Danielle Hohm, FNP
FAMILY WELLNESS CLINIC

New Patient Intake Paperwork

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 will 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

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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 will be charged for checks returned due to insufficient funds.

Family Wellness Clinic reserves the right to charge up to $50 for missed appointments or canceled appointments without 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 and Medicare beneficiaries above

____ (initials) I have reviewed a copy of Family Wellness Clinic's Privacy Notice

____ (initials) Our providers use a HIPPA compliant, secure dictation program during their appointments to help expedite documentation and billing in a timely manner. I consent to the use of Freed to record and transcribe notes during my visits

HIPAA Release of Information

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 needed 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.

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

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

_____ (initials) My information <u>is not</u> to be released to anyone.

_____ (initials) Spouse _____ ____All Information ____Billing Information Only

_____ (initials) Child (ren)_____ ____All Information ____Billing Information Only

_____ (initials) Parent _____ ____All Information ____Billing Information Only

_____ (initials) Other _____ ____All Information ____Billing Information Only

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

_____ _____

Patient/Guardian Signature Date

Updated 07/14/2025

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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:
How did you hear about Family Wellness Clinic? (**please check one**) ___Friend ___Family member ___Chiropractor ___Medical Provider ___Advertisement ___Facebook ___ Online ___ Other			
Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages: *Phone:* *Text Message:* *E-mail:*			
Can we leave a message regarding your medical care & test results? Yes / No			
Current Family Physician or Pediatrician:	Date of Birth:		Gender: 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 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 circle one): English Bosnian Indian (including Hindi & Tamil) Sign Language Spanish Russian Other			

Insurance Information

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

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New Patient Medical Information

NAME:_____ DOB:_____ DATE:_____

MEDICATION ALLERGIES:_____

PREFERRED PHARMACY NAME & LOCATION:_____

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

Last Menstrual Period	Date:	Normal / Abnormal	Pregnant?	Yes/No Due Date:
Pap	Yes/No Date:	Normal / Abnormal	Trying to conceive?	Yes/No
Mammogram	Yes/No Date:	Normal / Abnormal	Children?	How many?
DEXA (Bone Density Scan)	Yes/No Date:	Normal / Abnormal		
Colonoscopy	Yes/No Date:	Normal / Abnormal		

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:_____

SIBLINGS:

_____

_____

SOCIAL/CULTURAL HISTORY:

Education Level: _____ Occupation: _____

Are there any vision problems that affect your communication? Yes / No, If yes, please explain: _____

Are there any hearing problems that affect your communication? Yes / No, If yes, please explain: _____

Are there any limitations to understanding or following instructions (either written or verbal)? Yes / No

Current Living Situation (circle all that apply):

Single family household / Multi-generational Household / Homeless / Shelter / Skilled Nursing Facility / Other: _____

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

Are there any cultural or religious concerns you have related to our delivery of care? Yes / No

Are there any financial issues that directly impact your ability to manage your health? Yes / No

How often do you get the social and emotional support you need? Always / Usually / Sometimes / Rarely / Never

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

_____

_____

Patient/Guardian Signature:_____ **Date:**_____

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