## CFHC Privacy Practices Policy (All patients/guarantors must sign and date this section)

A. Right to Review Notice of Privacy Practices. You have the right to review copy or our Notice of Privacy Practices before signing this consent. Our Privacy document details how we may use and disclose your health information. We may amend the Notice from time to time. You may obtain a copy of our notice of Privacy Practices by requesting one in person at 2301 N Martin Luther King Boulevard Clovis NM 88101. You may call to request this notice by calling the administrator at 575-762-4455.

B. Right to Request Restrictions on Use/Disclosure. You have the right to request that we restrict how we use and or disclose your protected health information for purposes of providing treatment, obtaining payment for our services and/or conducting health care operations. Such requests must be made in writing. Please note that we are not required d to agree to any requested restriction. If however, we decide to agree to a restriction you have requested, we must restrict our use and or disclosure of your health information in the manner described in your request.

C. Right to Revoke Consent. You have the right to revoke your consent at any time. Your revocation of this consent must be in writing. If you wish to revoke this consent, please contact the HIPAA Privacy Official at CFHC at 2301 N Martin Luther King Boulevard Clovis NM 88101 or call 575-762-4455 to request a revocation form. Note that your revocation of this consent will not be effective for disclosures we have already made in the reliance on your prior consent. We also have the right to refuse further treatment if you revoke this consent.

D. Right to receive a copy of this Consent Form. You have the right to receive a copy of this form after you sign it.

E. Effective Period. This consent is effective unless and until you revoke it in writing.

I hereby authorize Clovis Family Healthcare Center to use and or disclose my health information for treatment, payment or health care operations.

Patient/Guarantor Signature _____ Date _____ Time _____

Relationship to Patient if not the patient: _____

## Authorization for Assignment & Release (All patients/guarantors must sign and date this section)

I, _____ (Patient/Guarantor Name) agree to the following terms as a patient or guarantor of Clovis Family Health Care. Please initial each line to acknowledge our policies.

_____ I agree to pay my co-pay at the time of service.

_____ I agree to pay all deductible and/or percentage of coinsurance, as a result of insurance processing.

_____ I authorize my insurance benefits to be paid directly to Clovis Family Health Care.

_____ I authorize my medical information to be released as required to justify medical necessity on all billing documents.

_____ I understand and agree to be responsible for any elective or non-covered services that may be provided.

_____ I understand that I am financially liable for payment for services rendered and that I am responsible for providing all pertaining insurance information to expedite insurance reimbursement.

_____ I agree that if I do not possess current insurance coverage, that I will pay the minimum cash pay price of $105.00 for each scheduled visit, $125.00 for after hours (walk ins), and additional fees for any other provided services (labs, oral or injected medications, x-rays, etc.) at the conclusion of my visit.

_____ I understand a no show fee of $50 will be collected if I do not cancel or reschedule my appointment an hour in advance.

Patient/Guarantor Signature _____

Date _____ Time _____

For Office Use Only

Employee Responsible for Scanning: _____

Name _____ Date of Birth _____

Reason For Visit _____ Sex: M F

| Allergies | Reaction |
|---|---|
| 1) | |
| 2) | |
| 3) | |
| 4) | |
| 5) | |

| Medications taken presently | Dose | Times/day |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |
| 5) | | |

## Past Medical History

- ☐ Diabetes
- ☐ Cancer _____
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Other heart trouble
- ☐ Asthma
- ☐ Pneumonia
- ☐ Stroke
- ☐ Epilepsy
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Chicken pox
- ☐ Valley fever
- ☐ Tuberculosis / (+) skin test
- ☐ Depression/anxiety
- ☐ Glaucoma
- ☐ Sexually transmitted disease
- ☐ Fractures _____

_____

- ☐ Headaches
- ☐ Neck problems
- ☐ Back problems
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Esphogeal reflux (GERD)
- ☐ Kidney/bladder disease
- ☐ Hepatitis
- ☐ Peptic ulcer
- ☐ Appendicitis
- ☐ Other stomach/bowel disease

Immunizations:

- ☐ Polio vac (year) _____
- ☐ MMR vac (year) _____
- ☐ DPT vac (year) _____
- ☐ Chicken Pox Vaccine
- ☐ Flu Shot in last 12 months
- ☐ Pneumovax (year) _____
- ☐ Tetanus (year) _____
- ☐ Hep B vac (year) _____

- ☐ Pap (mo./yr.) _____
- ☐ Mammogram (mo./yr.) _____
- ☐ Prostate exam (mo./yr.) _____
- ☐ Colonoscopy (mo./yr.) _____

Specialists (seen regularly)

- ☐ Cardiologist _____ ☐ Chiropractor _____
- ☐ Allergist _____ ☐ Other _____
- ☐ Pulmonologist _____ ☐ Other _____

(Females only) ☐ Menopause

# full term pregnacies_____ # premature deliveries_____

# C-sections_____

During pregnancy did you have:
- ☐ high blood pressure
- ☐ diabetes
- ☐ pre-eclampsia or eclampsia

# vaginal deliveries_____

# miscarriages/abortions_____

## Surgical History

- ☐ Tonsillectomy
- ☐ Knee / hip surgery
- ☐ Shoulder surgery
- ☐ Heart bypass
- ☐ Back surgery
- ☐ Appendectomy
- ☐ Thyroid surgery
- ☐ Prostate surgery
- ☐ Cataract R(___) L(___)
- ☐ Breast surgery / biopsy
- ☐ Gallbladder surgery
- ☐ Hysterectomy
- ☐ Vasectomy
- ☐ Hernia repair
- ☐ C-section
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

## Family History

Circle major medical problems

| | | | | | | |
|---|---|---|---|---|---|---|
| Mother | Diabetes | Cancer | High Cholesterol | High blood pressure | Heart Disease | Other_____ |
| Father | Diabetes | Cancer | High Cholesterol | High blood pressure | Heart Disease | Other_____ |
| Brothers | Diabetes | Cancer | High Cholesterol | High blood pressure | Heart Disease | Other_____ |
| Sisters | Diabetes | Cancer | High Cholesterol | High blood pressure | Heart Disease | Other_____ |
| Children | Diabetes | Cancer | High Cholesterol | High blood pressure | Heart Disease | Other_____ |
| Grandmothers | Diabetes | Cancer | High Cholesterol | High blood pressure | Heart Disease | Other_____ |
| Grandfathers | Diabetes | Cancer | High Cholesterol | High blood pressure | Heart Disease | Other_____ |

## Social History

Occupation _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Tobacco ☐ never ☐ now ☐ quit

# per day_____

Year quit _____

Age started_____

Alcohol use: ☐ never or ☐ Liquor _____ per day / week / month

☐ Beer _____ per day / week / month

Rec. Drugs: ☐ never ☐ now ☐ in past

☐ Wine _____ per day / week / month