Danielle Hohm, FNP
FAMILY WELLNESS CLINIC

Consent for Medical Treatment

Medical care at Family Wellness Clinic requires a relationship between the patient, the providers, and the clinic staff. The relationship requires trust and mutual respect. In addition to the policies noted below, signing this form authorizes the medical providers at the Family Wellness Clinic, to take a history and perform a medical exam in order to diagnose and develop a treatment plan.

Scope of Treatment

Family Wellness Clinic (FWC) provides primary care and acute care services. Consultations and referrals are made to other healthcare providers and specialists as appropriate.

Clinic Policies

- Examination of sensitive or personal areas may be in the presence of a chaperon. A family member is not a legal chaperon.
- Prescriptions for patients under 18 must be released to the parent or legal guardian.
- For patients under the age of 18, a legal guardian must be present for treatment or there must be a signed consent for treatment from a legal guardian if another adult is present.
- Family Wellness Clinic is a nondiscriminatory environment, however, genetic and, therefore, racial and cultural differences are used to make medical decisions based on scientific studies that support this approach.

Patient

- You have the right to obtain a second opinion, refuse treatment, or change your mind without judgment or pressure.
- You are encouraged and requested to ask questions in order to understand the diagnosis and treatment options for your medical problem.
- Consent forms for minor procedures and injections are not required for treatment. Receiving treatment is acknowledgment that you understood the risks and benefits and agreed to proceed.
- Results of sensitive tests cannot be sent by text, e-mail or answering machines. You must call in for the results.

Provider

- Providers frequently have to ask sensitive, personal questions to diagnose medical conditions appropriately.
- Providers are not obligated to provide medical care or services that they feel are not warranted.
- Providers are required by law to report episodes of complete loss of consciousness to the health department.
- Providers are required to report any suspected episode of child or elder abuse to the police.

Medical Records

- Medical Records will be maintained in electronic format for the duration of time required by South Dakota State law.
- You may obtain a copy of your records at any time in digital format or as a printed copy. Charges apply for copies of your medical records.
- Employees at FWC may contact and disclose medical information to the persons listed as guardians and emergency contacts, without additional notification or permission from you, the patient.

Therefore, I hereby authorize and request Family Wellness Clinic to provide such medical care and administer such diagnostic and/or therapeutic procedures and treatments as in judgement of the providers in attendance that are deemed necessary and advisable.

______________________________ ______________________________

Patient/Guardian Signature Date

Authorization for Release of Information for Insurance Benefits

I hereby authorize and direct Family Wellness Clinic (FWC) having treated me, to release to government agencies, insurance carriers, or others, who are financially liable for my care, all information need to substantiate payment for my care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

NOTICE OF PAYMENT POLICY I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Family Wellness Clinic (FWC) all money to which I am entitled for medical expenses related to the services performed from time to time by FWC, but not to exceed my indebtedness to FWC. I authorize FWC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $40 returned check fee may be charged for checks returned due to insufficient funds. Family Wellness Clinic reserves the right to charge $35 for missed appointments or canceled appointments without a 24-hour notice.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to FWC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

____ (initials) I Certify that I have read and agree to Family Wellness Clinic's Payment Policy above
____ (initials) I have reviewed a copy of Family Wellness Clinic's Privacy Notice

HIPAA Release of Information

_____ I authorize the release of information including the diagnosis, records, examination rendered to me, billing, and claims information.

This information may be released to (list name of individuals):

___ Spouse ____

___ Child (ren)____

___ Parent ____

___ Other ____

___ My information is not be released to anyone.

This release of information will remain in effect until terminated by me in writing.

_____________________________________ _____________________________________
Patient/Guardian Signature Date

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Patient Information		
Patient Information		
First Name and Middle Initial:	Last Name:	Previous Name (if applicable):
Mailing Address:		Apt #
City / State / Zip:	E-Mail Address:	
Home Phone:	Cell Phone:	Work Phone:
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: *Phone:*	*Text Message:* Provider: AT&T, Cricket, Sprint, Verizon, Other: __________	*E-mail:*
Can we leave a message regarding your medical care & test results? Yes / No		
Current Family Physician or Pediatrician:	Date of Birth:	Sex: Male / Female
Marital Status:	Social Security Number:	
Employer name and address:	Emergency Contact Name:	Relationship to Patient:
	Emergency Contact Phone Number:	

Responsible Party and Additional Information		
Responsible Party – If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor		
First Name:	Middle Initial:	Last Name:
Date of Birth:	Social Security Number:	Phone:
Address of Person Responsible:		
City / State / Zip:		Relationship to Patient:
Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)		
Race (please circle): White / American Indian or Alaska Native / Asian Hispanic / Black or African American / Native Hawaiian or Pacific Islander Other _____________ / Decline		Ethnicity (please circle one): Hispanic or Latino Not Hispanic or Latino Decline
Preferred Language (please select one): English, Bosnian, Indian (including Hindi & Tamil), Sign Language, Spanish, Russian, Other		
Preferred Pharmacy Name & Location:		

Insurance Information	
Primary Insurance	**Secondary** Insurance
Insurance Company Name:	Insurance Company Name:
ID number and Group Number or Claim Number:	ID number and Group Number or Claim Number:
Policy Holder Name:	Policy Holder Name:
Policy Holders Date of Birth and Social Security Number:	Policy Holders Date of Birth and Social Security Number:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Signature of Responsible Party: X____

Printed Name of Responsible Party: X____

Patient Medical Information

NAME:____DOB:_____________________DATE:_______________

MEDICATION ALLERGIES:____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins.
Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heartbeat)
Arthritis
Asthma
Bipolar disorder
Bladder Problems/Incontinence
Bleeding Problems
Cancer:________________
Headaches/Migraines
Crohn's Disease
COPD/Emphysema
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hernia
High Blood Pressure
Kidney Stones
Kidney Disease
High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Macular Degeneration
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)
Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Hypo/Hyperthyroidism
Ulcerative Colitis
Other: ________________
____
____
____

Last Menstrual Period	Date:	Normal / Abnormal
Pap	Yes/No Date:	Normal / Abnormal
Mammogram	Yes/No Date:	Normal / Abnormal
DEXA (Bone Density Scan)	Yes/No Date:	Normal / Abnormal
Colonoscopy	Yes/No Date:	Normal / Abnormal

Pregnant?	Yes/No Due Date:
Trying to conceive?	Yes/No
Children?	How many?

SURGICAL HISTORY: Please list all your prior surgeries and approximate dates performed.

____
____
____

List all medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.): ____
____
____

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FAMILY HISTORY:

FATHER: Living: Age_____________ Deceased: Age__________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:________________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (blood clot)	Kidney Disease	Hypothyroidism
Arthritis	Dementia	Heart Disease	Migraines	Hyperthyroidism

Other:____

MOTHER: Living: Age_____________ Deceased: Age__________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer:________________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (blood clot)	Kidney Disease	Hypothyroidism
Arthritis	Dementia	Heart Disease	Migraines	Hyperthyroidism

Other:____

GRANDPARENTS:____
____

AUNTS/UNCLES: ____
____

SIBLINGS:____
____

SOCIAL/CULTURAL HISTORY:

Education Level: ___________________________________ Occupation: ____

Any vision problems that affect your communication? Yes / No

Any hearing problems that affect your communication? Yes / No

Any limitations to understanding or following instructions (either written or verbal)? Yes / No

Tobacco Use: ☐ Current ☐ Past ☐ Never Type: ______Amount/day: _______Number of Years:________ Quit Date:___________

Vaping: ☐ Current ☐ Past ☐ Never Type: __________Amount/day:___________Number of Years:________

Alcohol: ☐ Current ☐ Past ☐ Never Type: __________ Drinks/week:______________

Recreation Drug Use: ☐ Current ☐ Past ☐ Never Type:____

Are you sexually active? Yes / No

Comments (please feel free to comment on any answers marked "yes" or circled above):___________________________________
____
____
____

Patient/Guardian Signature:____ Date:________________________

Patient Condition/Reason for Visit

Name:______________________________________ DOB: ______________________ Date: ______________

Reason for Visit: ____

When did your symptoms begin:____________________ Are they improving? Worsening? Staying the same?

Briefly Describe Your Symptoms: ____

____

What have you tried to relieve your symptoms (Ice, Heat, OTC medications, etc)?

____

Does anything make your symptoms better?____

Does anything make your symptoms worse? ____

Do these symptoms interfere with your (circle all that apply?) Work/Sleep/Daily Routine/Recreation

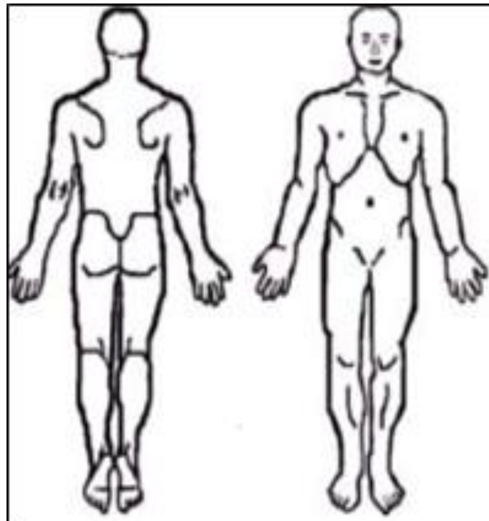
Have you seen any of other providers for these symptoms?____

Has there been any work-up completed for your current symptoms? Labs, Imaging, etc

____

Please circle on the picture where you have your symptoms.

Circle/Mark on the picture where you have symptoms



Please circle a number indicating the severity of your symptoms

1 2 3 4 5 6 7 8 9 10

Provider Reviewed: __________ Date:__________