Clinch Memorial
FAMILY PRACTICE

PATIENT HISTORY FORM Preferred Language_____

Name: _____ Date of Birth _____

Reason for Visit: _____

_____

Allergies/Reactions: Latex Allergy? Yes No

Food: _____

Medications: _____

Current Medications: _____

_____

Pharmacy: Clinch Memorial Hospital Pharmacy Other: _____

PAST MEDICAL HISTORY:

☐ Hypertension (Blood Pressure) ☐ Diabetes ☐ Kidney Disease ☐ High Cholesterol ☐ Stroke

☐ Heart Disease ☐ Arthritis ☐ Gastric Ulcers ☐ Thyroid Disease ☐ Asthma/COPD

☐ Cancer: Type _____

☐ Other: _____

SURGICAL HISTORY WITH DATE OF SURGERY:

- Gastrointestinal: _____
- Heart/Vascular: _____
- Bone: _____
- Gynecological: _____
- Urological: _____
- Head/Neck: _____
- Kidney: _____
- Other: _____

Family History:

☐ Heart Disease: Mother Father Both

☐ Diabetes: Mother Father Both

☐ Thyroid Disease: Mother Father Both

☐ Hypertension: Mother Father Both

☐ High Cholesterol: Mother Father Both

☐ Cancer: Type? _____ Who? _____

☐ Other: _____

Social History:

Tobacco: Yes / No How Much? _____ Quit? (Years) _____

E Cig: Yes / No How Much? _____ Quit? (Years) _____

Alcohol: Yes / No How Much? _____ Quit? (Years) _____

Drug Use: Yes / No How Much? _____ Quit? (Years) _____

RACE:

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian

☐ Native Hawaiian or Other Pacific Islander

ETHNICITY:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Emergency Contact Information:

_____

Emergency Contact Name Phone Number Relationship

PATIENT INSURANCE INFORMATION

_____ _____ _____
Name (First, Middle, Last) Date of Birth Age

☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

_____
Address City / State / Zip Code

_____ _____ _____
Home Phone Cell Phone Social Security Number

_____
Responsible Party or Parents Name (if patient is a minor) Employer or Parent's occupation

_____
Work Phone Email Address

_____
Spouse's Name Spouse's Employer

_____ _____
Primary Insurance Carrier Name Secondary Insurance Carrier Name

_____ _____
Insured Name Date of Birth Insured Name Date of Birth

_____ _____
Relationship to Insured Relationship to Insured

_____ _____
Policy Number / Member ID Number Policy Number / Member ID Number

---

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Your Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____
Signature Date

Clinch Memorial
FAMILY PRACTICE

FINANCIAL AGREEMENT

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this agreement, asking questions as necessary. A copy will be provided to each patient upon request. Please initial each line.

_____ **1. Insurance:** We accept assignment participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at the time of each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance provider with any questions you may have regarding your coverage to receive the maximum benefit.

_____ **2. Patient Payment:** All copays and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company.

_____ **3. Forms:** There is a $10 fee for completing FMLA, sick leave, AFLAC, and disability insurance forms. This fee must be paid before the forms are completed. There is also a $5 fee for any forms that need to be mailed instead of faxed.

_____ **4. Weight Management**: All visits are a $45.00. This does not get billed to your insurance company.

_____ **5. Registration:** All patients must complete our patient information form, which will be entered into our computer system to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of the claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment, and you will be responsible for the remaining balance.

_____ **6. Claims:** We will submit your claims and assist you in any way reasonably to help you get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

_____ **7. Uninsured Patients:** We offer a 70% discount to our patients that do not have insurance. Please be advised that payment is due at time of service.

_____ **8. Credit and Collection:** If your account is more than 90 days past due, please be aware that that it will be sent to a collection agency.

_____ **9. Returned Check Fee:** Please be aware that we charge $35.00 for returned checks.

Print Name: _____

Signature: _____ Date: _____

Clinch Memorial
FAMILY PRACTICE

AUTHORIZATION AND AGREEMENT FOR TREATMENT

THE UNDERSIGNED HEREBY MAKES THE FOLLOWING ACKOWLEDGEMENTS AND AGREEMENTS REGARDING THE TREATMENT TO BE PROVIDED TO THE PATIENT WHOSE NAME APPEARS ON THIS FORM HEREOF:

CONSENT TO TREATMENT: I understand that medical treatment is necessary for the parent and that such medical care, treatment and procedures will be performed by employees of CMFP. I hereby grant my authorization and consent to such treatment and procedures and certify that no guarantee or assurance has been made to the results which may be obtained.

TREATMENT OF A MINOR: CMFP will not treat a minor child under the age of 18 without written consent of a parent or legal guardian present at the time of service. The individual who requests the medical services is financially responsible for any balance due.

RELEASE OF MEDICAL INFORMATION: I hereby authorize CMFP to release my medical information in connection with these services for health insurance purposes or to the parent's personal physician or to a referral physician.

FINANCIAL AGREEMENT: I understand if I am choosing to have CMFP file a claim with my insurance that the amount collected at the time of service is only an estimate of the allowable amounts set by my insurance company. If my deductible has not been met or if my insurance benefits cannot be verified, $129-$150 is the predetermined price range that CMFP collects at the time of service. The final determination of the total amount due by me will be according to my specific insurance plan's contracted rate; therefore, I may receive a statement for an additional amount due after my insurance has been filed. All co-payments, deductibles, co-insurance, past due balance and fee for services are due at the time of service and are my responsibility. I acknowledge that the filing of insurance claims is not a guarantee of payment, and that I am financially responsible for payment if such claims are unpaid.

STUDENT, MANUFACTURING OR COMPANY REPRESENTATIVE OBSERVATION OR ASSISTANCE: I consent that students, including fellows, residents, Physician Assistants students, Medical students, Interns, Physician Assistants, clinical nursing or technical students, and manufacturing or company representatives, may observe or assist in the care which will be undertaken at CMFP.

HIPAA NOTICE OF PRIVACY PRACTICES: I hereby understand these forms are always available by front office staff members by request. CMFP provides printed copies to parents at any time. By law, CMFP follows federal guidelines for the safe handling of PHI (protected health information). The federal government defines PHI as any information whether oral, electronic, or payment for the provision of medical services. This includes not only the results of tests and notes written by doctors, nurses and other clinical personnel, but also certain demographic information (such as name, address, and telephone number) that is related to your health records.

I have read the above acknowledgements and agreements and fully understand the same.

Patient Signature: _____ (Parent or Guardian if patient is under 18)

Print Name: _____ (Parent or Guardian if patient is under 18)

Date: _____

Address: _____ Date: _____

Clinch Memorial
FAMILY PRACTICE

Designated Party Release

You may give Clinch Memorial Hospital written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, e-mail, or another party that you designate.

Patient Name: _____ **Date of Birth:** ___/___/_____

At my request, I authorize CMFP to communicate my protected health information to me via the following methods:

- Leave detailed message at (**circle one**) home/work/cell phone #: _____
- Confidential e-mail for detailed medical information
  (E-mail Address: _____)

At my request, I authorize CFMP to communicate my protected health information to:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Authorized Signature: _____ Date: _____

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will not affect any action CMFP took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Canceled: ___/___/_____

Clinch Memorial
FAMILY PRACTICE

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare professionals involved in my treatment).
- Obtaining payment from third party payers (my insurance company).
- The day-to-day healthcare operations of your practice such as quality assessments.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more detailed description of the uses and disclosures of my protected health information and my rights under HIPAA.

_____

Patient Name Printed

_____

Signature (Patient, parent/Guardian)

_____

Date

Clinch Memorial
FAMILY PRACTICE

MEDICAL RECORDS AUTHORIZATION FORM

I do hereby consent and authorize the release of copies of my medical records.

Patient Name _____

DOB _____ Phone Number _____

Address _____

_____

Records Requested From:

Facility Name/Physician: _____

Facility Address: _____

Facility Phone Number: _____Fax _____

Records to Use or Disclose to:

Facility Name/Physician: _____

Facility Address: _____

Facility Phone Number: _____Fax _____

Please select the specific documents that apply to your request:

- ☐ Progress Notes
- ☐ History and Physical
- ☐ Radiology Reports
- ☐ Lab Reports
- ☐ Complete Medical Record
- ☐ Other: _____