**Forest Family Care, INC.**

Adult Patient Information Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider you prefer to see:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Provider Last Seen**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please Print) Last First Middle

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_

Phone: Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # Patient \_\_ \_\_ \_\_- \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ Age\_\_ \_\_ \_\_ Birth Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Sex: \_\_\_\_\_\_Male \_\_\_\_\_\_Female \_\_\_\_\_\_\_Transgender

Marital Status: \_\_\_\_Single \_\_\_\_Married \_\_\_\_Widowed \_\_\_\_Divorced \_\_\_\_\_Separated

Race: \_\_\_\_White \_\_\_\_\_Hispanic \_\_\_\_\_\_\_Black \_\_\_\_\_\_\_Other

Language: \_\_\_\_\_\_English \_\_\_\_\_\_Hispanic \_\_\_\_\_\_\_\_\_Other

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Co.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder SS # \_\_ \_\_ \_\_- \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

Secondary Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder SS # \_\_ \_\_ \_\_- \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the FINANCIAL POLICY OF THIS OFFICE IS AS FOLLOWS: Payment to be made prior to service. Co-pays’, deductible and non-covered services are to be paid at time of service. I understand that my signature is valid for the purpose of filing me or my child's insurance and I authorize payment of benefits to Forest Family Care, INC.

PLEASE GIVE YOUR CURRENT INSURANCE CARD(S) TO RECEPTIONIST TO COPY. THANK YOU.

Patient 's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Forest Family Care, INC.**

1785 W. Lee Hwy (276) 228-6499 Phone

Wytheville, VA 24382 (276) 228-3311 or (276) 228- 6145 Fax

**Statement of Patient Financial Responsibility**

 Forest Family Care appreciated the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

 I have read the above policy regarding my financial responsibility to Forest Family Care for providing services to me. I certify that the insurance and demographic information I have supplied to this office is, to the best of my knowledge, true, and accurate.

 **I agree to pay**

 **a. Co-pay at time of visit**

 **b. Deductibles owed when statement is received**

 **c. Balance owed on my account or any accounts that I am Guarantor**

 **Non-payment will result in cancellation or rescheduling of appointments and also placing account/accounts with collection agency.**

Patient/Guarantor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**UN-INSURED (SELF-PAY) POLICY**

If un-insured, I agree to pay Forest Family Care **$100.00** (or full balance of the office visit, whichever is less) on the office visit, and then pay **$85.00** per month on the remaining balance of the account until the account is paid in full.

I agree if payments are not made in the full amount stated above/ or payments are not received on time, the entire balance will be considered delinquent and balance due in full.

Patient/Guarantor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Forest Family Care, INC.**

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**Authorization for the Release of Protected Health Information**

Patients Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(One Physician From Whom you are Requesting Records) (One physician per page-Make Copies if needed)**

To Provide Confidential Information Contained Within My Medical Record: Forest Family Care

Information to be released should include:

Complete health record Office Notes Discharge Summary History & Physical Exam Consulting Reports Progress Notes Laboratory Test Results X-ray reports Itemized Bill X-ray Films/Images Immunization Record Demographic/Insurance Information

**The purpose of this request is:**

Treatment and/or Consultation At the request of the patient Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following Dates of Service Should be Included in this request:**

 All dates of service From (Date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To (Date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, have read and authorize the staff on the disclosing facility named to disclose information as herein contained. I understand the information disclosed by this authorization may be subject to re-disclose by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1988. The facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified about under "Purpose of Request". I can inspect or copy the protected health information to be used or disclosed. Except to the extent that action has been taking in compliance with this request, this authorization may be revoked by me at any time, by

submitting a notice in writing to the Privacy Office at Forest Family Care. Unless revoked, this authorization will expire in six months unless otherwise specified, or in the event of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Initial \_\_\_\_\_\_\_ I acknowledge and hereby consent to such, that the released information may contain alcohol abuse, psychiatric, sexually transmitted disease, Hepatitis B or C, HIV testing, HIV results or AIDS information.

**Forest Family Care, INC.**

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Wytheville, VA 24382 (276) 228-3311 or (276) 228- 6145 Fax

Adult History

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ AGE:\_\_\_\_\_\_\_\_\_\_\_\_\_

**To help us meet all of your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.**

Today's date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was your last physical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you seen any of the providers in our office in the past three years?** \_\_\_\_Yes \_\_\_\_\_NO

Our providers: Susan Moore, CFNP, Jill Snider, CFNP, Etthan Miller, CFNP, Tammy Terry, CFNP, & Dr. Griffin

1. **Current Medications/Vitamins/Supplements**

|  |  |  |
| --- | --- | --- |
| Drug Name:  | Dose:  | How Often:  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

* Have you been seen in the past for chronic pain management? Circle one: Yes or NO
* Current medication you are presently out of? (Please provide medications in space below) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
1. **PAST Medical History:**

|  |  |  |
| --- | --- | --- |
|  | YES | NO  |
| Abnormal Weight Gain  |  |  |
| Abnormal Weight Loss |  |  |
| Excessive Fatigue  |  |  |
| Insomnia  |  |  |
| Anemia |  |  |
| Cancer |  |  |
| Tumor  |  |  |
| Glasses/Contacts  |  |  |

|  |  |  |
| --- | --- | --- |
|  | YES | NO  |
| Glaucoma |  |  |
| Cataracts |  |  |
| Hearing Loss |  |  |
| Ear Problems |  |  |
| Ringing in Ear |  |  |
| Dentures |  |  |
| Dental Problems |  |  |
| Heart Attack  |  |  |

|  |  |  |
| --- | --- | --- |
|  | YES | NO  |
| High Blood Pressure  |  |  |
| Breathing Problems |  |  |
| Frequent Bronchitis |  |  |
| Emphysema  |  |  |
| Pneumonia |  |  |
| Asthma |  |  |
| Heartburn |  |  |
| Ulcer disease  |  |  |
| Gallbladder Disease |  |  |
| Blood in Stool  |  |  |
| Hepatitis |  |  |
| Diarrhea, Constipation, or other changes in bowel habits |  |  |
| Hemorrhoids |  |  |
| Abdominal Pain  |  |  |
| Colon Polyp |  |  |
| Gout |  |  |
| Broken Bones |  |  |
| Rash  |  |  |
| Hives |  |  |
| Seizure |  |  |
| TIA |  |  |
| Stroke |  |  |
| Numbness |  |  |
| Weakness |  |  |
| Memory Loss |  |  |
|  | YES  | NO  |
| Headaches |  |  |
| Depression |  |  |
| Anxiety/Panic Attacks |  |  |
| Suicide Attempt |  |  |
| Physical Abuse  |  |  |
| Sores in Mouth |  |  |
| Angina |  |  |
| Frequent Chest Pain |  |  |
| Irregular Heartbeat |  |  |
| Heart Murmur |  |  |
| Rheumatic Fever |  |  |
| High Cholesterol  |  |  |
| Heart Failure |  |  |
| Urinary Frequency |  |  |
| Bladder Infections |  |  |
| Prostate Problems |  |  |
| Urinary Incontinence  |  |  |
| Kidney Problems |  |  |
| Arthritis or joint pain  |  |  |
| Sexual Abuse  |  |  |
| Mental Illness |  |  |
| Diabetes |  |  |
| Thyroid Disease |  |  |
| Abnormal Pap Smear |  |  |
| Breast Lump  |  |  |

**3. CURRENT Medical Issues:**

\_\_\_\_Fever

\_\_\_\_Weight Gain

\_\_\_\_Weight Loss

\_\_\_\_Fatigue

\_\_\_\_Insomnia

\_\_\_\_ Vision Changes

\_\_\_\_Problems Swallowing

\_\_\_\_Trouble Hearing

\_\_\_\_Chest pain/pressure

\_\_\_\_Swelling

\_\_\_\_Palpitations/Racing Heartbeat

\_\_\_\_Shortness of Breath

\_\_\_\_Painful Breathing

\_\_\_\_Cough

\_\_\_\_Wheezing

\_\_\_\_Vomiting

\_\_\_\_Acid Reflux/Heartburn

\_\_\_\_Nausea

\_\_\_\_Rectal Bleeding/blood in stool

\_\_\_\_Constipation

\_\_\_\_Diarrhea

\_\_\_\_Painful urination

\_\_\_\_Increased urinary frequency

\_\_\_\_Urinary urgency

\_\_\_\_Urinary incontinence

\_\_\_\_Back Pain

\_\_\_\_Joint Swelling

\_\_\_\_Joint redness

\_\_\_\_Rash

\_\_\_\_Concerning or changing skin lesion

\_\_\_\_Headache

\_\_\_Memory Loss

\_\_\_Weakness

\_\_\_\_Anxiety

\_\_\_\_Depression

\_\_\_\_High blood sugar

\_\_\_\_Low blood sugar

\_\_\_\_High blood pressure

\_\_\_\_Low blood pressure

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.** **Please list any food or drug ALLERGIES you have had:**

|  |  |  |
| --- | --- | --- |
| **Name of drug/food:** | **Reaction:** | **Date of Occurrence:**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

5. **Please list an HOSPITALIZATIONS you have had in the past 3 years:**

|  |  |  |
| --- | --- | --- |
| **Location:**  | **Reason:**  | **Year:**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**6. Please check or list all of the SURGERIES you have had**:

|  |  |  |
| --- | --- | --- |
|  | **Type of Surgery** | **Year:**  |
|  | Appendectomy |  |
|  | Arthroscopy (joint) |  |
|  | Back or Neck Surgery |  |
|  | Cataract Surgery |  |
|  | Cesarean Section |  |
|  | Gallbladder Removal |  |
|  | Heart Surgery |  |
|  | Hemorrhoids |  |
|  | Hernia |  |
|  | **Type of Surgery:**  | **Year:**  |
|  | Hysterectomy |  |
|  | Knee or Hip Replacement |  |
|  | Mastectomy or Lumpectomy |  |
|  | Polyp Removal (colon) |  |
|  | Tonsillectomy/Adenoidectomy |  |
|  | Tubal Ligation or Vasectomy |  |
|  | Plastic Surgery  |  |
|  | Other Specify  |  |

**7. For WOMEN:**

|  |  |
| --- | --- |
| Last menstrual period  |  / / |
| Last pap smear |  / / |
| Last mammogram |  / / |
| Last bone density |  / / |

|  |  |
| --- | --- |
| Age of first period  |  |
| # of days in cycle |  |
| # of days in flow  |  |
| Are you menopausal  | YES or NO  |
| Age at onset of menopause  |  |

|  |  |
| --- | --- |
| # of pregnancies  |  |
| # of live births |  |
| # of miscarriages |  |
| # of abortions |  |
| # of living children  |  |

**8. Please list any SPECIALTY providers you currently see:**

|  |  |
| --- | --- |
| **Specialty:**  | **Providers Name:**  |
|  |  |
|  |  |
|  |  |
|  |  |

**9. Have any of your FAMILY members had any of the following?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Member** | **Diabetes** | **Hypertension** | **Heart Disease** | **Stoke** | **Mental Illness** | **Cancer** | **Unknown** |
| Daughter |  |  |  |  |  |  |  |
| Father |  |  |  |  |  |  |  |
| Son |  |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |  |
| Paternal Grandfather |  |  |  |  |  |  |  |
| Paternal Grandmother |  |  |  |  |  |  |  |
| Maternal Grandfather |  |  |  |  |  |  |  |
| Maternal Grandmother |  |  |  |  |  |  |  |
| Sibling(s) |  |  |  |  |  |  |  |

**10. Social History**

* Do you smoke currently? YES or NO
	+ If so, how much? \_\_\_\_\_\_\_ cig/day \_\_\_\_\_\_# of years smoking
* If no, did you smoke in the past? YES or NO
* Are you exposed to smoke? YES or NO
* Any other tobacco use? YES or NO
	+ If so, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you drink caffeine? YES or NO
* Do you drink alcohol? YES or NO
	+ If so, how much? \_\_\_\_\_\_\_\_\_ drinks/day
* Have you ever used drugs? YES or NO
* Do you exercise? YES or NO
* Do you wear a seatbelt? YES or NO
* How many members are in your household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Is there concern for your safety (emotional, physical, or sexual abuse)? YES or NO

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**NOTICE OF DEEMED CONSENT**

**TESTING FOR BLOOD BORNE INFECTIONS**

Should an employee of Forest Family Care be exposed to my blood or bodily fluid in a way that might allow transmission of infection due to blood borne disease(i.e. HIV, Hepatitis B, Hepatitis C, etc.) or other communicable diseases, then I understand that according to Virginia State Law, for the safety, health and possible treatment of the employee, samples of my blood or bodily fluid may be tested for evidence of infectious diseases.

Likewise, I also understand that Forest Family Care employees and physicians are obligated to submit to blood tests for certain infectious diseases if I am inadvertently exposed to their blood or bodily fluid during the course of my treatment.

Routine testing of blood for HIV and other blood borne infection is not performed. Testing for such will only be performed as outlined above unless I am specifically informed and counseled otherwise.

Patient Name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Acknowledgement of Receipt of Privacy Notice and Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations. Consent for photograph.**

1. I acknowledge that I have provided with Forest Family Care Notice of Privacy Practices that provides a more complete description of information uses and disclosure. I understand that I have the right to review the Notice of Privacy Practices prior to signing this content. I understand that Forest Family Care reserve the right to change its Notice of Privacy Practices prior to implementation may mail a copy of any revised notice to the address I have provided.
2. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and the Forest Family Care is not required to agree to the restrictions requested, but if it does, it is bound by such restrictions.
3. I understand that I may revoke this consent in writing, except to the extent that Forest Family Care has already taken action in reliance thereon.
4. By signing this form, I consent to Forest Family Care use and disclosure of my health information for treatment, payment, and health care operations.
5. I understand and consent for the patient's photograph to be taken either via camera or valid picture ID, as part of my medical record.

{Optional}

* I request the following restriction to the use or disclosure of my health information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Restrictions Accepted
* Restrictions Denied

Employee Signature/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give my permission to the person(s) listed below to authorize treatment and to receive information about the care of the patient named below:

|  |  |  |
| --- | --- | --- |
| **Name:**  | **Relationship:** | **Phone Number:**  |
|  |  |  |
|  |  |  |

In order for the person(s) listed above to obtain information by telephone, the party calling the practice must provide the following Patient Identifier:

**Responsible Party**

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Portal Authorization Form**

**Purpose of this Form:**

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you registered with the Patient Portal, you will be allowed the following:

* Update your contact information
* Communication of laboratory results from staff to patient
* Request prescription refills
* View your medical summary, medication list, treatment history and visitation dates
* Receive reminders through your email
* View current and past statements

The following will **NOT** be accepted through Patient Portal:

* Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when you are seen for an office visit.
* Request for narcotics/controlled medications or for medication not currently being prescribed by a Forest Family Care provider.

**Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.**

**Reminders for Patient Portal:**

* You will have 10 failed log in attempts before the account is locked
* You will be receiving reminders via email from reminders@eclinicalmail.com regarding your appointments, test results posting etc. Please make security adjustments to your email or computer to receive our emails. You will not be able to reply to our email reminders. If you have any questions regarding these emails please send us a message via Patient Portal.
* If you forget your password you may request another one through Patient Portal by clicking on the Forgot Password link.
* After you are finished accessing Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
* Avoid using a public computer to access Patient Portal.
* Patient Portal is provided as a courtesy service for our patients. There is no service fee. However if the patient abuses or misuses Patient Portal we reserve the right to terminate the patient's account.
* Our hours of operation are 7:00-5:00 Monday-Friday. We encourage you to use the web site at any time; however messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
* We reserve the right to suspend or terminate the patient portal at any time and for any reason.

**How the Secure Patient Portal Works:**

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

**Protecting Your Private Health Information and Risks:**

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1. The secure message must reach the correct email address and,
2. Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and hat you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

**Patient Acknowledgement and Agreement:**

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand this risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complete the following for accounts for minor children:**

Name of Parent/Guardian requesting access:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name Middle Initial First Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the Patient Date

Our Patient Portal site may be accessed by two different URLs.

Our website: www.forestfamilycare.com

Patient Portal direct site: https://health.healow.com/ForestFamilyCare

Practice Code: JIDBCA

**Consent to Use Electronic Communication**

Forest Family Care (FFC) offers electronic communication. Electronic communication means talking through texts, emails, automated phone calls, and the patient portal. Once you sign this form, your doctor, nurse, or other health care providers at FFC may use electronic communication to get in touch with you. You can also use electronic communication to get in touch with us.

**How do we use electronic communication at FFC?**

We use texts, emails, and automated phone calls:

* to remind you of appointments
* to let you know if you are due for a health service,

 like a mammogram or pap smear

* to let you know what's going on at FFC

(for example, if we have new services

available or we are closing our health centers early).

You can use the patient portal to:

* see your health information online,

 including test results

* send messages to your doctor
* refill your medicine
* view statements

**Patient Acknowledgement and Agreement to Electronic Communication**

I have read this form completely. I fully understand this consent form. I understand the risks and agree to the terms. I agree to follow the rules of the electronic communication services. I understand that FFC may stop communicating with me electronically if I do not follow these rules. I understand that FFC may stop this service at any time and for any reason. I understand that it is my choice to use these services. I can opt-out of, or stop using, these services at any time. I agree to use these electronic services. Please write your initials next to each service that you want to use.

\_\_\_\_\_ Email. Please write your email here\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Patient Portal

\_\_\_\_\_Automated Phone Calls

\_\_\_\_\_Text Messages

\_\_\_\_\_I do not want to use any of these services

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

These services are only for FFC patients. We keep a record of the things we talk about with you through electronic communication in your private health record. Call us at 276-228-6499 if you have questions.

We do not give emergency care by electronic communication. If you have an emergency, call your FFC health center or call 911.

We do not use electronic communication to :

* give you advice about your health
* prescribe you a new medicine
* sell any information

There are some risks using electronic communication:

* Someone who does not have permission to see your patient portal may see it. Protect your cell phone, computer, user name, and password. Even if you protect your user name and password, someone might be able to guess it.
* Someone who does not have permission to see your patient portal may break the law and hack into your account.

There may be other risks of using electronic communication not listed here. FFC is not responsible for messages sent by mistake.

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Forest Family Care, INC.**

1785 W. Lee Hwy (276) 228-6499 Phone

Wytheville, VA 24382 (276) 228-3311 or (276) 228- 6145 Fax

Consent to Obtain Prescription History

This consent form authorizes Forest Family Care to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Forest Family Care can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Forest Family Care to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Forest Family Care, INC.**

1785 W. Lee Hwy (276) 228-6499 Phone

Wytheville, VA 24382 (276) 228-3311 or (276) 228- 6145

**Controlled Medication Agreement**

This agreement is between the patient and Forest Family Care. We are committed to doing all we can do to treat medical conditions. In some cases, narcotic pain medicines and/or potentially addictive nerve medications may be necessary to treat your condition. These medications are strictly regulated by both Federal and State Agencies. This contract is designed to protect both you and your physician by establishing guidelines, within the laws for proper controlled medication use. It is agreed that controlled medication will be given by Forest Family Care to the patient ONLY if the following terms are met:

1. By signing a contract for controlled administration, the patient indicated that he/she understood the discussion about the use of controlled medications, including side effects and is agreeable to start this treatment under the terms set by FFC.
2. The patient has the chance to ask questions regarding alternative to the use of controlled medications.
3. Forest Family Care should be the ONE AND ONLY SOURCE of controlled medications unless written permission is given by a FFC physician for the patient to get controlled prescriptions from another physician.
4. ONLY ONE PHARMACY will be used for filling controlled prescriptions.

Pharmacy Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If it is found that the patient received prescriptions for controlled medications from a source other than a FFC physician, without written permission, FFC may void this agreement and discontinues any prescriptions of controlled medications to the patient.
2. The patient agrees to have a **urine test** for medications done randomly at the physician's request.
3. The patient must agree to follow the FFC physician to communicate with the referring physician and any pharmacists regarding the patient's use of controlled substances.
4. The patient must supply documentation of treatment by other physician for co-existing, or relating condition, including psychiatric conditions.
5. The patient understands that FFC will **NOT replace** any lost or inaccessible controlled prescriptions or controlled medications, for **ANY REASON**.
6. The patient must take the controlled medications as instructed by a FFC provider.
7. Any unauthorized increase in the dose of controlled medication may be viewed as a cause for discontinuation of the treatment with controlled medications.
8. If the patient demonstrates unacceptable behavior patterns, the FFC physician may discontinue prescribing the controlled medications for the patient.
9. The patient must keep all regular follow-up appointments as recommended by the FFC physicians. Failure to comply may cause discontinuation of controlled prescriptions.
10. The patient must comply with all aspects of the treatment plan, including, but not limited to, physical therapy, behavioral management, and self-help programs.
11. All prescriptions must be picked up by the patient himself/herself. If the patient is too debilitated or sick, and exception may be allowed.
12. **NO controlled prescriptions will be refilled on weekends or over the phone.**
13. Controlled medications WILL NOT be refilled early.
14. The patient understands the benefit of the controlled medications will be evaluated periodically using the following criteria of pain relief, increase in general functions, increase in exercise, completion of rehabilitation program, return to work, maintenance of job, etc.
15. The patient understands the controlled medications can be discontinued immediately, at the treating physician's discretion, if the patient does not fulfill the terms of this agreement. Medications can also be discontinued if there is evidence of rapid tolerance, loss of effectiveness or if significant side effects develop.
16. The patient certifies or agrees to the following.:
	1. That he/she is not currently abusing illicit or prescriptions drugs.
	2. That he/she has never been involved in the sale, illegal possession, diversion or transport of controlled substances (controlled, sleeping pills, nerve pills, or pain killers).
	3. That she is not pregnant and that she will use appropriate contraception during her course of treatment.
	4. Sharing your controlled medications is strictly prohibited. Any sharing will result cancellation of our prescription refills.
17. Evidence of medication hoarding, increasing the amount of medication without communication to your FFC physician, refilling our prescription too frequently, getting the medication from multiple physicians, increasing the amount of medication despite significant side effects, altering prescriptions, medication sales, unapproved use of other drugs (alcohol, sedatives or using non-prescription, medications inconsistent with drug labeling) during controlled analgesic treatment or other unacceptable behavior will result in tapering and discontinuing of controlled therapy.
18. If the patient is non-compliant or un-cooperative with the provider or office staff we reserve the right to discharge you at any time.

I fully understand the explanations regarding the benefits and the risks of this method of treatment. This has been fully explained to me, I have read it or have had it read to me, and I understand it. I have had the opportunity to ask questions, and have received acceptable answers. I agree to the terms of this contract.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Forest Family Care, INC.**

1785 W. Lee Hwy (276) 228-6499 Phone

Wytheville, VA 24382 (276) 228-3311 or (276) 228- 6145

I hereby declare that the information provided is true and accurate. I also understand that any willful dishonesty may render for refusal of this application or dismissal from the practice. 30 days from being accepted to our office or upon your initial face to face, if any of the above information is false or inaccurate this will result in dismissal from the practice.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_