ALL FAMILY WALK-IN CLINIC

Patient Registration

Patient Information

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

Other Name(s) Used	E-mail Address

Gender ☐ M ☐ F ☐ Nonbinary	SSN	Preferred Language	Driver's License

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Life Partner

Preferred Contact
- ☐ Mail
- ☐ Home Phone
- ☐ Day Phone
- ☐ Cell Phone
- ☐ Patient Portal (MyChart)

Ethnicity
- ☐ Cambodian
- ☐ Filipino
- ☐ Hispanic/Latino
- ☐ Non-Hispanic

Race
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other

Primary Care Provider	Referring Provider?

Responsible Party (Guarantor) ☐ Same as patient

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for other parent)

First Name	Last Name	MI	Date of Birth

Address	City	State	Zip

Please check Primary Phone	Home Phone ☐	Work Phone ☐	Cell Phone ☐

How did you hear about us?

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of the All Family Walk-in Clinic or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I fully understand this agreement and consent will continue until canceled by me in writing.

Signature of Patient/Responsible Party _____ Date _____

Name of Patient/Responsible Party (Please Print) _____ Relationship to Patient _____

Patient Registration

Pharmacy Information	
Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ HC Proxy

Date Reviewed:

Medications – List all medications you take, prescription and non-prescription, and the dosage

☐ I do not take any medications

Medication Name	Dosage

Medication and Food Allergies – List all known allergies (drugs, food, animals, etc.)

☐ No Known Allergies

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
☐ None		☐ Gallbladder Disease	
☐ Allergies		☐ GERD (Reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia	
☐ Anxiety		☐ Hypertension	
☐ Arthritis		☐ Irritable Bowel Disease	
☐ Asthma		☐ Liver Disease	
☐ Atrial Fibrillation		☐ Migraine Headaches	
☐ Benign Prostatic Hypertrophy		☐ Myocardial Infarction	
☐ Blood Clots		☐ Osteoarthritis	
☐ Cancer – Type		☐ Osteoporosis	
☐ Cerebrovascular Accident		☐ Peptic Ulcer Disease	
☐ Coronary Artery Disease		☐ Renal Disease	
☐ COPD (Emphysema)		☐ Seizure Disorder	
☐ Crohn's Disease		☐ Thyroid Disease	
☐ Depression		☐ Other	
☐ Diabetes		☐ Other	

Surgical History – Check if you have received the following procedures, and year performed.			
Surgical Procedure	Year	Surgical Procedures	Year
☐ None		Male Only	
☐ Angioplasty		☐ Prostate Biopsy	
☐ Angioplasty w/Stent		☐ TURP (Trans-urethral resection of Prostate)	
☐ Appendectomy			
☐ Arthroscopy Knee		☐ Vasectomy	
☐ Back Surgery		☐ Other	
☐ CABG (heart bypass)		☐ Other	
☐ Carpal Tunnel Release			
☐ Cataract Extraction		Female Only	
☐ Cholecystectomy		☐ Augmentation Mammoplasty	
☐ Colectomy		☐ Bilateral Tubal Ligation	
☐ Colostomy		☐ Breast Biopsy	
☐ Gastric Bypass		☐ Cesarean Section	
☐ Hernia Repair		☐ D and C	
☐ Hip Replacement		☐ Hysterectomy	
☐ Knee Replacement		☐ Mastectomy	
☐ LASIK		☐ Myomectomy	
☐ Liver Biopsy		☐ Reduction Mammoplasty	
☐ Pacemaker		☐ TAH/BSO	
☐ Small Bowel Resection		☐ Vaginal Hysterectomy	
☐ Thyroidectomy		☐ Other	
☐ Tonsillectomy		☐ Other	

Health Maintenance – Check if you have received the following, and date of most recent exam.			
Exam	Date	Exam	Date
☐ None		☐ GYN Exam	
☐ Breast Exam		☐ Influenza Vaccine	
☐ Cardiac Stress Test		☐ Lipid Panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ PAP Test	
☐ Echocardiogram		☐ Physical Exam	
☐ EKG		☐ Pneumococcal Vaccine	
☐ Eye Exam		☐ Pulmonary Function Test	
☐ FOBT (stool card for hidden blood)		☐ Sigmoidoscopy	
☐ Foot Exam		☐ Tetanus Vaccine	

Family History – Check if any family member(s) has had any of the following conditions.

☐ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Blood Disease	☐	☐	☐	☐	☐	☐	☐
CAD (Heart Attack)	☐	☐	☐	☐	☐	☐	☐
Cancer – Type:	☐	☐	☐	☐	☐	☐	☐
CVA (Stroke)	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Developmental Delay	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐

Family History – continued							
Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
Eczema	☐	☐	☐	☐	☐	☐	☐
Hearing Deficiency	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia (High Cholesterol)	☐	☐	☐	☐	☐	☐	☐
Hypertension (High Blood Pressure)	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Disease	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
PVD	☐	☐	☐	☐	☐	☐	☐
Renal Disease	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

Social History for Adult Patient			
Occupation		Employer	
Do you have children? ☐ Yes ☐ No	How many?	Female(s)	Male(s)
Tobacco Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless Brand:	
Alcohol Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Beer ☐ Wine ☐ Liquor ☐ Other:	
Exercise Activity	☐ Moderate ☐ Vigorous ☐ Sedentary Days/Week:	Sleep Pattern: ☐ Changes ☐ No Changes	
Caffeine Use ☐ No	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year quit:	☐ Chocolate ☐ Coffee ☐ Soda ☐ Tea ☐ Tablets ☐ Other:	

For Pediatric Patient					
Patient Reside with:	Primary	☐ Mother	☐ Father	☐ Both Parents	☐ Other:
	Secondary	☐ Mother	☐ Father	☐ Other:	
Mother's Occupation			Father's Occupation		
Parents Relationship ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed			Childcare ☐ Mother ☐ Grandparent ☐ Father ☐ Nanny ☐ Sibling ☐ Daycare		
Tobacco Exposure: ☐ Yes ☐ No Smokers at home: ☐ Yes ☐ No			Patient is current smoker? ☐ Yes ☐ No		

ALL FAMILY WALK-IN CLINIC

Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine's/voice mail.**

Please check all boxes that give All Family Walk-In Clinic permission to use for your communications:

❑ You may contact me by telephone Phone Number: _____ ❑ You may leave a message/voice mail Phone Number: _____
❑ You may contact me by mail
❑ You may contact me through email (myChart)

Please list any persons you would like to have access to your billing, appointment or health information, such as your spouse, caretaker or other family member. We will ask for additional consent prior to releasing information related to psychiatric services and/or HIV test results.

Name/Phone Number	Relationship	Options
1.		❑ Billing Information ❑ Appointment Information ❑ Medical/Health Information
2.		❑ Billing Information ❑ Appointment Information ❑ Medical/Health Information
3.		❑ Billing Information ❑ Appointment Information ❑ Medical/Health Information
4.		❑ Billing Information ❑ Appointment Information ❑ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Print) Relationship to Patient

Insurance:

_____

Patient Questionnaire:

Name:_____ Date of Birth:_____

Describe the Reason for Your Visit Today:

_____

_____

Symptom(s): _____

_____

When Symptoms Started: _____

_____

_____

Provider/ MA Evaluation:

Vital Signs:

Height:		
Weight:		
Temperature:	Route:	Location:
Blood Pressure:	Location:	
Pulse:	Regular ☐	Irregular ☐
Respirations:	Unlabored ☐	Labored ☐
Sp02:		
Oxygen: L/min	Route:	

Provider notes:

Patient Consent Form

I hereby authorize Kelly Gordon APRN, Hillary Ramondo APRN, or any other nurse practitioner associate, (hereinafter "Provider) to furnish medical evaluations and other miscellaneous medical procedures / treatments as indicated by my physician.

I authorize Provider to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys.

I authorize Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Financial Responsibility / Assignment of Benefits

I understand that I am **responsible** for paying my co-payments, co-insurance and deductibles at the time of service. I also understand that I am **responsible** for any balance due after payment by my insurance company.

I, the undersigned, understand that Provider will bill my insurance carrier for services rendered upon verification of coverage by my insurance company. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, for any reason other than a contractual adjustment, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payment within 60 days, I understand that I will be responsible for the balance due in full.. I also agree that should my insurance company send a check to me, I agree to immediately turn those funds over to the Provider within 30 days of receipt of any payment, and that if I do not, I agree to be billed for and pay for the full amount of the bill.

I hereby request that my insurance carrier make payment directly to All Family Walk-In Clinic , for all services rendered by this facility. If my current policy prohibits direct payment to Provider, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to Provider. I also authorize Provider, to deposit check received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Workers Compensation injury shall be forwarded to the Workers Compensation Insurance carrier and I will not be held personally responsible for these charges. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

Benefits that we have received from your insurance carrier at the time of service are not a guarantee of benefits. The patient, legal guardian, or parent (if the patient is under 18 years old) will be responsible for the co-payment and the deductible at the time of service.

_____ _____

Patient/Guardian **Date**

_____ _____

Witness **Date**

ALL FAMILY WALK-IN CLINIC

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.