AFFINITY FAMILY HEALTH

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Cell or Alternate no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Email address:

Other family members seen here:

RESPONSIBLE PARTY/INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ BCBS ❑ Aetna ❑ Cigna ❑ United ❑ Medicare ❑ Medicaid ❑ Other

Subscriber's name:	Subscriber's SS no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Subscriber's SS no.:	Subscriber's DOB	Subscriber's Employer:	

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Affinity Family Health or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Patient Information

Name: _____ **Date of birth:** _____

Are we becoming your primary care provider? _____Yes _____No

Current Primary Care Provider: _____ Phone number _____

Medication Allergies: _____

Medications **Pharmacy**_____

Please list all the medications you are taking, including vitamins, herbal medicines, and "over the counter" medications.

Name of medication	Dose	Frequency

Medical History

☐ Hypertension (High blood pressure) ☐ Heart attack ☐ DVT ☐ Stroke ☐ Asthma ☐ Bronchitis	☐ COPD ☐ Cirrhosis ☐ G.E.R.D ☐ Hepatitis ☐ Ulcer ☐ UTI(s) ☐ STD(s) ☐ Kidney disease	☐ Diabetes ☐ Fibromyalgia ☐ Arthritis ☐ Seizures ☐ Migraines ☐ Depression ☐ Anxiety ☐ Thyroid disease	☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Cancer ☐ Glaucoma ☐ Congestive heart failure ☐ GI Disorder

Please list any other medical conditions not listed above: _____

_____

Surgeries

Type	Date	Type	Date

Social History

☐ Current Smoker Amount per day? _____ ☐ Chewing Tobacco Amount per day? _____ ☐ Former smoker/chewing tobacco user Quit Date: _____ Years of use: _____	☐ Alcohol: Type / amount _____ _____ ☐ Drug use: Type / amount _____ _____ ☐ Regularly exercise _____ _____
☐ Eat healthy meals ☐ Take a daily aspirin ☐ Wear seat belts ☐ Household smoke detectors ☐ Keep fire arms in the home	☐ Sexually active ☐ Type of birth control _____ _____ **Women only:** ☐ Date of last PAP exam_____ ☐ Planning pregnancy ☐ Pregnant

Family History –Please check all that apply.

	Father	Mother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Deceased						
Thyroid Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Bleeding Disorder						
Kidney Disease						

Symptoms –*Please circle any of the following symptoms that you have now or have had recently.*

Fever	*High Blood Pressure*	*Numbness/ Tingling*
Chills	*Palpitations*	*Memory Loss*
Weight Loss	*Swelling of Legs*	*Increased Thirst*
Fatigue	*Short of Breath*	*Anemia*
Weakness	*Abdominal Pain*	*Easy Bleeding*
Dizziness	*Nausea*	*Urinary Frequency*
Headaches	*Diarrhea*	*Blood in Urine*
Fainting	*Vomiting*	*Painful Urination*
Sweating	*Constipation*	*Worrisome or Changing skin lesions*
Blurry Vision	*Back Problems*	*Poor healing*
Cough	*Joint Pain*	*Nasal Congestion*
Short of Breath	*Rashes*	*Ear Pain*
Tonsils Enlarged	*Sore throat*	*Depression*

Please list any additional symptoms not listed above:

_____

_____

_____

Affinity Family Health
707 Conrad Hilton Blvd
Cisco, TX 76437

HIPAA

Patient Information Acknowledgement

I have read and fully understand ***Affinity Family Health*** Notice of Patient Information Practices. I understand that ***Affinity Family Health*** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ***Affinity Family Health*** will consider requests for restriction on a case-by-case basis.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in ***Affinity Family Health's*** Notice of Patient Information Practices. I understand that I reserve the right to revoke this acknowledgement by notifying the practice in writing at any time. I hereby acknowledge that I have received a copy of the Notice of Patient Information Practices.

PLEASE CIRCLE YES/NO FOR THE FOLLOWING

Is it okay if we leave you a message on the home or cell phone number provided? YES / NO

Is it okay if we send you text message reminders for appointments and follow ups? YES / NO

Patient Name (Print)_____

Patient/Guardian Signature_____Date_____

Designated Individuals Authorization

I hereby authorize one or all of the designated parties below to request and receive the release of protected health information regarding my treatment, payment or administrative operations related to treatment and/or payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name_____Relationship_____

Name_____Relationship_____

Patient Name (Print)_____

Patient/Guardian Signature_____Date_____

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NOTICE OF PATIENT INFORMATON PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED
AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL DUTY

Affinity Family Health is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Affinity Family Health uses your personal health information and may disclose this information primarily for providing treatment and continuity of care; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, ***Affinity Family Health*** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Affinity Family Health may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, ***Affinity Family Health's*** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Affinity Family Health may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request and updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. ***Affinity Family Health*** will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that ***Affinity Family Health*** may have violated you privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on ***Affinity Family Health's*** health information practices or if you have a complaint, please contact us at:

Affinity Family Health, PLLC
Jacqueline Belk, MSN, APRN, FNP-C
707 Conrad Hilton Blvd
Cisco, TX 76437
(254) 761-5909

We at Affinity Family Health do our best to provide you with the best care possible. Out of consideration for our other patients and staff, please read over the following office policies.

Cancellation/No-Show Policy

Please give 24 hours' notice for a cancelled appointment. Appointments cancelled after this period of time, or no-show appointments, may be charged a $25.00 fee. If the patient arrives 15 minutes late to an appointment, the appointment will be rescheduled at the next convenient time. After 3 no-shows, the patient may try to be seen as a walk in. We will not block time from the schedule and the patient is not guaranteed to be seen.

Refill Policy

Please allow 48 business hours for all medication refills. Keep in mind that our office is closed on weekends and all federal holidays.

Payment Policy

Payment is due at time of service. Patients with past due accounts must pay account in full before being seen by the practitioner. If insurance does not pay for a claim, the patient will be responsible for payment.

Patient Portal

If you would like to be included in our Patient Portal, please include your email on the first page. By signing up for the Patient Portal, you will have access to the documents in your chart, lab results, a list of your medicines, and direct messaging to staff.

Please sign this document stating that you have read the above policies and are in agreement.

Print_____

Signature_____