your drinking?**

   ☐ Yes

   ☐ No

3. **Have you ever felt bad or guilty about your drinking?**

   ☐ Yes

   ☐ No

4. **Have you ever had a drink first thing in the morning to calm your nerves or get rid of a hangover?**

   ☐ Yes

   ☐ No

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PHYSICAL HEALTH SCREENING

☐ ***ADULT*** ☐ ***CHILD*** ☐ ***MALE*** ☐ ***FEMALE***

Client's Name: _____ Date _____ ID# _____

Date of Birth: _____ Primary Care Physician: _____

Date of Last Physical: _____ Current Height: _____ Current Weight: _____

Allergies: _____

Symptom Assessment
Have you or your biological parents experienced any of the following? Check Box and Describe below:

	Client	Mother	Father		Client	Mother	Father
Asthma/Emphysema				Arthritis			
Cancer				Epilepsy/Seizure			
Dizziness/Fainting				Heart Disease			
Heart Murmur				Diabetes			
Liver Problems				Jaundice			
Constipation/Diarrhea				Fatigue/Tiredness			
Head Trauma				Headaches			
Fever				Chest Discomfort			
Coughing				Rash			
Night Sweats				Bed Bugs/Lice/Fleas			
Sore Throat				Diarrhea/Vomiting			
Drainage-Wound/Lesion				Coughing up Blood			
Substance Use/Abuse				Unexplained Weight Loss			
Sleep Problems/Apnea				Sexual Problems			
Hearing/Vision Problems				Stroke			

Describe those checked:

_____

_____

_____

Are you taking any prescribed or over the counter medication? If yes, please list medication and daily dosage amount:_____

_____

_____

Hospitalizations/Surgeries (Explain for **what condition** and **when**):

_____

Have you traveled outside of the country? ____ Yes ____ No If so, where _____

Have you ever been to West Africa? ____ Yes ____ No

Have you ever had a positive reaction to a TB test or positive chest x-ray for a TB test? ___Yes ___ No

Other Health Concerns: _____

_____

Nutritional Screening
Have you experienced any of the following?

	Yes	No		Yes	No
Special Diet/Restrictions/Food Allergies			Decrease in Food Intake and/or Poor Appetite		
Weight loss or gain of 10 lbs. or more within the last 60 days			Dental Problems – Difficulty Chewing or Swallowing		
Starving yourself to lose weight			Vomiting /Using Laxatives to Lose Weight/Stay Slim		
Binge Eating			Eating Disorder		

Pain Screening
Are you experiencing any chronic or acute pain now? ___ No ___ Yes If yes, please explain, including the pains effect on daily living:

_____

Using the scale below, check the item that best describes the pain intensity you are presently experiencing:

___ No Pain (0) ___ Minimal Pain (1-2) ___ Mild Pain (3-4)
___ Uncomfortable Pain (5-6) ___ Intense Pain (7-8) ___ Very Severe Pain (9-10)

_____

HIV Screening (for clients 15 years of age or older)

Individuals who are in certain groups or practice certain behaviors are at a high risk for HIV infection. The following are several risk factors for HIV:

1. Multiple sexual partners
2. Unprotected vaginal, anal or oral sex
3. Using needles to inject street drugs or a sexual partner who uses needles to inject street drugs
4. A current or previous diagnosis of a sexually transmitted disease

Do any of these groups apply to you? ____ Yes _____No

For Persons Over 50 Years Old

Date of last Colonoscopy? _____ _____ Not Sure

For Women Only
If applicable, when was the last menstrual period? _____ _____Not Sure
What was the date of your last mammogram? _____ _____ Not Sure
What was the date of your last Pap smear? _____ _____ Not Sure
Are you pregnant? _____Yes _____No _____Not Sure

_____

THIS SECTION TO BE COMPLETED BY GRACEPOINT STAFF AND THE INFORMATION ENTERED INTO THE ELECTRONIC HEALTH RECORD. PAPER FORM IS TO BE SHREDDED.

Refer client to PCP for assessment of identified medical issues when at least one "Yes" response to the Nutritional Screening is checked and/or a Pain Screening score of "5 - 10".

Recommend client have a physical assessment: Yes _____ No _____

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Authorization to Use and Disclose Protected Health Information

Patient's Name: _____ Dates of Treatment: _____

Address: _____
(Street) (City) (State) (Zip)

DOB: _____ SS#: _____ Phone: ( ) _____

I acknowledge and hereby consent to release information from my health record including psychiatric and alcohol/drug abuse treatment information. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV or AIDS. I understand that my records are protected under Federal and State regulations governing the confidentiality and privacy of health information under CFR 45, CFR 42 Part 2, FS 394, 397, 381 and 90.503 cannot be disclosed without my written authorization unless provided for by the regulations.

Please check the information you want disclosed:

☐ Discharge/Continued Care Summary ☐ Psychiatric Evaluation ☐ History & Physical
☐ Labs & X-Ray Results ☐ Psychosocial Assessment ☐Medication Evaluation
☐ Dates of Treatment Letter ☐Other (Please specify): _____

I authorize Gracepoint to make disclosure to the individual or organization identified below:
(RELEASE TO) (RECEIVE FROM) (EXCHANGE WITH)
---------- Please circle one of the above ----------

Name: _____ Relationship: _____

Telephone: _____ Fax Number: ( ) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Type of Disclosure: ____ Written _____Verbal _____Fax _____Electronic

The information that I am authorizing for disclosure will be used for the following purpose:

☐ Continuity of Healthcare Treatment ☐Education ☐ Insurance/Disability ☐ Legal Reasons ☐ My Personal Records

This consent will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire automatically in one year.

I understand that:

- I have the right to revoke this authorization at any time by notifying the Privacy Officer in writing at:
  - 2815 East Henry Ave., Suite D7, Tampa, Florida 33310 (I understand that the revocation will not apply to information that has already been disclosed in response to this authorization).
- If the requester or receiver is not a health plan or healthcare provider, then the disclosed information may no longer be protected by Federal Privacy Regulations and may be re-disclosed.
- I am entitled to receive a copy of this authorization.
- I may refuse to sign this authorization, and my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits.
- I hereby release Gracepoint from liability which may arise as a result of information disclosed under this authorization if such information is later used to my detriment.

Signature of Patient/Guardian/Representative (circle one): _____ **Date:** _____

Signature of Patient's Legal Representative (if applicable): _____ **Date:** _____

If signed by Legal Representative, Relationship to the patient: _____

Proper documentation establishing relationship is provided (specify documentation): _____

Signature of Witness: _____ **Date:** _____

CURRENT MEDICATION LIST- PATIENT REPORTED

****Please note: This information is to be entered in to Avatar and then this form is to be shredded - Do not scan**

Patient Name: ___________________________ **ID#** _____________ **Date:**______________

CURRENT MEDICATIONS ONLY/ VITAMINS/OVER THE COUNTER	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN