1600 Coleman Drive Humboldt, TN 38343 Phone (731) 470-4020 Fax: (731) 562-0349

Patient Information

Date:_____ Language:_____

Name: Last_____ First _____ MI _____

Address: Street_____

City_____ State_____ Zip_____

Phone #: Home_____ Work_____ Cell_____

Email Address:_____ Living Will: Yes_____ No_____

SS#:_____ Age:_____ Birthday:_____

Gender:_____ Race:_____ Marital Status: Single, Married, Divorced, Single, Widowed

Name of Employer: _____

Emergency Contact:_____ Relationship_____

Phone #: Cell_____ Home: _____ Work_____

Responsible Party (IF OTHER THAN PATIENT)

Name: Last _____ First _____ MI _____

Address: _____

SS#_____ Relationship to Patient _____

Phone # Home_____ Cell _____ Work _____

Employer: _____

Patients preferences

Preferred method of contact: Email, Home phone, Cell phone, Work, Do not contact me I will call the clinic

Preferred pharmacy: _____

HUMBOLDT FAMILY WALK-IN CLINIC

www.HFWIC.com 731-470-4020
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NAME _____DATE _____

PLEASE CIRCLE YES FOR EACH PROBLEM THAT APPLIES TO YOU:

Yes Allergies
Yes Anemia
Yes Anxiety
Yes Blood Transfusion
Yes Cancer- if yes please state type
_____

Yes Cataracts
Yes Coronary Artery Disease
Yes Heart Failure
Yes Clotting Disorder
Yes COPD
Yes Cholesterol Problems
Yes High Blood Pressure

Yes Depression
Yes Diabetes Mellitus
Yes Emphysema
Yes GERD
Yes Glaucoma
Yes Heart Attack

Yes Heart Murmur
Yes HIV/AIDS
Yes Kidney Disease
Yes Meningitis
Yes Nerve/Muscle Disease
Yes Osteoporosis
Yes Sickle Cell Anemia

Yes Stroke
Yes Substance Abuse
Yes Stomach Ulcers
Yes Thyroid Disease
Yes Tuberculosis
Yes Heavy snoring

Yes Sleep Apnea

Females only

Age of last period

Number of pregnancies

Age a Menopause

Number of Children

History Abnormal Pap Smear

PLEASE MARK THE BOX FOR EACH SURGERY THAT APPLIES TO YOU:

- ○ Appendix Removal
- ○ Brain Surgery
- ○ Cardiac Bypass Surgery
- ○ Cardiac Stent Placement
- ○ Colon Surgery
- ○ Ear Surgery-ear Tubes
- ○ Eye Surgery
- ○ Other

- ○ Fracture
- ○ Gall Bladder
- ○ Gastric Bypass Surgery
- ○ Hernia
- ○ Hysterectomy Total/ partial
- ○ Joint Replacement
- ○ Eye Surgery

- ○ Prostate Surgery
- ○ Small Intestine Surgery
- ○ Tonsillectomy/Adenoidectomy
- ○ Thyroidectomy
- ○ Valve Replacement
- ○ Vascular Replacement
- ○ Vasectomy

Yes No Alcohol Use Indicate how much _____ circle: cans liquor wine
Yes No Drug Abuse Comment use: _____
Yes No Tobacco use Pack per day: _____ Years of smoker: _____
(Smokeless) Can per day: _____ Years of chew: _____
Yes No Caffeine Intake amount: _____

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PLEASE CIRCLE THAT APPLIES TO FAMILY HISTORY

	MOTHER	FATHER	SISTER	BROTHER	DAUGHTER	SON
Arthritis:	____	____	____	____	____	____
Asthma:	____	____	____	____	____	____
Dementia:	____	____	____	____	____	____
Depression:	____	____	____	____	____	____
Diabetes- Type I/ Type II:	____	____	____	____	____	____
Heart Disease:	____	____	____	____	____	____
High Blood Pressure	____	____	____	____	____	____
High Cholesterol:	____	____	____	____	____	____
Kidney Disease:	____	____	____	____	____	____
Obesity:	____	____	____	____	____	____
Osteoporosis:	____	____	____	____	____	____
Stroke:	____	____	____	____	____	____
Substance Abuse:	____	____	____	____	____	____
Breast Cancer:	____	____	____	____	____	____
Colon Cancer:	____	____	____	____	____	____
Lung Cancer:	____	____	____	____	____	____
Skin Cancer:	____	____	____	____	____	____
Stomach Cancer:	____	____	____	____	____	____
Thyroid Cancer:	____	____	____	____	____	____
Ovarian Cancer:	____	____	____	____	____	____
Uterine Cancer:	____	____	____	____	____	____

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Reason for Visit:_____

_____

Current Medications: _____

_____

_____

Allergies: _____

Medical Problems: _____

_____

Injuries and Dates: _____

Hospitalization Dates: _____

Treatments and Dates: _____

Date of last Annual Physical: _____

Mammogram_____ **Dexa Scan** _____

Pap_____ **EKG** _____

PSA_____ **Cardiac Testing** _____

Colonoscopy_____ **Sigmoidoscopy** _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

[Name]
[Street address]
[City, ST ZIP Code]

This request and authorization applies to:

◉ Healthcare information relating to the following treatment, condition, or dates

[List here]

○ All healthcare information ○ Other

[List here]

[Additional information]

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: _____

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PATIENT CONSENT FOR CLINIC TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, AND HEALTHCARE OPERATIONS

PATIENTS NAME: _____ DOB: _____

PATIENTS SSN: _____

I understand that my health information is private and confidential. I understand that **Humboldt Family Walk-In Clinic** works very hard to protect my privacy and preserve the confidentiality of my health information.

I understand that signing this document means that **HFWIC** may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in **HFWIC** declining to treat me.

HFWIC has a detailed document called the "Notice of Privacy Practices ". It contains more information about the policies and practices under which the clinic protects their patient's privacy. I understand that I have the right to read the "notice" before signing this agreement.

HFWIC may update this "Notice of Privacy Practices ", and if asked, **HFWIC** will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask **HFWIC** to restrict how many Personal Health Information is used or disclosed to carry out treatment, payment, or healthcare options. I understand that **HFWIC** does not have to agree with my request. If **HFWIC** does not agree to my request, I understand that HFWIC would follow the agreed limits.

I understand that I have the right to cancel this consent in writing at any time. If I do cancel the consent, I understand that **HFWIC** may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

1. Sign and date a form that **HFWIC** can give me called a "Revocation of Consent for Use and Disclosure of Health Care Information".
2. Write, sign and date a letter to **HFWIC**. If I write a letter to **HFWIC**, it must state that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment and health care operations.

I understand if I cancel this consent, **HFWIC** doesn't have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of **HFWIC's** "Notice of Privacy Practices".

_____ _____

Patients or legally authorized individual's signature **Date**

_____

Relationship to patient if signed by legally authorized person

I,_____, give HFWIC permission to release my Personal Health Information to _____ (spouse or other authorized person)

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Controlled Substance Agreement

The providers at Humboldt Family Walk-In Clinic understand the need for pain control for patients suffering from chronic pain. Ultimately, it is our goal to decrease pain and discomfort for each of our patients in a safe, effective manner. Below, is a contract intended to promote a mutual understanding between the provider and the patient regarding controlled medications for pain and other scheduled medications such as Adderall, Xanax, etc. Patients with prolonged (chronic) symptoms will have an individualized plan to improve symptoms which may include Physical Therapy, Psychological Assessment, Counseling, or a reduction and eventual cessation of narcotic use. The pain management plans are based upon clinical findings, the patient's pain level and ultimately, the discretion of the providers. Generally, the providers at Humboldt Family Walk-In Clinic prescribe controlled substances on a short-term basis for acute problems and will not prescribe these medications for long term use.

*A narcotic is a controlled substance intended to decrease pain and may affect mood, behavior, or has the potential for dependence or tolerance.

* The providers of Humboldt Family Walk-In Clinic define narcotic abuse as the following:

1. Repeatedly requesting early refills on narcotic medication
2. Receiving multiple narcotic prescriptions from different providers
3. Altering written prescriptions
4. Selling narcotics
5. Sharing pain medications with others (including family members)
6. Using narcotics other than as prescribed.

*Please read this contract carefully and sign in the labeled areas. If you have any questions regarding this contract, please contact our office.

- Humboldt Family Walk-In Clinic (HFWIC) cannot replace medications which are lost or stolen unless a police report of theft has been filed and sent to us. In the case of theft, a legal investigation will take place. If medications are lost or stolen a second time in any twelvemonth period, they cannot be replaced, no matter the circumstance. Medications or prescriptions lost in the mail cannot be replaced.
    - It is the policy of HFWIC to occasionally perform random urine drug screens. There may, or may not be a cost to the patient for this test, however HFWIC will be unable to prescribe medications if a patient refuses such testing. HFWIC will be unable to prescribe medications to any patient who tests positive for any illegal substance, tests positive for narcotics not prescribed to the patient, or any evidence of narcotic prescription diversion.
- It is the responsibility of each patient to keep all appointments. If a patient does not keep his or her appointments, HFWIC will not refill any medications unless the patient returns to the clinic for an appointment. Ultimately, it is at the discretion of the provider to continue to prescribe any medication after repeated appointment cancellations, no-shows or provider conflicts within or outside the office.
- The pain regimen of the patient will only be changed at the providers' discretion. The patient should only receive pain medication refills from the original prescribing provider. In any event, if the original provider is unavailable to renew the prescription, another provider from HFWIC may renew or deny the prescription. The initial provider's plan for pain management will be followed in most instances at the providers' discretion. Medication type, strength, quantity and frequency of use may differ from the

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patient's preference if deemed appropriate by the provider. If the patient feels he/she is not receiving adequate pain control, the patient may be referred to a certified pain clinic for evaluation and treatment. *Once referred to a pain management facility, all further pain medications will be managed by the Pain Management Specialist to whom they are referred.*

I understand if I violate one or more of the terms listed above, the agreement will be null and void. The medication regimen will be stopped and I may be dismissed as a patient from Humboldt Family Walk-In Clinic. _____
Patient Initials

The pharmacy that I will use to fill my prescriptions is:

Pharmacy: _____Phone: _____

By signing this contract, I signify my understanding and agree to adhere to its terms.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Provider Signature: _____ Date: _____