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New Patient Packet

Welcome to our practice. Please complete each section as fully as you can. Everything you share stays confidential and helps us take better care of you.

IMPORTANT — PLEASE READ

Our office must review your completed New Patient Packet before you can be considered for acceptance as a patient. Please complete all sections.

PATIENT DETAILS

FULL LEGAL NAME | DATE OF BIRTH | SSN

Sex: ☐ Male ☐ Female

HEIGHT | WEIGHT

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

US Veteran: ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Other — *IF OTHER, SPECIFY*

Hispanic or Latino: ☐ Yes ☐ No

Race: ☐ Asian ☐ Black / African American ☐ White ☐ I choose not to report

CONTACT INFORMATION

TELEPHONE | EMAIL ADDRESS

This number is my: ☐ Home ☐ Cell ☐ Work

STREET ADDRESS | CITY | STATE / ZIP

EMERGENCY CONTACT

NAME | PHONE NUMBER | RELATIONSHIP

CARE HISTORY

PREVIOUS PRIMARY CARE PHYSICIAN | HOW DID YOU HEAR ABOUT US?

INSURANCE INFORMATION

Policy Holder: ☐ Self ☐ Spouse ☐ Child

Primary Insurance

INSURANCE NAME | SUBSCRIBER NAME | SUBSCRIBER DOB

SUBSCRIBER ID | GROUP NUMBER | COVERAGE DATE

Secondary Insurance *(if applicable)*

INSURANCE NAME | SUBSCRIBER NAME | SUBSCRIBER DOB

SUBSCRIBER ID | GROUP NUMBER | COVERAGE DATE

PREFERRED PHARMACY

PHARMACY NAME | PHARMACY CITY

HEALTH & LIFESTYLE

Answer yes or no

Do you smoke or use tobacco products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Do you use drugs? ☐ Yes ☐ No

ALLERGIES

Are you allergic to any medications? ☐ Yes ☐ No

IF YES, LIST EACH MEDICATION AND THE REACTION IT CAUSED

Any other allergies (food, latex, environmental)? ☐ Yes ☐ No

IF YES, PLEASE LIST

YOUR MEDICAL BACKGROUND

MAJOR ILLNESSES OR ONGOING CONDITIONS

CURRENT MEDICATIONS *include dose if known, and who prescribes each one*

MAJOR OPERATIONS OR HOSPITALIZATIONS *include the date or year*

FAMILY HISTORY *conditions that run in your family, such as heart disease, diabetes, or cancer*

SPECIALIST CARE

Are you currently seeing a specialist? ☐ Yes ☐ No

IF YES, LIST THE SPECIALIST AND WHAT THEY TREAT YOU FOR

PRESCRIPTION HISTORY CONSENT

I hereby authorize Family First Health & Wellness Clinic, PLLC to obtain my previous prescription and medication history through external sources.

INITIALS

FINANCIAL RESPONSIBILITY & ASSIGNMENT OF BENEFITS

The information provided in this packet is complete and correct. I hereby authorize the release of information necessary to file a claim with my insurance company, and I assign benefits otherwise payable to me to Family First Health & Wellness Clinic, PLLC.

I understand that I am financially responsible for charges for medical services rendered regardless of insurance coverage. I am also responsible for any office visit copayment due at the time of service and/or deductibles, as well as additional fees for form processing, returned checks, copying of medical records, and missed appointments that may apply.

If this account is assigned to an attorney for collection and/or suit, a copy of this signature is as valid as the original.

PRINT NAME

SIGNATURE

DATE

OUTSIDE LABORATORY SERVICES BILLING

I understand that certain laboratory studies will be sent out to a reference lab such as Quest, LabCorp, or the provider's lab of choice, and that the reference lab will send a separate bill for those studies. I understand that Family First Health & Wellness Clinic, PLLC charges a technical fee for equipment, technicians, and other operating expenses, and that I will receive a separate bill from the reference lab for any lab work sent to them.

INITIALS

ELECTRONIC PRESCRIBING CONSENT

Family First Health & Wellness Clinic, PLLC provides electronic prescriptions (E-Prescribing) to pharmacies through Sure Scripts. E-Prescribing allows the practice to send prescriptions electronically, eliminating the need for a more time-consuming, and sometimes more costly, approach through paper, phone, and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective, and safe.

INITIALS

PRESCRIPTION REFILL POLICIES

- If you are prescribed medications, you will receive an initial prescription with refills to last until your suggested follow-up visit. It is your responsibility to schedule that follow-up before your prescription runs out to ensure a continued supply of medication.
- Medication refill requests will not be authorized if you fail to keep your follow-up appointments. To provide good clinical care, patients must be seen on a regular basis.
- Only minor changes to your medication regimen can be made between appointments. Major changes require a visit with your provider first.
- We do not accept faxed refill requests from your pharmacist.
- Please allow up to 48 hours for us to review your medical history and determine whether the requested refill is appropriate.
- Please check with your pharmacy to see if your request was processed before calling the office to request the same refill a second time.
- Routine prescription refills are not provided on weekends.
- All medications are to be taken as prescribed. If medication is taken in excess of what is prescribed and runs out early, the refill will not be authorized until the scheduled refill date.
- If you are already being treated by a pain management physician, all pain medications must be managed by your existing pain management specialist.
- Regular blood work is required for all patients on prescription medication to monitor safety and effectiveness. The interval varies by medication. Patients who do not complete their scheduled blood work will not have prescriptions refilled.

By signing below, you indicate that you understand the refill policies listed above and authorize Family First Health & Wellness Clinic, PLLC to electronically transmit prescriptions to the pharmacy of your choice and to review pharmacy benefit information and medication dispensing history while you are a patient of this office or until you withdraw that consent.

PATIENT NAME

DATE OF BIRTH

PATIENT REPRESENTATIVE (IF APPLICABLE)

RELATIONSHIP

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE

CONSENT FOR TREATMENT

I understand that various screening and diagnostic procedures may be necessary to diagnose my condition, and that I will be given various treatment options following diagnosis. I hereby give Family First Health & Wellness Clinic, PLLC providers and ancillary staff the authority to perform the screening and diagnostic studies deemed necessary and/or the treatment options of my choice.

I understand that Family First Health & Wellness Clinic, PLLC employs the services of a Nurse Practitioner to assist in pati

INITIALS

I am willing to be seen by a Nurse Practitioner if a physician is unavailable: ☐ Yes ☐ No

AUTHORIZATION TO FURNISH AND/OR OBTAIN MEDICAL RECORDS

With the procedures and hazards having been fully explained, the undersigned consents to any x-ray, anesthesia, medical, surgical, or dental treatment rendered to the patient by physicians and designated clinic personnel, including Registered Nurses, Licensed Vocational Nurses, Nurses' Aides, Medical Assistants, Nurse Practitioners, Pharmacists, Dietitians, and any other persons who are not licensed physicians but are trained to assist under the general and special instructions provided by them.

I further understand that I may revoke this authorization at any time, and I hereby authorize Family First Health & Wellness Clinic, PLLC to furnish and/or obtain confidential medical records. This consent is subject to revocation at any time, except to the extent that action has already been taken in reliance on it.

I hereby authorize Family First Health & Wellness Clinic, PLLC to furnish information to insurance carriers concerning this illness or accident, and I assign to the clinic all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that the information I have provided to Family First Health & Wellness Clinic, PLLC is complete and accurate to the best of my ability and knowledge.

PRINT NAME	SIGNATURE	DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I have been given an opportunity to ask questions about anything I do not understand, and I know I am entitled to a copy of this document upon request.

INITIALS

PRIVACY POLICY

Initial ONE option below

As a patient of Family First Health & Wellness Clinic, PLLC, you have rights and responsibilities, and so does the clinic. We want you to understand them so you can help us provide quality health care for you. Please read this statement and ask us any questions you may have. The law requires that we make every effort to inform you of your rights related to your personal health information. By initialing and signing below, I acknowledge that:

_____ I have read, or had explained to me, the clinic's Notice of Privacy Practices and Patient & Center Rights and Responsibilities, and I AGREE to continue my care with Family First Health & Wellness Clinic, PLLC under said terms.

_____ I was given the opportunity to read the clinic's Notice of Privacy Practices and Patient & Center Rights and Responsibilities and DECLINED, but I wish to continue my care with Family First Health & Wellness Clinic, PLLC under said terms.

_____ I have read, or had explained to me, the clinic's Notice of Privacy Practices and Patient & Center Rights and Responsibilities, and I DO NOT wish to continue my care with Family First Health & Wellness Clinic, PLLC under said terms.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

PRINT NAME | SIGNATURE | DATE

AUTHORIZED CONTACTS

Who may we leave information with?

I give permission for Family First Health & Wellness Clinic, PLLC staff to leave information with the following authorized people:

1. NAME | RELATIONSHIP | PHONE

2. NAME | RELATIONSHIP | PHONE