FHV Health

Is todays visit work related or motor vehicle accident related?
If YES , do not complete this form.
PLEASE SEE THE FRONT DESK FOR INSTRUCTIONS.

Patient Information—Please use blue or black ink.

Today's Date: _____

LAST NAME _____ FIRST NAME _____ MID. INITIAL _____ DATE OF BIRTH _____

PRIMARY ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

SEX _____ SOCIAL SECURITY NO. _____ MARITAL STATUS _____

EMAIL ADDRESS _____ DO YOU HAVE A LIVING WILL? YES NO
(If yes, please provide a copy for your medical file)

EMPLOYER'S NAME _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

NUMBER OF INSURANCE PLANS _____ ARE YOU RESPONSIBLE FOR FEES? YES NO WHO? _____

PRIMARY INSURANCE & POLICY ID _____ PRIMARY INSURANCE POLICY HOLDER _____

SECONDARY INSURANCE & POLICY ID _____ SECONDARY INSURANCE POLICY HOLDER _____

EMERGENCY CONTACT LAST NAME _____ FIRST NAME _____ MID. INITIAL _____ DATE OF BIRTH _____

RELATIONSHIP _____ PHONE NUMBER _____

PRIMARY CARE PHYSICIAN _____ PHONE NUMBER _____

PLEASE GIVE INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST TO COPY TO YOUR FILE

HIPAA

I have read the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and understand my rights.

SIGNATURE _____ DATE _____

Consent for treatment and lifetime authorization for assignment of benefits and information release.

I hereby give consent to FHV Health to provide whatever treatment they may deem necessary to the patient above. I understand that I am responsible for charges not covered by the insurance policy or Medicare, and should it become necessary to collect these charges through an attorney or other collection process, I shall be responsible for all court costs, interests, collection costs and attorney fees.

I hereby request payment of authorized Medicare benefits and/or any other supplemental insurance benefits for me to be paid directly to FHV HEALTH for any services furnished to me by FHV HEALTH. I authorize FHV HEALTH and staff to release to my insurance carrier and its agents any information concerning health care, advice, treatment or supplies provided, needed to determine these benefits payable for related services. I understand this is a lifetime authorization.

SIGNATURE OF PATIENT AUTHORIZATION _____ DATE _____ SIGNATURE OF RESPONSIBLE PERSON _____ DATE _____

FHV Health

Information Regarding the Health Insurance Portability & Accountability Act

This notice describes how medical information about you may be used and disclosed, and how you can access this information. Please read it carefully.

The **Health Insurance Portability & Accountability Act (HIPAA)** of 1996 is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, to be kept properly confidential. This Act gives you, the patient, rights to control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are maintaining the privacy of your health information and how we may use and disclose your health information.

We at FHV Health create a medical chart with your personal medical information, along with a computerized account for payment. Treatment: We may use and disclose information about you to provide you with medical care. We may disclose information about you to other physicians or those designated on the "Authorization To Release Information." Payment: We may use medical information, along with Insurance information, and any additional information provided, in order that payment for services is received. Operations: We may use and disclose PHI from you for normal daily medical operation of our office. We may also disclose information to our Business Associates who provide contracted services for us (accounting, legal representation, claims processing, consulting, etc.). We may contact you to remind you of appointments, health related issues, or billing concerns. Every effort will be made to comply with any particular request or restriction designated in writing.

Your Rights Regarding Medical Information About You

(1) You have the right to request restrictions on certain uses and disclosures of Protected Health Information. We are however not required to agree to a requested restriction and should we not agree may request you seek another physician. (2) The right to reasonable requests to receive confidential communication of protected health information from us. This request must be in writing. (3) The right to request an amendment. Should you feel the medical information is incorrect or incomplete, you may request an addition or amendment. Requests must be made in writing and submitted to FHV Health, with attention to your attending physician. If you desire your medical record to be changed there is a form, which will be sent to you. The physician may decline your request if it's not accurate. (4) Right to an Accounting of Disclosures. You have a right to request a list of certain types of disclosures we have made of your medical information. We are not required to account for disclosures that were authorized by you, to carry out treatment, payment and healthcare operations.

I have read the Health Insurance Portability & Accountability Act of 1996 and understand my rights.

_____ _____

SIGNATURE **DATE**

_____ _____

PRINTED FIRST NAME **PRINTED LAST NAME**

If you would like a copy of this form, Please ask the front receptionist.

FHV Health

HIPAA Patient Consent Form

I consent to the use or disclosure of my protected health information by FHV Health for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of FHV Health. I understand that diagnosis or treatment of me by FHV Health physicians may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. FHV Health is not required to agree to the restrictions that I may request, and may request I seek another physician. However, if FHV Health agrees to a restriction that I may request, the restriction is binding.

I have the right to revoke this consent in writing at any time, except to the extent that FHV Health has taken action in reliance on this consent.

My protected health information means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The FHV Health Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the FHV Health. The Notice of Privacy Practices for FHV Health is also provided in the reception area. This notice of Privacy Practices also describes my rights and the FHV Health duties with respect to my protected health information.

FHV Health reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of private practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE **DATE**

FHVHealth

Medical History Questionnaire: Urgent Care

Date of Service_____Name_____DOB_____

What is the main reason you came in today? _____

MEDICATION DOSE TIMES/DAY

_____
_____
_____
_____

ALLERGIES_____

List Current Pharmacy_____Location_____

Do you use Tobacco? _____How many packs/day? _____How many years? _____

Females LMP:_____ Any Recent Foreign Travel: Yes/No

Past Medical History: (Circle what applies)

Arthritis	Epilepsy	Phlebitis	Hepatitis
Asthma	Glaucoma	Pregnancy, Normal	Jaundice
Bleeding Problems	Heart Problems	Pregnancy, Abnormal	Liver Disease
Cancer_____	Hypertension	Rectal Bleeding	Pancreatitis
Constipation	Rheumatic Fever	Stroke	Tarry, Black Stools
Diabetes	Kidney Disease	Tuberculosis	Ulcer(s)
Diarrhea	Neurological Problems	Difficulty Swallowing	Vomiting
Emphysema	Nervous Condition	Gallbladder Problems	Vomiting blood

Past Surgical History: (Circle what applies and write in the year)

Appendectomy	_____	D&C	_____	Spine	_____
Tonsils/Adenoids	_____	Hysterectomy	_____	Thyroid	_____
Gallbladder	_____	Joint Replacement	_____	Heart	_____
Hernia	_____	Colon/Stomach	_____		
Chest	_____	Lung	_____		

Family History: Please check if there is family history and indicate which member is affected.

- ○ Diabetes _____
- ○ Hypertension _____
- ○ Heart Disease _____
- ○ Mental Illness _____
- ○ Cancer _____
- ○ Unknown _____
- ○ Liver Disease _____
- ○ Colon/Rectal Disease _____
- ○ Stroke _____
- ○ Breast Cancer _____
- ○ Kidney Disease _____