Thank you for choosing Affinity Family Health & Wellness located within Market Street Medical. To assure we have all the necessary information to assess your health care needs, and secure your appointment, we ask patients to complete the following items PRIOR to being scheduled for a new patient appointment with our office.

* All paperwork must be completed, signed and returned to our office.
* Signed authorization to release medical records from previous PCP/Specialists/Hospitals
* Photo ID/Driver’s license (required at every visit)
* Insurance card or current Illinois Medicaid card (required at each visit)
* Power of Attorney, Living Will, Guardianship documentation (if applicable)
* Complete the Patient Portal form (if you have an email address)
* List of specialists you currently see

The following items are required on the day of your appointment:

* Insurance card(s) and photo ID
* All current medications in their original bottles
  + Please note: No refills will be given for medications that are not presented at appointment
  + Please allow 48 business hours for all medication refills
* All co-pays are expected at the time of visit

We appreciate your business and respectfully ask:

* Cell phones be silenced while patients are being seen by our providers
* No smoking or firearms are allowed on the property
* Showing up late for a scheduled appointment may result in cancellation of that appointment. (Please see No show/Cancellation policy on page 3)
* Patients should be advised it is not the practice of our providers to prescribe long-term narcotics or benzodiazepines. The need for use of these types of medications will be determined on a case-by-case basis. If these medications are prescribed, you will be asked to sign a controlled substance agreement.

I have read and agreed to the above requirements for my new patient appointment.

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

Signature of patient or patient representative Date

**New Patient Information**  Today’s Date:Click here to enter a date.

Full Name: Click here to enter text. Date of Birth: Click here to enter text. SSN: Click here to enter text.

Race: Click here to enter text. Gender: M  F

Address/City/State: Click here to enter text. Home Number: Click here to enter text.

Email Address: Click here to enter text.

Employer Name: Click here to enter text.

Employer Address: Click here to enter text.

**Emergency Contact Information**

Emergency Contact Name: Click here to enter text.

Relationship: Click here to enter text. Phone Number: Click here to enter text.

**If you are registering a minor (17 years or younger) complete below**

Name of guardian: Click here to enter text.

Relationship to child: Click here to enter text. Phone Number: Click here to enter text.

Address (if different than above): Click here to enter text.

**Insurance information**

Primary Insurance: Click here to enter text.

Policy Holder Name: Click here to enter text. Policy Holder DOB: Click here to enter a date.

Policy Holder SSN: Click here to enter text.

Policy Number: Click here to enter text. Group Number: Click here to enter text.

Secondary Insurance: Click here to enter text.

Policy Holder Name: Click here to enter text. Policy Holder DOB: Click here to enter text.

Policy Holder SSN: Click here to enter text.

Policy Number: Click here to enter text. Group Number: Click here to enter text.

**I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical or surgical benefits to include all major medical benefits to which I am entitled to Affinity Family Health & Wellness, PLLC photocopy is considered valid. I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges.**

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

Signature Date

**FINANCIAL POLICY**

Thank you for choosing Affinity Family Health & Wellness, PLLC as your health care provider. In an effort to provide affordable, quality healthcare and avoid confusion/misunderstanding, we have adopted the following Financial Policy and require you to read and sign it prior to the commencement of any treatment.

**Insurance – all patients**

We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy to you, we will file claims for those plans with which we have an agreement. Please be advised that you are ultimately financially responsible for payment of medical services rendered by this clinic. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. Affinity Family Health & Wellness, PLLC does not bill any third-party insurers. If you received services that are payable by a third-party insurer, you will be charged the appropriate amount from our standard fee schedule, and are responsible for payment at the time of service.

**Non-insured patients**

If you have insurance coverage with a plan with which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. We offer a competitive cash fee schedule for our patients with no insurance.

**Deductibles/Co-pays**

Our insurance contracts require us to collect deductibles and co-pays at the time of service.

**Appointments**

We strive to provide the best possible service and availability to all of our patients. Our policy is to charge $25 for missed appointments unless cancelled at least 24 hours in advance. Please help us serve you better by keeping your scheduled appointments or by calling as early as possible to cancel.

**Paperwork Services**

Any paperwork filled out by our providers (ex: Short-term disability or FMLA) are subject to a $25 charge.

**Medical Record Copies**

Copies of medical records for personal use or for parties other than your insurance company or other physicians involved with your care are subject to a $25 charge.

**Returned Checks**

All checks returned from the bank for non-payment are subject to a $25 charge.

\*\*This financial policy supersedes all prior written financial policies, contracts, or verbal agreements.

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE TO AFFINITY FAMILY HEALTH & WELLNESS, PLLC FOR ANY SERVICES PROVIDED BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE.

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

Patient Signature Date:

117 East Market St Olney, IL 62450

Ph: 618-392-1301 Email: affinityfamilyhealth@gmail.com

Credit Card Authorization Form

In order to reduce charge backs, it is necessary to have a completed credit card authorization form as shown below. Also, it is critical to capture an AVS (Address Verification System) match when processing the transaction. Entering in the billing zip code of the cardholder captures AVS. Submitting the cardholder’s address and CVV code lowers risk further. When applicable, a proof of delivery is required.

**Credit Card Information:**

Card Type: Visa M/C AMEX DISC Other: Click here to enter text.

Card Holder (name as shown on card): Click here to enter text.

Card Number: Click here to enter text.

Exp. Date: Click here to enter a date. CVV Code (on back): Click here to enter text.

Card Holders Billing Address: Click here to enter text.

Street, City & Zip

By signing below, I authorize Affinity Family Health & Wellness, PLLC to encrypt my debit or credit card to be held on file for the account of Click here to enter text.. I am authorizing my card to be charged for any balance incurred on this account including missed appointment fees, monthly late fees, bank retrieval fees, insurance co-pays, co-insurance or any amount determined to be the patient’s responsibility. I understand that these amounts will be charged to my debit or credit card as the expenses are incurred. I understand my information will be encrypted and held on file for future transactions on this account. I understand if my card is declined, I will be charged a late fee of $10.00 per month from this day forward until my amount is paid in full.

Printed Name (Cardholder): Click here to enter text.

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

Cardholder Signature Date

**Consent to Treat**

**Patient information**

Client Name: Click here to enter text. Date of birth: Click here to enter a date.

Current address: Click here to enter text.

Phone: Click here to enter text. Guardian Name: Click here to enter text.

**Consent to treatment:**

I authorize and request that Affinity Family Health & Wellness, PLLC provide medical services determined to be clinically appropriate for myself, the patient. By signing below, I certify that I have read and understand the terms stated in the Treatment Consent Form and Release and Authorization Form. I fully understand the scope of services, fees, cancellation/no-show policies, payment policy, insurance reimbursement and I agree to abide by the terms stated throughout the course of our therapeutic relationship.

**Consent to Treatment of Minors:**

I authorize and request that Affinity Family Health & Wellness, PLLC provide medical services determined to be clinically appropriate for my child. I hereby represent that I have the legal authority to obtain medical treatment for the minor child for whom I am requesting treatment. I am a biological parent or the legal guardian. If group home or foster family settings, I am designated to authorize treatment. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent.

**Limits of Relationship and Liability**

I understand that communications between a client and the clinician are confidential and protected by law. I also understand that expectations include when a client is a danger to themselves or others, or when there is a reasonable suspicion of sexual or physical abuse, child or elder abuse, then, by the Illinois State Law, Affinity Family Health & Wellness, PLLC, is obligated to report the information to the Illinois Department of Child and Family Services. Other exceptions include when a court of law orders the information or when information is shared with your insurance company to process your claims.

**­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**

Relationship to patient (if patient not signing): Click here to enter text.

Reason patient did not sign: Patient is a Minor (Under 17) Other (specify)Click here to enter text.

**Acknowledgment of Privacy Practices and Permission to Leave Messages**

Patient Name: Click here to enter text. Date of Birth: Click here to enter a date.

**I acknowledge that I have received and/or reviewed a copy of Affinity Family Health & Wellness, PLLC Notice of Privacy Practices**

I give permission to communicate messages in the following manner:

You may leave a message at this number Click here to enter text.

You may leave a message at this email address Click here to enter text.

You may leave a message with my spouse, Click here to enter text.at this number Click here to enter text.

You may leave a message with another person, Click here to enter text.at this number Click here to enter text.

I give permission to communicate messages about the following:

Appointment date/time/provider

Labs, x-rays, and other test results

Prescriptions

Billing or insurance matters

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

Patient Signature Date

**NEW PATIENT HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire will become part of your medical record.

Name: Click here to enter text. DOB: Click here to enter a date.

Marital status: Single Partnered Married Separated Divorced Widowed

Previous/referring doctor: Click here to enter text. Date of last physical exam: Click here to enter text.

**Please check any medical problems you have had in the past:**

**past:**

Liver disease

Migraine headaches

Neuropathy

Osteoporosis/Osteopenia

Parkinson’s disease

Pulmonary embolism

Rheumatic fever

Seasonal allergies

Shingles

Sleep apnes

Stroke or TIA

Thyroid disease

Ulcers, Type:

Other, (specify): Click here to enter text.

Depression

Diabetes mellitus

Skin disorder; Type: Click here to enter text.

Fibromyalgia

GERD (heartburn)

GI bleed

Glaucoma

Heart attack

Heart disease or pacemaker

High cholesterol

High blood pressure

Inflammatory bowel disease

Irritable bowel syndrome

Insomnia

Kidney disease/stones

Anemia

Anxiety

Arthritis

Asthma

Atrial fibrillation

Autoimmune disease

Blood transfusion

Cancer, type: Click here to enter text.

Cataracts

Chronic lung disease/COPD

Chronic pain

Colon polyps

Congestive heart failure

DVT/Blood Clots

Dementia

**Please check any surgeries you have had:**

Pacemaker

Spine Surgery; Type: Click here to enter text.

Tubal Ligation

Vasectomy

Other (specify): Click here to enter text.

Gall bladder removal

Heart surgery, type: Click here to enter text.

Hernia repair, type: Click here to enter text.

Hysterectomy

Orthopedic surgery, type: Click here to enter text.

Appendectomy

Bariatric surgery

Breast surgery

Colonoscopy

Cosmetic surgery

C-section

Eye surgery; Type: Click here to enter text.

**Family Health History**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Age | Sex | Significant Health Problems |  | Age | Sex | Significant Health Problems |
| Father |  |  |  | Children |  | M  F |  |
| Mother |  |  |  |  |  | M  F |  |
| Siblings |  | M  F |  |  |  | M  F |  |
|  |  | M  F |  | Grandma  Maternal |  |  |  |
|  |  | M  F |  | Grandpa  Maternal |  |  |  |
|  |  | M  F |  | Grandma  Paternal |  |  |  |
|  |  | M  F |  | Grandpa  Paternal |  |  |  |

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:**

Name of Drug Dose/Type Frequency/Method Taken

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Aspirin Daily? Yes No | Medical Marijuana Yes No |  |
| Opioids Chronic? Yes No | Contraception Yes No |  |

**Allergies to Medications**:

Name of the Drug Reaction You Had Age when occurred

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Health Habits and Personal Safety**

|  |  |  |
| --- | --- | --- |
| Caffeine | None Coffee Tea Other | How much? \_\_\_\_\_\_\_\_\_\_\_\_ |
| Alcohol | Do you drink alcohol? | Yes No |
|  | What type |  |
|  | How many drinks per week? |  |
| Tobacco | Do you use tobacco or nicotine products? | Yes No |
|  | Cigarettes – #/day E-cig - #/day Chew - #/day |  |
|  | # of years used \_\_\_\_\_ | Yes No |
| Gynecological History | # of pregnancies:\_\_\_\_\_ # of live births: \_\_\_\_\_ Menopause Yes No |  |

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

Signature (patient or guardian) Date

**Authorization for the Release of Patient Information**

**FROM:**

Provider/ Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:**

**Complete medical record**

**Office notes, consult notes, operative reports, and hospital records**

**Labs**

**X-rays and other imaging reports**

**Pharmacy and prescription records**

**Billing records**

**Mental Health Records**

**Drug/Alcohol abuse treatment**

**Communicable Diseases (including HIV & AIDS)**

This protected health information is disclosed for the purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You are authorized to release the above records to:**

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

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand the following:**

**That I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization; that the information released in response to this authorization may be re-disclosed to other parties; and that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.**

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or two years from date of execution.

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

Relationship to patient (if patient not signing)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason patient did not sign: Patient is a Minor (Under 17) Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_