SMITH LAKE FAMILY CARE

Urgent & Primary Care

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/ Unit #

_____
City State Zip Code

Phone: _____
Cell Phone Home or Alternate Phone

Email: _____

Birth Date: _____ SSN: _____

Reason for Visit today: _____

Preferred Pharmacy: _____

Place of Employment: _____ Work Phone: _____

Responsible Party: _____ Parent / Spouse / Self (Please Circle)

Responsible Party's DOB: _____

****

Emergency Contact: _____

Contact's Phone: _____ Relationship: _____

****

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. COPAYMENT IS DUE PRIOR TO EACH VISIT. I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to this visit center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

Past Medical History: (please circle all that apply to you) **NONE**

Acne	Coronary Artery Disease	Hyperthyroidism	Seizures
Anxiety	Depression	Hypothyroidism	Stroke
Arthritis	Diabetes	Hearing loss	
Asthma	Dry Skin	Hay Fever/Allergies	**Not Listed**
Atrial Fibrillation	Eczema	Hepatitis	
Bone Marrow Transplant	End Stage Renal Disease	Leukemia	_____
BPH	GERD	Lung Cancer	
Breast Cancer	High Blood Pressure	Lymphoma	_____
Colon Cancer	HIV/AIDS	Prostate Cancer	
COPD	High Cholesterol	Psoriasis	_____

Past Surgical History: (please circle all that apply to you) **NONE** **Not Listed**

Appendix Removed	KidneyRemoved(left,right)	_____
Bladder Removed	Kidney Stone Removal	
Mastectomy (left, right, bilateral)	Kidney Transplant	_____
Lumpectomy (left, right, bilateral)	Liver Transplant	
Breast Biopsy (left, right, bilateral)	Ovaries Removed:	
Endometriosis	Right or Left	_____
Breast Reduction	Ovaries Removed: Cyst	
Breast Implants	Ovaries Removed: Cancer	_____
Colectomy: Colon Cancer Resection	Ovaries: Tubal Ligation	
Colectomy: Diverticulitis	Pancreas Removed	_____
Colostomy	Prostate Removed: Prostate Cancer	
Gallbladder Removed	Prostate Biopsy	_____
Coronary Artery Bypass	TURP (Prostate Removal)	
Mechanical Valve Replacement	Spleen Removed	_____
Biological Valve Replacement	Testicles Removed (left, right, bilateral)	
Heart Transplant	Tonsillectomy	_____
Joint Replacement, Knee (left, right, bilateral)	Thyroidectomy	
Joint Replacement, Hip (left, right, bilateral)	Hysterectomy	_____
Joint Replacement, within last 2yrs		

Social History: (please circle all that apply to you)

Tobacco Use:	**Alcohol Use:**	**Illegal Drug Use:**	**Caffeine Use:**
Smoke / Vape / Chew / Dip	None	Daily use	None
Daily use	Less than 1 drink per day	Never used	1 drink / day
Never used	1-2 drinks per day	Former user	2-3drinks/day
Former user	3 or more drinks per day		Energy shots

Family History:

Mother: Alive / Deceased Health Conditions: _____

Father: Alive / Deceased Health Conditions: _____

Current Medication List

Medication Name	Dosage or Mg	Number of times per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

ALLERGIES: _____

I attest this is a complete list of all my current medications or supplements I am taking. I understand providing inaccurate information could be harmful to my care and affect my treatment plan.

Signature: _____ Date: _____

CONSENT FOR MEDICAL TREATMENT

I volunteer for SLFC and consent for the treatment of the doctor or provider on duty and whom I can designate as his assistant, associate, medical treatment and patient care staff to take care of me. The type of care may include, but is not limited to, diagnostic procedures, and the administration of medications considered advisable in my course of care, diagnosis, and treatment. I acknowledge that it cannot be done or has been done regarding the results of the treatments or examinations and I understand that all medical treatments contain inherent risks.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, hereby assign and transfer to SLFC any and all rights, which I have against the insurance companies or third parties bound, for the payment of charges for services rendered by SLFC to me or one of my dependents. I authorize payment said to apply to any unpaid balance that I am liable. I understand that I am responsible and will pay the portion of my account not covered by the insurance companies or third party payers. I agree to pay the bill in full upon receiving my statement unless payment arrangements are made with SLFC. If my account is placed with a collection agency, an additional 35% will be added to my balance. ***It is our policy that any insurance Co Pays and deductibles or any balance of an account of those people without insurance is due at the time of service.***

COMPLIANCE WITH GOVERNMENT RULES

In compliance with the Stark Act and Affordable Care Act and newly enacted patient protection, SLFC must inform you that there are other options in the laboratory, diagnostic and radiographic services. Specifically it should be noted that SLFC has been urgently required to voluntarily attend to its medical needs and that as part of the evaluation of its conditions and any required treatment, the attending provider may determine that particular laboratory diagnosis, and may require radiographic examinations. SLFC offers many of these services on site as a service to our patients. If any patient would like to have their lab or radiographic services elsewhere we can provide you with a list of nearby places.

RELEASE AND USE OF INFORMATION FOR THE PATIENT

I authorize the release of my medical records, information, treatment and counseling and specific health information:

1. TREAT MEDICS in the SLFC Emergency Care personnel and their staff, agents of another health facility if transfer to another institution is necessary, and to my primary care physician or provider or any referrals for follow up care.

2. THE EMPLOYER requesting services. This may include the physics lab, personal medical history, and diagnostic tests and drug tests (including the presence of drugs, alcohol and or marijuana).
3. Insurer or any other paying third party and its agents as well as any governmental organization or agency review in order to determine the eligibility and benefits available, obtain payment for services rendered and ensure government compliance.
4. Or SCIENTIFIC INSTITUTIONS, authorized to health care professionals in training, internal quality improvement, risk management and legal advice when considered to be beneficial to my continued medical care, medical research, quality improvement, education Health or science; for any purpose authorized by law. I understand that if I refuse to authorize access to my records for coordination of care, my treatment may be adversely affected and I may be held liable for the full cost of the SLFC care services. I understand that this information may contain my personal medical history, physical and treatment (if necessary), radiographic and laboratory results and more specifically results in reference to alcohol, drug use or abuse, mental health or infectious disease (including human immunodeficiency virus, hepatitis and other infectious diseases). I understand that I have the right to revoke this authorization.

_____ PATIENT INITIALS

(SIGNATURE TO FOLLOW ON PAGE 2)

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION TO YOUR FAMILY OR OTHER PERSON

In agreement with the federal government's privacy regulations through the Health Insurance Portability and Accountability Act of 1996, in order for your medical provider or health care staff in SLFC to give copies of or discuss your condition/ examination/ procedures / x-rays with family members or others you designate as your primary care physician or specialist, we must obtain your authorization before doing so.
In the event of a critical episode or if you are unable to give authorization due to the severity of your medical condition, the law states these rules are authorized.

I authorize SLFC to release any information including verbal information, copies of x-rays, and medical paperwork about my medical care to the following persons:

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

_____ I *AUTHORIZE* SLFC TO LEAVE A DETAILED MESSAGE ABOUT MY CARE AT THE FOLLOWING WITH THE PHONE NUMBER I HAVE PROVIDED SLFC WITH ON MY FILE.

_____ ***I DO NOT*** authorize SLFC to leave a detailed message on my answering machine or voicemail. I acknowledge that by choosing this option, that as a patient, I take full responsibility for contacting SLFC for the results of all tests.

RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge receipt of the privacy rights notice with detailed information on how SLFC may use and disclose my protected health information. I understand that SLFC reserves the right to amend the privacy notice.

Signature: _____ Date: _____