



Tammie Gore, DNP, APRN, CGRN, FNP-C
105 Highway 96 South Silsbee, TX 77656
Office# 409-385-3118 Fax# 409-351-3686

Name: _____ **Date of Birth:** _____ **SSN:** _____

Telephone: _____

Home Cell Work **Email Address:** _____

Address: _____ **City:** _____ **State/Zip:** _____

Emergency Contact Name: _____ **Phone Number:** _____ **Relationship:** _____

Sex: Male Female **Height:** _____ **Weight:** _____

Marital Status:
 Single Married Divorced Widow Separated

Are you a US Veteran?
 Yes NO

Primary Language English Spanish Other

Ethnicity: Are you Hispanic or Latino? Yes No

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

Previous Primary Care Physician:

Insurance Information: Self Spouse Child

Primary Insurance name:
Subscriber Name _____ Subscriber DOB _____

Subscriber ID: _____ Group Number: _____ Coverage Date: _____

Secondary Insurance name:
Subscriber Name _____ Subscriber DOB _____

Subscriber ID: _____ Group Number: _____ Coverage Date: _____

Pharmacy Name:

Pharmacy City:

MEDICAL HISTORY (Please answer YES or NO to the questions below)

Do you smoke or use tobacco products? ___ YES ___ NO

Do you drink alcohol? ___ YES ___ NO

Do you use drugs? ___ YES ___ NO

Are you allergic to any medications? ___ YES ___ NO

If **Yes** please list and the reaction's it caused:

Any other allergies? ___ YES ___ NO

If **Yes** please list:

Please list any major illnesses:

Please list your current medications: and Who prescribes medication:

Please list all major operations or hospitalizations with **Date/Year:**

Family History:

Specialist? ___ YES ___ NO

RX History Consent:

I hereby authorize Family First Health & Wellness Clinic, PLLC to obtain my previous prescription/medication history through external sources: _____ **(Initial)**

The above information is complete and correct. I hereby authorize the release of information necessary to file a claim with my insurance company. 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 also understand that I am responsible for any office visit copayment due at the time of services and/or deductibles, 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 the signature is valid as the original.

Print Name: _____

Signature

Date

Family First Health & Wellness Clinic, PLLC

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ELECTRONIC PRESCRIBING CONSENT _____ Initial

Family First Health & Wellness Clinic, PLLC provides electronic prescriptions (E-Prescribing) to pharmacies through Sure Scripts. E-Prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need or a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone, and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective, and safe. By signing below, you are indicating you understand the above listed refill policies and authorize Family First Health & Wellness Clinic, PLLC to electronically transmit prescriptions to the pharmacy of your choice, review pharmacy benefit information and medical dispense history if you are a patient at this office or until you withdraw that consent.

PRESCRIPTION REFILL POLICIES

Prescription refills

- If you are prescribed medications, you will be provided with an initial prescription and refills to last until the suggested follow-up visit. It is your responsibility to schedule your follow-up appointment before the prescription runs out to insure a continued supply of medication.
- Medication refill requests will not be authorized if you fail to keep your follow-up appointments. To give good clinical care patients must be seen on a regular basis.
- Only minor changes in your medication regimen can be made between appointments. If a major change in your medication regimen is needed you will need to be seen by your provider before these changes can be made.
- We do not accept faxed refill requests from your pharmacist.
- It may take up to 48 hours for reviewing your medical history and deciding if the requested refill is appropriate.
- Please call your pharmacy to see if your request was processed before calling the office to request the same refill a second time.
- Routine prescription refills will not be provided on the weekends.

- All medications are to be taken as prescribed. If patient takes medication in excess of what is prescribed and runs out of medication early (prior to refill date), the refill will not be authorized until refill date.
- In general, if a patient is already being treated by a pain management physician, all pain medications will need to be managed by the patient's existing pain management specialist.
- We require regular blood work for all patients on prescription medication, which is necessary for monitoring the safety and effectiveness of the medication. The interval will vary based on the medication prescribed. Patients who do not schedule for their regular intervals of blood work will not have their prescriptions refilled.
- Family First Health & Wellness Clinic, PLLC provides electronic prescriptions (E-Prescribing) to pharmacies through Sure Scripts. E-Prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need for a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone, and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective, and safe.

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

Patient Name: _____ **DOB:** ____/____/____
Patient Representative: _____
Relationship: _____
Signature of Patient or Representative: _____
Date: ____/____/____

OUTSIDE SERVICES BILLING ____ Initial

I understand that certain laboratory studies will have to be sent out to a reference lab, i.e., Quest, LabCorp, or Provider's choice Lab. This 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. I understand I will be receiving a separate bill from the reference lab for any lab work sent to them.

CONSENT FOR TREATMENT ____ Initial

I understand various screening/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 Services providers and ancillary staff the authority to perform the screening/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 Nurse Practitioner to assist in patient care.

*** I am willing to be seen by a Nurse Practitioner in the event a physician is unavailable. ____ Yes ____ No**

CONSENT FOR TREATMENT AND 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 the patient by physicians, designated clinic personnel including Registered Nurses, Licensed Vocational Nurses, Nurses' Aides, Medical Assistant, Nurse Practitioners, Pharmacists, Dietitians, and any other persons who are not licensed physicians who are trained to assist under the general and special instructions provided by them. I further understand I may revoke this authorization at any time; and I hereby authorize the 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 been taken in reliance thereon. I hereby authorize Family First Health & Wellness Clinic, PLLC to furnish information to insurance carriers concerning this illness/accident, and I hereby assign to the Center all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

I certify the information which 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 _____ Initial

I acknowledge 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 if I do not understand. I understand I am entitled to a copy of this document upon request.

Print Name: _____

Signature

Date

PRIVACY POLICY

As a Family First Health & Wellness Clinic, PLLC patient, you have rights and responsibilities. The Center also has rights and responsibilities. We want you to understand these rights and responsibilities so you can help us provide quality health care for you. Please read this statement and ask us questions if you have any.

The law requires that Family First Health & Wellness Clinic, PLLC make every effort to inform you of your rights related to your personal health information. By my initialing and signing below, I acknowledge that:

(Choose One to initial by)

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

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

_____ I have read or had explained to me Family First Health & Wellness Clinic, PLLC Notice of Privacy Practices and Patient & Center Rights and Responsibilities and **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

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

Name:

Relationship:

Phone#:

1. _____

2. _____