Internal Medicine Physicians (IMP)

It is our pleasure to welcome you to Internal Medicine Physicians (IMP). Internal Medicine Physicians has three convenient locations with six providers working to be your Patient Centered Medical Home. The information included here, in the Patient Notices, and the IMP brochure is provided to help familiarize you with our practice.

Internal Medicine Physicians Locations

1207 West State St., Ste N, Alliance, Ohio 44601	(330) 821-3244	Fax: (330) 868-5782
1168 Alliance Rd. NW, Minerva, Ohio 44657	(330) 868-3711	Fax: (330) 868-5782
4080 Holiday St. NW., Canton, Ohio 44718	(330) 492-8117	Fax: (330) 868-5782

Practicing Providers	**Specialty**
Mark E. Hostettler, M.D.	Board Certified in Internal Medicine
David B. Kimbell, M.D.	Board Certified in Internal Medicine
Pamela A. Rodocoy, M.D.	Board Certified in Internal Medicine
Matthew S. Gooch, APRN, CNP	Advanced Practice Registered Nurse
Jacquelyn M. Dennis, APRN, CNP	Advanced Practice Registered Nurse
Eric R. Paliswat, APRN, CNP	Advanced Practice Registered Nurse
Quinn M. Repp, PA-C	Physician Assistant, Certified

PAYMENT POLICY

Our policy is to collect the appropriate payment due at the time service is rendered. The amount due may be your co-payment, deductible, or co-insurance. You will be asked for payment at the time of your visit. If you have no insurance, you are responsible for paying the entire amount for your visit at the time of service. We accept Cash, Check, Debit Card, American Express, Discover, MasterCard, and Visa.

Please check with your insurance company for your specific information.

***Co-Payment*:** A cost sharing amount of your insurance plan. This is usually a fixed dollar amount designated by your insurance company, that is your responsibility to pay at each visit (also known as co-pay).

***Deductible*:** The amount of cost sharing that you must pay for medical services rendered, often before your health insurance company begins to pay.

***Co-Insurance*:** The part of your bill, in addition to the co-payment, that your insurance plan requires you to pay. This is usually a percentage of the total medical bill; for example, 20 percent.

APPOINTMENTS

New Patient vs Annual Physical/Wellness visit. The new patient visit will not be scheduled or billed to your insurance company as your Annual Physical or Wellness visit. The Annual Physical/Wellness visit can be scheduled after completing the New Patient visit.

***Arrival time*:** We ask that you arrive at least 15 minutes prior to your scheduled appointment to begin the intake process. When arriving, please have photo ID, insurance card(s), and copay ready along with your completed New Patient forms. This will prevent delays and/or rescheduling of your appointment. We reserve the right to reschedule this or any future appointments if you arrive 10 or more minutes late for your scheduled appointment time.

***Cancelling/Rescheduling*:** To provide the best care for all our patients, we ask that you provide at least 24-hour advance notice to cancel or reschedule this or any future appointments. Please note, a New Patient visit will not be rescheduled if at least 24-hour notice is not received. Additionally, a fee of $50.00 will be charged.

Please complete the enclosed Health Questionnaire and bring it with you to your appointment. If you have questions about any of the information included, our staff will be happy to help you. We appreciate you selecting Internal Medicine Physicians for your medical care and will work hard to serve your needs.

Sincerely,
IMP Providers and Staff

NEW PATIENT HEALTH QUESTIONNAIRE

Patient Name _____ Today's Date _____

Name patient uses: _____ Date of Birth _____

Demographic Information			
Preferred Language:			
Race:	☐ White	☐ African American	
Ethnicity:	☐ Hispanic/Latino/Spanish	☐ Not Hispanic or Latino	
Relationship Status:	☐ Single	☐ Widowed	☐ Domestic Partner
	☐ Married	☐ Divorced	
How do you identify your sexual orientation?	☐ Choose not to disclose	☐ Straight or Heterosexual	☐ Bisexual
	☐ Unknown	☐ Lesbian, Gay, or Homosexual	☐ Something else
Gender Identity:	☐ identifies as male	☐ transgender male (female to male)	☐ choose not to disclose
	☐ identifies as female	☐ transgender female (male to female)	☐ other gender category
Assigned sex at birth:	☐ male	☐ female	☐ choose not to disclose
Pronouns:	☐ he/him	☐ she/her	☐ they/them

Where would you like your prescriptions filled? Please provide pharmacy name and address.	
Local Pharmacy:	Mail-Order Pharmacy:
Address:	Address:

List other medical professionals involved in your care.			
	Name	Phone Number	Reason for Specialist
Dentist			
Eye Doctor			
Gynecologist			
Other Specialist			
Other Specialist			
Other Specialist			

Allergies/Intolerances			
Allergen Name	Reaction	Intolerance or Allergy	Start Date
		☐ Intolerance ☐ Allergy	
		☐ Intolerance ☐ Allergy	
		☐ Intolerance ☐ Allergy	
		☐ Intolerance ☐ Allergy	
		☐ Intolerance ☐ Allergy	

MEDICATIONS: List all prescription medications you currently take. Use additional paper if necessary.				
Medication	Strength	How Often	Start Date	Reason

SUPPLEMENTS: List vitamins, hormones, alternative remedies, or over-the-counter medications you use.				
Supplement	Strength	How Often	Start Date	Reason

IMMUNIZATIONS: List date of last injection. (PLEASE BRING ANY IMMUNIZATION RECORDS WITH YOU)					
Name	Date	Name	Date	Name	Date
Tetanus		Hepatitis A		Prevnar	
Tdap		Hepatitis B		Pneumovax 23	
Polio		Typhoid		Zostavax	
MMR		Gardasil		Shingrix	
Meningitis				Influenza	

FAMILY HISTORY

Family History: Follow lines across the page for each person and check the appropriate boxes.	Alcoholism	Anemia	Arthritis	Asthma/Lung disease	Cancer	Diabetes	Gout	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Mental Illness	Migraine	Seizures	Stroke	Tuberculosis	other
Father																	
Paternal GM																	
Paternal GF																	
Mother																	
Maternal GM																	
Maternal GF																	
☐ Brother ☐ Sister																	
☐ Brother ☐ Sister																	

SOCIAL HISTORY

Tobacco Smoking Status:

☐ Never smoked ☐ Former smoker ☐ Current Every Day smoker ☐ Current Some days smoker

Smoking- How much?

☐ 1PPW ☐ 2PPW ☐ ¼ PPD ☐ ½ PPD ☐ 1 PPD ☐ 1½ PPD ☐ 2 PPD ☐ 3+ PPD

Smokeless Tobacco Status:

☐ Never used smokeless tobacco ☐ Former smokeless tobacco user

☐ Current snuff user ☐ Currently chews tobacco ☐ Currently uses moist powdered tobacco

E-cigarette/vape status: ☐ Never used E-cigarettes ☐ Current user of E-cigarettes

☐ Former user of E-cigarettes

Tobacco years of use _____

Most recent tobacco use screening _____

SOCIAL HISTORY continued					
Deaf or serious difficulty hearing			☐ Yes	☐ No	
Blind or serious difficulty seeing			☐ Yes	☐ No	
Difficulty concentrating, remembering, or making decisions			☐ Yes	☐ No	
Difficulty walking or climbing stairs			☐ Yes	☐ No	
Difficulty dressing or bathing			☐ Yes	☐ No	
Difficulty doing errands alone			☐ Yes	☐ No	
Able to care for self			☐ Yes	☐ No	
Do you have Advanced Directives?		☐ Durable Power of Attorney		☐ Living Will	
		☐ Healthcare Power of Attorney		☐ DNR or DNRCC	
(PLEASE BRING YOUR ADVANCED DIRECTIVES TO THE OFFICE TO BE COPIED & PLACED IN YOUR CHART.)					
Live alone or with others			☐ alone	☐ with others	
Dental care within the last 12 months			☐ Yes	☐ No	
Transportation difficulties			☐ Yes	☐ No	
Social support system:					
Difficulty making ends meet at the end of the month			☐ Yes	☐ No	
Highest grade or level of school completed or highest degree received:					
How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?					
On the days you engage in moderate-strenuous exercise, how many minutes on average do you exercise?					
How hard is it for you to pay for the basics like food, housing, medical care, and heating?					
☐ very hard	☐ hard	☐ somewhat hard	☐ not very hard	☐ decline to answer	
Do you feel stress- tense, restless, nervous, anxious, or unable to sleep at night because your mind is troubled					
all the time - these days?		☐ not at all	☐ only a little	☐ to some extent	
		☐ rather much	☐ very much	☐ decline to answer	
Alcohol intake:	☐ none	☐ occasional	☐ moderate	☐ heavy	
Caffeine intake	☐ none	☐ occasional	☐ moderate	☐ heavy	
Do you now or have you ever had a problem with drug use?			☐ Yes	☐ No	Type:
Occupation:		☐ Retired	☐ Unemployed	☐ Permanently disabled	
Exercise level	☐ none	☐ occasional	☐ moderate	☐ heavy	
Single or multi-level home/work		☐ single level home	☐ single level work		
		☐ multi-level home	☐ multi-level work		
Marital status	☐ single	☐ married	☐ separated	☐ divorced	☐ widowed	☐ domestic partner
Ambulatory?	☐ walks without assistance		☐ requires minimal help in wheelchair		
	☐ walks with an assistive device		☐ Limited self-mobility with assistive device		
	☐ independent in wheelchair		☐ dependent on helper pushing wheelchair		

PAST SURGERIES/PROCEDURES/HOSPITALIZATIONS			
Type	Approx. Date	Type	Approx. Date

HEALTH HISTORY: Are you being treated or have you ever been treated for any of the following?

Please check if applicable. Additional space is provided below for details or other health conditions not listed.

- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer
  Type _____
- ☐ Carotid Stenosis
- ☐ Colonic Polyp
- ☐ COPD
- ☐ Crohn's Disease/Ulcerative Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis/Diverticulosis
- ☐ DVT/Pulmonary Embolism
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Gout
- ☐ Heart Disease
  - __ Heart rhythm issue
  - __ Stents/Surgery
  - __ Pacemaker/Defibrillator
  - __ Heart Valve
  - __ Congestive Heart Failure
- ☐ Hyperlipidemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Migraine
- ☐ Neuropathy
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinson's
- ☐ Peripheral vascular disease
- ☐ Prostate disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Restless Leg Syndrome
- ☐ Rheumatoid Arthritis/Lupus
- ☐ Seizure disorder
- ☐ Spinal disease
- ☐ Stroke
- ☐ Valvular Heart Disease

PREVENTIVE CARE

Test	date of last	Physician	Facility/Office Location
Colonoscopy			
Gastroscopy/EGD			
Mammogram			
DEXA (Bone Density)			
Dental Exam			
Eye Exam			
Patients	**date of last**	**Female Patients**	**date of last**
PSA Laboratory		Breast examination	
Rectal/Prostate exam		Pap smear	
Testicular exam		Rectal exam	

ADDITIONAL COMMENTS OR INFORMATION:

Patient Signature _____ Date _____

Guardian/POA Signature (if applicable) _____ Guardian/POA Printed Name (if applicable) _____

IMPhysicians
The Future of Healthcare

As a convenience to you, we will request your medical records from your previous physician on your behalf.

On the following page titled **Authorization for Use or Disclosure of Protected Health Information Form**, please fill in the areas in parentheses with your name and date of birth and your previous physician and the physician's telephone number.

IMP Physicians
The Future of Healthcare

Authorization for Use or Disclosure of Protected Health Information

☐ 1168 Alliance Rd.	☐ 1207 W. State St., Ste. N	☐ 4080 Holiday St. NW
Minerva, OH 44657	Alliance, OH 44601	Canton, OH 44718
330-868-3711	330-821-3244	330-492-8117

Central Fax Number (330) 868-5782

I, (patient name) _____, (date of birth) ____/____/____,
hereby authorize Internal Medicine Physicians and my provider:

☐ Mark Hostettler, MD ☐ David Kimbell, MD ☐ Pamela Rodocoy, MD
☐ Matt Gooch, APRN, CNP ☐ Jacquelyn Dennis APRN, CNP ☐ Eric Paliswat, APRN, CNP ☐ Quinn M. Repp, PA-C

☑ to **request** my personal health information (PHI) **from:**

(previous physician name) _____ (phone #) _____

☑ Office visit notes from the past 12 months; most recent lab and most recent results of **ALL** diagnostic tests
Please note: we cannot accept medical records on CD/flash drive; please fax to (330) 868-5782.

The minimum necessary of the above checked items of PHI being released and/or received is being used or disclosed for the following purpose: **Transfer of patient's Primary Care**

I, the undersigned, authorize IMP to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. This authorization does not include permission to release outpatient Psychotherapy Notes as defined below. *Release of Psychotherapy Notes requires a separate authorization.

This authorization shall be in force and effect until (specify date or event that relates to the patient or the purpose of the use or disclosure) **1 year from date of patient signature** at which time this authorization to use or disclose this PHI expires.

I understand that I have the right to revoke this authorization in writing at any time by ending such written notification to Administrator at Internal Medicine Physicians. I understand that a revocation is not effective to the extent that Internal Medicine Physicians has relied on the use or disclosure of the PHI.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
Internal Medicine Physicians will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
I understand that I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.
- Receive a signed copy of this authorization upon request.

_____ _____
Printed Name of Patient or Personal Representative | Description of Personal Representative Authority

_____ _____
Signature of Patient or Personal Representative | Date

_____ _____
Witness | Date