FOREST FAMILY CARE, INC.

CHILD 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 Race: ____ White ___Hispanic ____Black ___Other

Language: ____ English ____Hispanic ____ Other

Child lives with: ___Mother & Father ___Mother only ___Father only ___Other

Mother's Name: _____
(or responsible party) Last First Middle

Home Address: _____City:_____State:_____Zip:_____

Phone: Home ( ) _____ Work: ( ) _____ Cell ( )_____

Social Security # __ __ __- __ __- __ __ __ __ Birth Date: _____/_____/ _____ Employer:_____

Father's Name: _____
(or responsible party) Last First Middle

Home Address: _____City:_____State:_____Zip:_____

Phone: Home ( ) _____ Work: ( ) _____ Cell ( )_____

Social Security # __ __ __- __ __- __ __ __ __ Birth Date: _____/_____/ _____ Employer: _____

Primary Insurance Co._____ Insurance ID # _____
Group # _____ Policy Holder SS # __ __ __- __ __ -__ __ __ __
Secondary Insurance Co. _____ Insurance ID # _____
Group # _____ Policy Holder SS # __ __ __- __ __ -__ __ __ __
Preferred Pharmacy: _____Phone: ( )_____-_____

In the event of my absence, I hereby grant permission to the following person(s) to seek medical attention for my child. This permission is extended for a period of one year from the date signed.

Name: _____Relationship to Child: _____

Home Phone: ( )_____ Cell Phone: ( )_____ Date Signed: _____

I Understand the FINANCIAL POLICY OF THIS OFFICE IS AS FOLLOWS: Payment to be made prior to service. Co-pay's, 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 my 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.

Signature:_____ Date: _____

FOREST FAMILY CARE, INC.

1785 W. Lee Hwy
Wytheville, VA 24382

(276) 228-6499—Phone
(276) 228-3311—Fax

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Forest Family Care appreciates 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 receive statement

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 the full balance of the office visit, whichever is less) on the office visit, and then pay **$50.00** 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: _____

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

PATIENTS NAME:_____ DOB: _____

ADDRESS: _____ CITY: _____ ZIP: _____

SOCIAL SECURITY NUMBER: _____

I herby 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 To: **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 redisclose by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1998. The facility, its employees, officers 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 taken 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.

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CHILD 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: _____

1. **BIRTH HISTORY**
   - **Length of pregnancy?** _____ **Type of Delivery:** __ **Vaginal**
   - Was patient premature? __ YES __ NO __ C-Section __ Induced
   - What was the patient's birth weight? _____

2. **CURRENT MEDICATIONS / VITAMINS OR SUPPLEMENTS**

Drug Name:	Dose:	How Often:

3. **Check any of the following MEDICAL problems that you have had.**

	YES	NO
Stimming (repetitive actions/movements)		
Rocking		
Head banging		
Self- Mutilation		
Nail Biting		
Hand/arm biting		
Nail/skin picking		
Aggressiveness (hitting, kicking, biting others)		
Mood Swings		
Irritability/tantrums		
Fears/anxieties		
Hyperactivity		
Inability to concentrate/focus		
Impulsive		
Breath holding		
Seizures		

	YES	NO
Processing problems – visual, motor, language, etc.		
Problems with social interactions		
Sensitive to Crowds		
Low self-esteem		
Fatigue		
Recurrent/chronic fever		
Flushing		
Difficulty falling asleep		
Night walking		
Nightmares		
Bed wetting/soiling		
Daytime wetting/soiling		
Numbness/tingling in hands/feet		
Headache		
Tics		
Earaches		

	YES	NO
Sensitive to sounds/noise		
Bad breath		
Nose bleeds		
Sore throats		
Wheezing		
Canker Sores		
Dry lips/mouth		
Diarrhea		
Constipation		
Stomach ache		
Refusal to eat		
Difficulty swallowing		
Food craving		
Grinding teeth		
Mucous/blood in stools		
Anal itching		

	YES	NO
Calf cramps		
Other muscle cramps/spasms		
Tremors		
Weakness		
Stiffness		
Eczema		
Psoriasis		
Hives		
Acne		
Seborrhea (cradle cap)		
Other rashes		
Easy bruising		
Itchy scalp		
Dry skin		
Oily skin		
Sensitivity to texture of clothes		

	YES	NO
Cracking/peeling hands		
Cracking/peeling feet		
Strong body odor		
Strong urine odor		
Soft nails		
Thickening of nails		
Ridges/pitting of nails		
White spots/lines on nails		
Brittle nails		
Any OCD (obsessive compulsive behaviors)		
Masturbation		
Thrush		
Staring episodes		
Reflux		
Persistent colic		
Toe walking		

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

Name of drug/food:	Reaction:	Date of Occurrence:

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

	Type of Surgery	Year
	Appendectomy	
	Hernia	
	Tonsillectomy	
	Adenoidectomy	
	Wisdom Teeth Removal	
	Circumcision	
	Tubes in ears	
	Broken bones	
	Stitches	

	Type of Surgery	Year
	List other surgeries in space provided below:	

6. Please list any HOSPITALIZATIONS you have had in the past.

	Type of Surgery	Year

	Type of Surgery	Year

7. Have any of your FAMILY members had any of the following?

Family Member	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Father							
Mother							
Paternal Grandfather							
Paternal Grandmother							
Maternal Grandfather							
Maternal Grandmother							
Sibling(s)							

8. SOCIAL HISTORY

- **Who lives in the home with your child:**

- **Recent changes, losses, births, deaths, divorce, remarriage, or moves:**

- **Is your child exposed to cigarette smoke?**

- **Is your child involved in any sports, music or other activities? Please describe:**

- **Does your child attend public school?** **If so, what grade?**

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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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Acknowledgment 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 been 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 consent. I understand that Forest Family Care reserve the right to change its Notice of Privacy Practices and 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

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: _____

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Pediatric Controlled Medication Agreement

Patient Name: _____

Patient DOB: _____

Preferred Pharmacy: _____

This agreement between you and your child's provider at Forest Family Care, Inc. is made in order for you to understand your personal responsibilities while your child is taking a controlled medication.

Please read the agreement fully and ask any questions that you have prior to signing.

1. My child will need to have scheduled visits to this office to safely monitor his or her medication (s). The number of visits required will depend upon my child's progress.
2. I will be required to give a 48-hour notice for medication refills. I will also be required to pick up my child's script during the normal office hours and will show my ID card and sign for the prescription. I will not request medication for my child from after-hours "on-call" physician. FFC should be the one and only source of controlled medication for my child and if not; could be grounds for dismissal.
3. I understand that I am responsible to notify Forest Family Care of any changes to my address and phone number.
4. If my child is experiencing any side effect (s) from his or her medication (s), I will call the office immediately.
5. If I request a dosage change for my child, I will call the office to schedule an appointment. A review of my child's growth, blood pressure, blood work may be necessary.
6. I understand that I am responsible for my child taking medication (s) as prescribed and I am not allowed to request new prescriptions before they are due.
7. I understand that I am responsible for safeguarding my child's supply of medication (against theft, loss, unauthorized use by others, etc.) and will not receive early refills of the prescriptions. If theft occurs, information from the police report is required. Routine drug screen can be done at provider's discretion or if there is irregularity with a controlled medication, the provider can also request a urine drug screen and/or pill count done randomly. If the urine drug screen is negative, Child Protective Services may be notified for further investigation.
8. I will keep my child's appointments as scheduled. I will be respectful to all staff persons. I will contact Forest Family Care as soon as possible in the event I need to cancel or reschedule an appointment. If I fail to show up at the time of a scheduled appointment, it will be recorded in my child's chart as a "no show".
9. I agree to comply with the foregoing guidelines as a condition to the provision of services to my child by the practice. I understand that any violation of the above guidelines or requirements may result in my child's controlled medication prescription not being refilled and my child's discharge from the practice.

I, _____ agree to the above guidelines.
(Guardian's Printed Name)

Patient Name: _____

Signature of Guardian: _____ Relationship to Patient: _____

Date: _____