CENTER FOR FAMILY MEDICINE, P.A.

Authorization and Consent Agreement

Thank you for reviewing our Financial and Office Policies and Notice of Privacy Practices. Please sign in the spaces provided below to acknowledge receipt of this information, and to enter your authorized contacts.

ASSIGNMENT OF BENEFITS

I authorize direct payment to be made to the providers of Center for Family Medicine for any and all medical services rendered. I also authorize the release of any medical records for the purpose of my healthcare services.

FINANCIAL AND OFFICE POLICIES

I have read and understand the Financial and Office Policies of Center for Family Medicine and agree to abide by its guidelines.

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent.

I have had the opportunity to receive and review the Notice of Privacy Practices of Center for Family Medicine.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information

Keeping information private is important to us and by default we will only disclose information related to the patient's billing account and medical conditions to the patient or legal guardian.
Please note, in order to share protected health information with your spouse, children, or anyone else they must be listed as an approved contact.
The following names are people I would like to be involved in or have access to my protected health information on a routine basis. I give permission to Center for Family Medicine to share my protected health information with:

_____	_____	_____
Contact Name	**Phone Number**	**Relationship to Patient**
_____	_____	_____
Contact Name	**Phone Number**	**Relationship to Patient**

CONSENT AND AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Assignment of Benefits, Financial Policy, HIPAA policy, and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

_____	_____
Patient's Name (Please Print)	**Patient's Date of Birth**
_____	_____
Signature of Patient, Parent, or Legal Guardian	**Date**

CENTER FOR FAMILY MEDICINE, P.A.

Consent to Obtain Prescription History

This consent form authorizes Center for Family Medicine to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names and dosages.

By signing this consent form, you agree that Center for Family Medicine can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding the above, I hereby provide informed consent to Center for Family Medicine to request, view, and use my external prescription history for treatment purposes.

Patient Name (printed):_____

Patient Date of Birth:_____

Patient Signature:_____

Date of Signing Consent Form:_____

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:**
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

_____

_____

_____

_____

_____

_____

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers-Please give us list if you have one with you.		
Drug Name	**Strength**	**Frequency Taken**
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do/Did you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ e-cigarettes	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	I have had more than 1 sexual partner.				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				☐ Yes	☐ No

OTHER PROBLEMS
Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

FAMILY HEALTH HISTORY		
	AGE	**SIGNIFICANT HEALTH PROBLEMS**
Father If unknown, check here ☐		
Mother If unknown, check here ☐		
Sibling If unknown, check here ☐	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
Children	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
Grandmother *Maternal*		
Grandfather *Maternal*		
Grandmother *Paternal*		
Grandfather *Paternal*		

CANCER RISK QUESTIONNAIRE

I have light colored hair, eyes, or complexion.	☐ Yes	☐ No
I have a large number of "moles" or moles that are large or irregular in shape or color.	☐ Yes	☐ No
I frequently work or play in the sun.	☐ Yes	☐ No
I was sunburned (blistered) several times before age 20.	☐ Yes	☐ No
My skin is frequently exposed to chemicals or radioactive materials (arsenic, coal, petroleum, uranium, radioisotopes).	☐ Yes	☐ No
I have a family history of skin cancer.	☐ Yes	☐ No
I have been to tanning salons.	☐ Yes	☐ No
I am exposed to other people's cigarette smoke.	☐ Yes	☐ No
At work, I am exposed to arsenic, asbestor, chromates, nickel, petroleum, or uranium.	☐ Yes	☐ No
Someone in my family has had lung cancer. If yes, who?_____	☐ Yes	☐ No
I have had colon cancer.	☐ Yes	☐ No
Someone in my family has had colon cancer. If yes, who?_____	☐ Yes	☐ No
I have had polyp(s) in the colon.	☐ Yes	☐ No
I have had Crohn's disease or ulcerative colitis.	☐ Yes	☐ No
I have had a recent change from my usual bowel movements.	☐ Yes	☐ No
There is a history of cancer in my immediate family. If yes, who_____	☐ Yes	☐ No
I am 15 or more pounds overweight.	☐ Yes	☐ No
I eat a diet high in fat content.	☐ Yes	☐ No
I eat fewer than 5 servings of fruit and vegetables per day.	☐ Yes	☐ No
I have not had a complete physical in at least 5 years.	☐ Yes	☐ No
I have not been to a dentist in over three years.	☐ Yes	☐ No

CANCER RISK QUESTIONNAIRE, CONTINUED

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge after intercourse or between periods?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
I have had breast cancer.	☐ Yes	☐ No
Someone in my family has had breast cancer. If yes, who?_____	☐ Yes	☐ No
Date of last pap and rectal exam?	☐ Yes	☐ No
I have had an abnormal pap smear?	☐ Yes	☐ No
I gave birth to my first child after age 35 or am 35 years or older and have not been pregnant to full term.	☐ Yes	☐ No
I have had a female cancer (womb or ovary).	☐ Yes	☐ No
I began intercourse before age 18.	☐ Yes	☐ No

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
I have had testicular cancer.	☐ Yes	☐ No
I have one testicle which is smaller (atrophied) than the other.	☐ Yes	☐ No
Someone in my family had prostate cancer. If yes, who?_____	☐ Yes	☐ No
Date of last prostate and rectal exam?		
I have had a vasectomy. If yes, what year? _____	☐ Yes	☐ No

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PATIENT DEMOGRAPHICS

Name_____

DOB _____ SSN_____

Address_____

City _____State _____Zip_____

Phone Number _____

Alternate Phone Number_____

Sex: ☐Female ☐Male

Marital Status:☐Single☐Married☐Widowed ☐Divorced

Race: _____

Ethnicity: _____

Employer_____

Occupation_____

Emergency Contact Name: _____

Relationship to patient _____

Emergency Contact Phone #_____

Alternate Phone # _____

Preferred Pharmacy _____

Primary Care Provider:
☐Cooper ☐Schulze ☐Hodge ☐Woods ☐Haney ☐Ockwig
☐Kenworthy ☐Boatner ☐Mitchell ☐Reinert ☐Young
☐Moreno ☐Handlang

Parent/Guardian/Guarantor Information (Required if patient is under 18 years of age)

Name _____

DOB:_____ DL # _____Issuing State_____

Address

_____

City _____ State _____ Zip _____

Primary Contact Number _____

Relationship to Patient _____

INSURANCE INFORMATION

Primary Insurance Information

Insurance Company _____

Address _____

City _____State _____Zip_____

Phone # _____

Member ID # _____

Group # _____

Policy Holders Name _____

DOB _____SSN _____

Relationship to patient_____

Phone # _____

Address (if different from patient)

_____

City _____State _____Zip_____

Secondary Insurance Information (if applicable)
Insurance Company _____

Address _____

City _____State _____Zip_____

Phone # _____

Member ID # _____

Group # _____

Policy Holders Name _____

DOB _____SSN _____

Relationship to patient_____

Phone # _____

Address (if different from patient)

_____

City _____State _____Zip_____

Signature: _____

Date:_____

CENTER FOR FAMILY MEDICINE, P.A.

Patient Portal Communication Consent

To sign up for access to your health information through our secure patient portal complete the first portion of this form. To grant access to another adult who helps manage your medical care complete all portions of this form. Patient portal sign up includes free access to the following online services: lab results, appointment management, prescription refill requests, submitting billing questions, referral requests, and a medical summary including immunization records.

☐ **Yes,** I want Center for Family Medicine to communicate my information with me or those that I grant access to my record through the secure patient portal system that is designed to keep my personal information safe.

Your Information: (All sections required)

_____ _____

Patient's Name (Please Print) **Sex**

_____ _____

Date of Birth **Phone Number**

Please provide the email address you would like to use to be notified of secure messages

_____

E-mail address

_____

Primary Care Provider

-I understand that I must be 18 years or older in order to be signed up to access my record through the patient portal. If I am under 18 years of age and have become legally emancipated, I must provide legal documentation in order to be provided access to my record through the patient portal.
-I understand that the patient portal is intended as a secure online source of confidential medical information. If I share my user ID and password with another person, that person may be able to view me or my family member's health information.
-It is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
-I understand that the patient portal contains selected, limited medical information from me or my family member's medical record and that it does not reflect the complete contents of my medical record. I also understand that a paper copy of my records may be requested from the clinic.
-I understand that my activity within the patient portal may become part of my medical record.
-I understand that access to the patient portal is provided by Center for Family Medicine as a convenience to its patients and has the right to deactivate access to the portal at any time for any reason. I understand that use is voluntary and I am not required to use the portal.
-By signing below, I acknowledge that I have read and understand this Patient Portal Communication Consent and agree to its terms.

_____ _____

Patient Signature **Date**

Grant Access to Another Adult

Please grant access to my record through the secure patient portal to the following adult who helps to manage my medical care. I understand that all portal communication will be sent to their email/account.

Name (Please Print) _____ Relationship to Patient _____

Please provide the email address you would like to use to be notified of secure messages

_____

E-mail address

_____ _____

Patient Signature **Date**

CENTER FOR FAMILY MEDICINE, P.A.

Consent to Treat a Minor

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

This is a legal document. With it you may appoint anyone who is over the age of 18 years of age to be responsible for your child when you are unable to accompany them to their medical appointment.

Minor's full name_____ Date of Birth_____

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

☐ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for _____ days only, or

☐ Indefinitely or until revoked by written communication.

Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian accompanies the minor to their appointment. If such services need to be performed, another appointment will need to be scheduled in which the parent must be in attendance.

It is the policy of this office that the adult presenting the child or the child alone for treatment is responsible for payment of the patient portion at the time of service.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have it read to me and explained in the language that I can understand.

_____ _____ _____

Parent's/Guardian Signature Relationship to Patient Date