PATIENT INFORMATION

DATE _____

Patient Name: _____ Sex: _____

Age: _____ Birthdate: _____ Social Security#: _____ Race: _____

Mailing Address: _____ City _____ St _____ Zip _____

Cell Phone#: _____ Home Phone #: _____ Work Phone #: _____

Occupation: _____ Employer: _____

Email: _____ Can we email you? ___ Yes ___ NO

Marital Status: _____ Spouse Name: _____ Spouse # _____

If Minor, Mother Name: _____ Mother#: _____

Father Name: _____ Father#: _____

Guardian Name, (if not parent) _____ Guardian# _____

Emergency Contact: _____ Phone# _____ Relationship: _____

If there is a balance the person that is the financially responsible:

Name: _____ Relationship: _____

Mailing Address: _____

Phone #: _____ Date of Birth: _____ SS#: _____

Employer: _____ Occupation: _____

Primary Insurance: _____ Insured ID #: _____

Insured Group #: _____

Subscriber/Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Relationship to Patient: _____ Policy Holder Phone # _____

Secondary Insurance: _____ Insured ID #: _____

Insured Group #: _____

Subscriber/Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Relationship to Patient: _____ Policy Holder Phone # _____

PAYMENT/INSURANCE AUTHORIZATION-AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the clinic agrees otherwise. I understand that unless the named patient has coverage under a managed healthcare plan (i.e. HMO, PPO, EAP) to which I subscribe and in which the clinic is a participating provider, I am personally responsible for the payment of all charges. I understand that as a courtesy they will have my insurance claims filed but that it does not release me of responsibility for payment of these charges. Payment for any charges denied or not covered by my insurance company become my responsibility and I agree to pay these charges. I understand that any court order I have is an agreement between the courts and I – not the provider and I am still responsible for all payments. I further understand and agree that a collection agency and/or courts may be used in the event of delinquent payments and that I realize that such action could require the clinic release to the collection parties involved information which identifies me, diagnosis, dates, services rendered and charges as well as any other information needed on the claim filed. In addition, if I have requested the clinic have my charges filed to my insurance company I understand that securing benefits under health insurance or other health plans will require that the clinic provide plan management with confidential patient information including diagnosis, service dates and type of services rendered. Further, I understand that for utilization review, quality assurance and other claim review purposes, it may require the clinic to provide my confidential information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health claims made by or on behalf of the named patient. This consent shall remain in effect for 1 year

Signature of patient or parent/guardian: _____ Date: _____

Family First Clinic of Clarksdale

Medical History Form

Patient Name_____ Birth Date_____ Date _____

Are you allergic to any of the following: Iodine Latex Shellfish Stainless Steel Tape IV Contrast

Medications Patient is Allergic To	Reaction if Medication is Taken

List any medications that you have or have been directed to take on a regular basis:

Medication Name	Dosage	How Often Taken	Last Time Med Taken	Who Prescribes Medicine?

Do you smoke? YES NO Packs per day? _____ If you have quit smoking, when?_____

How long have or did you smoke?_____

Dip or chew tobacco? YES NO How much?_____ Smoke cigars on a regular basis? YES NO

Do you drink alcohol? YES NO How much and how often?_____

Surgeries	Date of Surgeries	Where and Who did surgery?

Family First Clinic of Clarksdale

Patient Name:_____ Date of Birth:_____

Circle if you have any of the following:

AIDS/HIV	Diabetes	Blood Clots	Migraines	Multiple Sclerosis
Alcoholism	Glaucoma	Kidney Problems	Low Back Pain	Suicide Attempts
Alzheimer's	Gout	Phlebitis	Staph Infection	Pacemaker
Anxiety	Hepatitis	Polio	Heart Problems	Defibrillator
Anemia	High Cholesterol	Peripheral Artery Disease	Reflux	Prostate Problems
Arthritis	Hypertension	Rheumatoid Arthritis	Ulcers	Lupus
Asthma	Hyperthyroid	Seizures	Varicose Veins	Heart Attack
Bleeding Disorder	Hypotension	Stroke	Scoliosis	COPD
Bronchitis	Hypothyroid	Swelling	Schizophrenia	Pneumonia
CAD/Heart Disease	Leg Cramps	Tuberculosis	Herpes	Chemical Dependency
Cancer_____	Liver Problems	Depression	Sexually Transmitted Disease_____	

Any other medical history: _____

Specialist Patient Has Seen	What For?	Where are they located?

Health Maintenance (Answer all that Apply)

Medical Procedure	Date of Procedure	Results if Applicable	Date for Recheck
Mammogram			
Pap Smear			
Cholesterol Test			
Eye Exam			
Colonoscopy			
Tetanus Vaccine			
Prostate Exam			
PSA Lab Test			
Flu Vaccine			
Pneumonia Vaccine			
Bone Density (DEXA Scan)			

Family History (Please Relationship to you under the diseases that apply to your family)

Diabetes	**Heart Disease**	**Cancer (Person & Type)**	**Any Other**

EMAIL AND TEXT COMMUNICATION OF HEALTH INFORMATION

FACT SHEET AND CONSENT FORM

As a patient of Family First Clinic of Clarksdale, you may request that we communicate with you via unencrypted electronic mail (email) and text message. This Fact Sheet will inform you of the risks of communicating with your healthcare provider via email or text message. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email or text, however, we reserve the right to deny any request for email or text communications when it is determined that granting such a request would not be in your best interest.

PLEASE READ THIS INFORMATION CAREFULLY

Family First Clinic of Clarksdale staff will make every effort to promptly respond to your requests for information via email or text, however, if you are experiencing an emergency, you should never rely on email or text communications and should seek immediate medical attention.

Risks of using email to send protected health information include, but are not limited, to:

• Risk of Unauthorized Access by a 3rd Party: Do you share a computer with your family? Is your email address or access to email provided through your employer? Do you access your email over an unsecured connection such as public Wi-Fi? Do you access your email on your mobile device? Emails may be accessed by someone you do not wish to know about your health information. Despite necessary precautions, email may be sent to the wrong address by either party. Email may be intercepted or altered in transmission by a computer hacker or computer virus.

• Unique Difficulty in Verifying the Sender: Email may be easier to forge than handwritten or signed papers. Family First Clinic of Clarksdale will only send emails to the email address you provide, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address.

Procedures

• Emails are not checked outside of normal business hours – this includes overnight, on weekends or holidays.

• Please call Family First Clinic of Clarksdale at 662-592-4170 to confirm that your request was received if you haven't received a response by email or telephone within 24 hours.

• If at any time you change your email address or cell phone number or wish to discontinue email and/or text communications altogether, you must notify Family First Clinic of Clarksdale immediately in writing.

EMAIL AND TEXT COMMUNICATION OF HEALTH INFORMATION

FACT SHEET AND CONSENT FORM

PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and cellular phone text messages and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone. By signing below, you agree to hold Family First Clinic of Clarksdale harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address or cell phone number you provide.

Patient Email Address: _____

Patient Cell Phone Number: _____

Patient Signature _____ Date of Birth: _____

Patient Name (printed) _____ Date: _____

If signed by someone other than the Patient, state your relationship to the Patient and a description of your authority to act on the Patient's behalf:

Name: _____ Relationship: _____

Initial all lines that you approve as an acceptable form of communication

____ Consent for phone (call or text) and/or email appointment reminder

____ Consent for phone (call or text) and/or email medical results notification

____ Consent for phone (call or text) and/or email patient balance notification

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FAMILY FIRST CLINIC OF CLARKSDALE STAFF USE ONLY

Staff member that entered info in Practice Fusion: _____

Staff member that scanned in Practice Fusion: _____

VERIFICATION OF
PATIENT RIGHTS

The Health Insurance Portability and Accountability Act **(HIPAA)** has created new patient protections surrounding the use or protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records (" privacy rules") and the storage and access to health care records ("the security rules"). HIPAA applies to all health care providers and health care agencies throughout the country. They are now required to provide patients with a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from you other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you do not have formal legal training. Our patient notification of Privacy Rights is our attempt to inform you of your rights in a simple yet comprehensive manner. Please read this document as it is important that you know what patient protection HIPAA affords to all of us. In Health Care, confidentiality and privacy are central to the success of our health care relationship and as such you will find we will do all we can do to protect the privacy of your medical records. If you have any questions about any of the matters discussed in this document please do not hesitate to ask us for further clarification.

By law we are required to secure your signature indication that you were offered a copy of our Patient Rights Document. Thank you for your thoughtful consideration in these matters.
I understand that if there are any changes in Family First Clinic of Clarksdale, I must be informed and sign a new HIPPA acknowledgement. I also understand that this document will be renewed annually.

I have been offered a copy of and understand Family First Clinic of Clarksdale Patient Rights document which provides detailed description of the potential uses and disclosures of my protected health information, as well as my rights in these matters. I understand that I have the right to review this document before signing this acknowledgement form.

_____

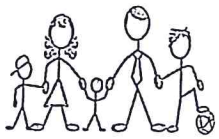
Patient Signature (or guardian/legal charge if minor) Date of Birth Date

UNPAID BALANCES

I understand that I am responsible for my unpaid balances. I acknowledge that Family First Clinic of Clarksdale has the right to refuse care to me for unpaid balances. Payment on account will be expected before further visits are permitted. Failure to pay account balance can lead to dismissal of the patient from the practice.

Patient Name:_____ Date:_____

Patient or Legal Guardian Signature: _____



Family First Clinic of Clarksdale

RELEASE OF INFORMATION

Patients Name: _____ Date of Birth:_____

I give my permission for the following people to receive all information concerning my medical record including but not limited to diagnosis, examination, diagnostic tests, labs, plan of care, claims, and referrals. The information may be released to:

- Spouse Name: _____ Spouse Phone #:_____
- Significant Other Name:_____ Significant Other Phone #:_____
- Child Name: _____ Child Phone #:_____
- Other Person Name:_____ Other Person #:_____
- DO NOT SHARE ANY OF MY INFORMATION WITH ANYONE.

I understand this permission is valid until revoked. If I wish to revoke it, I must submit something in writing.

_____ _____

Patient Signature Date