Family
HealthCare Clinic

Family HealthCare Clinic New Patient Paperwork

Date: _____

Patient Name: _____

Last First MI

DOB: _____ SSN: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ ☐ Cell ☐ Home ☐ Other

Marital Status: _____ Race/Ethnicity: _____

Annual Household Income: _____ How many people does that income support? _____

Preferred Pharmacy: _____ Insurance: ☐ SoonerCare ☐ Self-pay*

* ***Please note that we*** **DO NOT** ***accept private insurance. You will be charged as a self-pay patient.***

Please answer the following questions:

1. List your current medications, dosage and how often you take them (including prescriptions, over-the-counter and vitamins/supplements).

   _____

   _____

   _____

2. Allergies: _____
3. Are you currently under the care of a medical provider for any reason? ☐ Yes ☐ No

   If yes, please explain _____

   _____

   _____
4. Were you hospitalized in the last five years for longer than 2 days? ☐ Yes ☐ No

   If yes, please explain _____

   _____
5. List ALL medical surgeries and procedures, including month and year.

   _____

   _____

   _____

6. Past/Current Medical History. *Indicate whether you currently or previously had any of these conditions.*

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood disease ☐ Bleeding ☐ Cancer

☐ Pacemaker ☐ Convulsions ☐ Diabetes ☐ Epilepsy ☐ Glaucoma ☐ Heart murmur

☐ Heart disease ☐ Hepatitis ☐ Hypertension ☐ Jaundice ☐ Stroke ☐ Rheumatic fever

☐ Kidney condition ☐ Depression ☐ Anxiety ☐ Tuberculosis ☐ Ulcer ☐ Stroke

☐ Other: _____

7. Family Medical History. *Please mark who in your family has the following conditions.*

	Mother	Father	Sister	Brother	Maternal GM/GF	Paternal GM/GF
Diabetes						
Stroke						
Hypertension						
Cancer (include type below)						
Coronary Artery Disease						

8. Tobacco use
   a. Current tobacco use? ☐ No ☐ Yes How much per day? _____
      When did you start using? _____ Would you like to quit? ☐ No ☐ Yes
   b. Previous tobacco use? ☐ No ☐ Yes How much/how long? _____ When did you quit? _____
9. Do you use recreational or illicit drugs (including marijuana)? ☐ Yes ☐No

   If yes, please explain _____
10. Alcohol use
    a. Do you drink alcohol? ☐ Yes ☐ No How many drinks per occasion? _____ How often? _____
    b. Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No
11. Please list any additional health information you would like us to know.

    _____

    _____
12. Who do you live with? _____
13. How did you hear about Family HealthCare Clinic?

    ☐ Current patient ☐ Friend/Family member ☐ Facebook ☐ Internet search ☐ Other: _____

_____ _____

Patient Signature Signature of Responsible Party

Family
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Emergency Contact and Authorization for the Release of Personal Health Information

Patient Name: _____ DOB: _____

EMERGENCY CONTACT. Who would you like us to contact in the event of an emergency?

1. Name: _____ Relation to Patient: _____
   Address: _____ City/Sate/Zip: _____
   Phone: _____
2. Name: _____ Relation to Patient: _____
   Address: _____ City/Sate/Zip: _____
   Phone: _____

RELEASE OF INFORMATION. I authorize the release of my personal information including records, diagnoses, treatments, results, and appointment information to the representatives listed below.

Name: _____ Relation to Patient: _____
Phone: _____

Name: _____ Relation to Patient: _____
Phone: _____

☐ *Check this box if you do not wish your information to be released to anyone other than patient or patient's legal guardian/caregiver.*

I understand this authorization to release information will remain in effect until terminated by me in writing.

_____ _____
Patient/Legal Guardian Signature Date

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PATIENT GENERAL CONSENT FORM

I, _____ (**printed** name of patient) consent to medical examination, laboratory screenings, procedures, and/or treatment by a person authorized by Family HealthCare Clinic.

I understand that I will be responsible for expenses incurred if additional follow up is necessary through a private provider, laboratory, pharmacy, or specialist.

All my questions about this consent and about the policies and procedures at this clinic have been answered to my satisfaction.

I acknowledge I have been offered a copy of the Family HealthCare Clinic Privacy Notice as required by the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____

Patient Signature Date

_____ _____

Printed name of Parent/Guardian/Translator Date

_____ _____

Parent/Guardian/Translator Signature Relationship to patient

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PATIENT ACKNOWLEDGMENTS AND RESPONSIBILITIES

To ensure that the clinic can continue to provide quality care to as many patients as possible, any patient receiving care at Family HealthCare Clinic (FHC) is expected to adhere to the following policies and procedures. Failure to do so may result in permanent dismissal from the practice. Please initial next to each item to indicate your acknowledgement.

SCHEDULED DRUGS

_____ I understand FHC is in accordance with current scheduled drug laws and does NOT prescribe any controlled substances (including narcotics).

NO SHOW/LATE POLICY

_____ It is my responsibility to notify the clinic within TWO (2) hours prior to my scheduled appointment if I am no longer able to attend. I understand that failure to notify FHC staff within that timeframe result in a "NO-SHOW."

_____ Arriving more than 15 minutes late to my appointment will be considered a NO-SHOW, and I will be required to reschedule for another day if I am unwilling to wait until the provider is available to see me as a 'walk-in.'

_____ After FIVE (5) accumulated NO-SHOWs within 12 months of today's date, I will be dismissed from the practice.

MEDICATION REFILLS

_____ I understand that it is my responsibility as a patient or legal guardian to monitor when medication refills are due to be requested, and will submit a refill request **directly to my pharmacy** when I have 10 days or less left of the medication.

_____ It is my responsibility to keep any scheduled "medicine check" or "lab check" appointments as directed by the provider. Failure to do so may result in a delay in refilling my medication.

_____ I acknowledge that FHC requires up to **72 business hours** to process a medication refill. **FHC business hours are M-Th 8:00a-4:00pm**. Requests received on Wednesday or Thursday may not be completed until the following work week.

VOICEMAILS

_____ Any voicemail left for staff at FHC will be returned before the end of the **next business day**. Leaving multiple voicemails does not speed up the callback process. If you are having a medical emergency, please call 911.

MUTUAL RESPECT

_____ Just as I expect to be treated with dignity and respect as a patient, I understand that FHC staff expects the same courtesy returned. The clinic does not tolerate any aggressive, argumentative, manipulative, or abusive behavior from any patient or anybody accompanying a patient. Anyone displaying such behavior will be asked to leave the facility. FHC reserves the right to permanently dismiss any patient from the practice in response to display of disrespectful, aggressive, or abusive behavior.

_____	_____
Patient Name	Relationship to patient
_____	_____
Patient/legal guardian signature	Date

Family
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Provider/Medical Facility Records Request List

For the best continuity of care, please list any providers, specialists, or medical facilities that you would like us to retrieve medical records from. If possible, include the facility name, address, and phone number.

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____

4. _____
_____
_____

5. _____
_____
_____

6. _____
_____
_____

FAMILY HEALTHCARE CLINIC, INC.
1820 W. HENSLEY BLVD.
BARTLESVILLE, OK 74003

PHONE: 918-336-4822 | FAX 918-336-5017

PATIENT AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

Patient: _____
(First Name) (Middle Initial/Name) (Last Name)

Address: _____

Date of Birth: _____

Family Healthcare Clinic, Inc. is authorized to furnish to / receive from **(circle desired choice):**

Recipient/Discloser: _____

For the Purpose of: _____
(optional) _____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

☐ **I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS** including information and records relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

☐ **I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:**

_____

_____

I release Family Healthcare Clinic, Inc. and the Recipient/Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Family Healthcare Clinic, Inc., provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on ___/___/____ *(Optional). If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.*

_____ _____
Patient Signature (Parent's Representative if Minor) Date

_____ _____
Witness Signature Date

Revised 6/26/23

Family HealthCare Clinic - Privacy Notice

It is the responsibility of Family HealthCare Clinic to keep all patients' personal health information (PHI) confidential. This notice describes how health information about you (as a patient of this practice) may be used and disclosed.

We may use and disclose your PHI in the following ways:

Treatment. Our practice will use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI to treat you or to assist others in your treatment. Finally, if you have authorized it, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.

Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

Disclosures required by public health authorities. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury, or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees, or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

Lawsuits and similar proceedings. Our practice may disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We will disclose your PHI as required by law in response to a discovery request, subpoena or other lawful process by another party involved in the dispute.

Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Family HealthCare Clinic
1820 W. Hensley Blvd.
Bartlesville, OK 74003
918-336-4822

_____	_____	_____
Patient Printed Name	Patient Signature	Date
_____	_____	
Parent/Legal Guardian Signature	Relationship to Patient	

☐ Check here if patient's relative or guardian is legally required to sign

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Patient Satisfaction Survey

FHC is committed to providing the best possible experience in both service and care to our patients. Please take a moment to give us your feedback about your visit today.

How satisfied are you with the following?	Extremely Satisfied	Moderately Satisfied	Not Satisfied
Overall quality of medical care	1	2	3
Building appearance	1	2	3
Education provided about your health	1	2	3
Staff listened to my medical needs	1	2	3
Staff cared about my medical needs	1	2	3

How caring would you say the following individuals are?	Extremely Caring	Moderately Caring	Not Caring at All
Medical provider	1	2	3
Nurse	1	2	3
Front Office Staff	1	2	3
Other Staff	1	2	3

Please tell us about you! (This info is anonymous and only used for statistical purposes).

1. **Are you:** ☐ Self Pay ☐ Medicaid/SoonerCare
2. **How did you get to today's appointment?**

   ☐ Drove own car ☐ Got a ride ☐ Walked ☐ Bike ☐ Sooner Ride/City Ride ☐ Other _____
3. **If you are a self-pay patient, check the option that best applies to today's visit:**

   ☐ I had the money and paying was not a problem
   ☐ I had to borrow money to pay for the visit (someone else paid)
4. **Have you ever applied for SoonerCare/Medicaid (state-supported insurance)?** ☐ Yes ☐ No

   (If you would like information about applying to SoonerCare, please let us know)
5. **Age:** _____ **Gender:** ☐ Male ☐ Female ☐ Transgender ☐ Prefer not to say
6. **Can you afford your prescriptions from today's visit?** ☐ Yes ☐ No
7. **How did you find out about the clinic?**

   ☐ Current patient ☐ friend/family member ☐ Facebook ☐ Internet search
   ☐ Other:_____

Comments or suggestions for improvement (use the back if more room is needed):

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