THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

PATIENT INFORMATION/DEMOGRAPHIC FORM

Date: _____

PATIENT NAME:	
SSN:	**NICKNAME:**

Date of Birth: _____

Patient Mailing Address:

Street: _____

City: _____ State: _____ Zip: _____

Living Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Domestic partner

Gender per your health insurance
- ☐ Male
- ☐ Female

If different from above, what is your current gender identity?
- ☐ Trans male/Trans man
- ☐ Trans female/Trans woman
- ☐ Genderqueer/Gender non-conforming
- ☐ Different identity – please state: _____

Telephone Contact Information

Home: _____ (Mobile # if no home phone) **Work**: _____ (If employed) **Mobile**: _____ (If you have a mobile #)

Email address: _____

Occupation: _____ **Employer:** _____

Emergency Contact/Nearest Relative: _____

Emergency Contact/Nearest Relative Phone: ( ) _____

Relationship to patient:

☐ Father ☐ Mother ☐ Guardian ☐ Sibling ☐ Child ☐ Spouse ☐ Domestic partner ☐ Other

Race:

☐ I decline to answer ☐ Caucasian/White ☐ African American/Black
☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Asian
☐ Hispanic/Latino ☐ Other Pacific Islander ☐ More than one
☐ Unsure

Ethnicity

☐ I decline to answer ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Primary language spoken inhousehold: _____

I acknowledge that the information is correct to the best of my knowledge.
I authorize The Family Health Centers, PA, to render treatment to me and provide information to other care givers regarding my condition while under medical care. My signature below authorizes the release of medical records to another physician involved in my care or to the insurance company for payment of claims.

_____ _____

Signature **Date**

If you are a new patient, how did you hear about us?

☐ Doctor Referral ☐ Employer ☐ Family or Friend ☐ Insurance Provider ☐ Magazine Ad
☐ Street Sign ☐ Health Fair ☐ Social Media ☐ Search Engine ☐ Yellow Pages
☐ Brochure ☐ Other: ___

OFFICE USE ONLY MR #

Revised 3/2017

THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

TEEN PATIENT HISTORY

Date: _____

Please complete both sides of this form.

PATIENT NAME: _____ Prefer to be called / Nickname _____

Date of Birth: _____

Gender per your health insurance
☐ Male
☐ Female

If different from above, what is your current gender identity?
☐ Trans male/Trans man
☐ Trans female/Trans woman
☐ Genderqueer/Gender non-conforming
☐ Different identity – please state: _____

What type of diet do you follow? _____

Do you use tobacco or other cigarettes?

☐ No, never ☐ Yes,_____packs/day____age started
☐ Previously smoked_____packs/day, for_____years, stopped in_____(year)
☐ Oral tobacco user ☐ e-cigarette / vapor cigarette user

Do you drink alcohol?

Please check the item that best describes your current consumption of alcohol:

☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times per week
☐ Previous heavy alcohol use. If stopped completely – month/year: _____

If you drink alcohol, how much do you consume on a typical day when you are drinking:

☐ 1 or 2 drinks ☐ 3 or 4 drinks ☐ 5 or 6 drinks ☐ 7 to 9 drinks ☐ 10 or more drinks

Do you currently use street drugs (such as marijuana, cocaine, heroin, opioids or others)? ☐ Yes ☐ No

Have you ever used IV street drugs? ☐ Yes ☐ No

Are any firearms kept in or around your home? ☐ Yes ☐ No
If yes, are the firearms stored in a locked location? ☐ Yes ☐ No

Current exercise routine and school activities? _____

_____

What school do you attend? _____

Average grades in school: ☐ A's ☐ B's ☐ C's ☐ D's or lower

Living Arrangements: ☐ Both Parents ☐ Mother & Stepfather ☐ Father & Stepmother ☐ Mother only
☐ Father Only ☐ Part time in more than one house ☐ Grandparents ☐ Foster Parents ☐ Other

Who else lives with you (e.g. siblings) ?_____

If you work, what is your occupation?_____

Are you under any unusual stressors? ☐ Work ☐ Family ☐ Friends ☐ Financial ☐ Illness ☐ Other

Do you use any home medical equipment? ☐ Yes ☐ No
If yes, what medical equipment and who is your supplier:_____

What form of birth control, if needed, do you use? _____

Number of pregnancies: _____

Sexual History: ☐ Currently sexually active ☐ With men ☐ With women ☐ With men and women

☐ Never ☐ Not active in past 12 months ☐ More than 3 partners in lifetime

CURRENT HEALTH CONCERNS (please list):

_____

_____

Please complete both sides of this form.

TEEN PATIENT HISTORY *page 2*

IMMUNIZATIONS & HEALTH MAINTENANCE (give date of last shot/exam)

☐ HPV Vaccine_____ ☐ TdaP Vaccine_____ ☐ Varicella Vaccine (ChickenPox) _____

☐ Chicken Pox Virus Infection_____ ☐ Hepatitis A Vaccine series (2 shots) _____

☐ Meningococcal Vaccine_____ ☐ Hepatitis B Vaccine series (3 shots) _____

Women only:

☐ Date of first menstrual period_____ ☐ Last Period _____

Allergies to medications and the reaction you had: _____

New Patients: list all medications. **Current patients:** list any new medications. (Include non-prescription.)
Please ask for a second sheet if needed

Medication	Dose	How often

Medical history (Any illness for which you have received a diagnosis):

☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Back Problems ☐ Chronic Pain ☐ Depression

☐ Diabetes ☐ Reflux/ Heartburn ☐ High Cholesterol ☐ Migraines ☐ High Blood Pressure

☐ History of Cancer Type(s) _____ ☐ Kidney Disease ☐ Thyroid Disorder

Other: _____

List previous surgeries: _____

Family History of Major Medical Problems (if deceased, list cause and age of death)

Father: _____

Mother: _____

Brothers/Sisters: _____

Circle any of the following symptoms you currently experience

General	Appetite changes, chills, fatigue, fever, night sweats, weight gain, weight loss
Skin	Changes in wart/mole, new lesions, rash
HEENT	Eye exams by ophthalmologist or optometrist, glasses or contact lenses, headache, head injury, hearing loss, hoarseness, disturbances
Neck	Neck mass, neck pain
Respiratory	Shortness of breath, cough, coughing with blood, snoring
Breast	Breast mass, breast pain, nipple discharge
Cardiovascular	Chest pain, difficulty breathing lying down, difficulty breathing on exertion
Gastrointestinal	Abdominal pain, black stool, tarry stool, bloody stool, constipation, diarrhea, difficulty swallowing, indigestion, nausea
Female Genito-urinary	Blood in urine, change in bladder habits, painful urination, hot flashes, menstrual irregularities, painful menstruation
Male Genito-urinary	Blood in urine, change in bladder habits, painful urination, sexual difficulty, discharge from penis, urine leakage
Musculoskeletal	Back pain, joint pain, muscle weakness, swelling of extremities
Neurological	Dizziness, falls, loss of consciousness, stroke-like symptoms, seizures, falling, trouble walking
Psychiatric	Change in sleep pattern, depression, insomnia, mood changes, nervousness
Endocrine	Heat or cold sensitivity, excessive thirst, hunger or urination
Hematology	Easy bruising, easy bleeding, enlarged lymph nodes

THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

Compound Authorization for Release of Information

Date: _____ MRN: _____

PATIENT NAME: _____ **Date of Birth:** _____

Prefer to be called / Nickname _____

By signing this form, you authorize The Family Health Centers to release protected health information for the above named patient according to the instructions below.

Voicemail/Answering Machine

The Family Health Centers is authorized to leave appointment information and/or test results on your voicemail/answering machine.

☐ No ☐ Yes

_____

(Please verify your phone number)

Email Address

The Family Health Centers is authorized to send secure, HIPAA-compliant emails related to our Patient Portal, personal health information, practice hours and practice announcements.

☐ No ☐ Yes

Email address: _____

(Please verify your email address)

List below any individuals who may have access and can speak on your behalf about your health information, make/cancel appointments, pick-up prescriptions, and/or be designated as your emergency contact.

_____
Name / Relationship

_____
Phone

☐ Emergency Contact
☐ Family/Billing/Financial Information
☐ Medical Information
☐ Any/All Information

_____
Name / Relationship

_____
Phone

☐ Emergency Contact
☐ Family/Billing/Financial Information
☐ Medical Information
☐ Any/All Information

_____
Name / Relationship

_____
Phone

☐ Emergency Contact
☐ Family/Billing/Financial Information
☐ Medical Information
☐ Any/All Information

Rights of the Patient

I understand that:

- I have the right to revoke this authorization at anytime.
- I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to The Family Health Centers.
- A revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____
Signature Date

Description of patient representative's authority, if applicable: _____

_____

_____

Notice of Patient Privacy Practices
Uses and Disclosures of Health Information

We, (The Family Health Centers of Asheville, Arden and Hominy Valley), are required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow these guidelines.

Your health record is the physical property of The Family Health Centers; however, the information in the health record belongs to you.

We may use your personal health information for treatment, payments, and operations; for example, administrative purposes and evaluation of the quality of care we provide. You may request that we do not use or disclose this information to a particular entity or person, however, we ask that such a request be made in writing by you.

Although your request will be considered, please be aware we may not be able to grant your request under certain instances required by law. We review all such requests on an individual basis to determine our ability to grant them and we will respond to your request within thirty (30) days, if possible.

Understanding Health Information
A record is made of each visit you make to our practice. This typically contains your history, examinations, symptoms, diagnoses, test results, and plans of care or treatment. This information is referred to as your medical record and may serve as the following:

- *Basis for planning your care and treatment*
- *Means of communication with other health professionals who care for you, your child or dependents*
- *Legal document describing the care received*
- *Means by which you or third-party payers may verify services rendered and for payment purposes*
- *Tools for educating health professionals*
- *Sources of data for medical research*
- *Sources of information for public health officials*

We will not use or disclose your health information without your authorization except as described in this notice.

You may request to inspect or obtain a copy of your health information or that of your children or dependents. We may charge a reasonable fee for copies. We attempt to provide this information with thirty (30) days of your request.

If you believe any information in your record is incorrect or if important information is missing, you may request we amend or add such information. These requests must be in writing on a release form that we provide.

You may request a written accounting of all disclosures made of your Protected Health Information. This request may be made for all information we have after April 14, 2003. We will keep an accounting of disclosures made OTHER THAN those for treatment, payment or other healthcare operations as defined in this notice for six (6) years. We will respond to your request within thirty (30) days, if possible. If more than one request is made within a 12 month period, you may be charged a reasonable fee.

Use of your contact information

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purposes of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare-related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages to be left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

We must obtain a written authorization from you to disclose information for purposes other than outlined in this brochure. You have the right to revoke this authorization, except to the extent we have already used or disclosed this information.

You have the right to obtain and keep a written copy of this notice.

Concerns and Complaints

If you believe your privacy rights may have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services (DHHS). All such concerns or complaints must be submitted in writing. You will not be penalized for filing a complaint. To file a complaint or concern with our practice, contact our Privacy Officer:

Terry A. McLane MBA, CEO HIPAA
COMPLIANCE OFFICER
The Family Health Centers of Asheville, Arden & Hominy Valley, PA Email:
privacy@thefhc.net
Telephone: (828) 258-8681

Changes to this Policy

The Family Health Centers reserves the right to amend, change or update this policy at any time. When this occurs, a new “Notice of Patient Privacy Practices” will be posted on The Family Health Centers website, fhconline.com, and will be available at your next appointment or upon request.

Updated July, 2018

THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

ACKNOWLEDGEMENT OF RECEIPT OF PRACTICE NOTICES

My signature below acknowledges and authorizes that I understand, agree and have been informed of my rights in regard to my Protected Health Information (HIPAA – Health Insurance Portability and Accountability Act). I have received the Notice of Privacy Practices, and have been given the opportunity to ask questions about this notice, and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of my communications between the Practice and myself or others.

CONSENT OF CARE AGREEMENT

The Family Health Centers may render treatment to me and provide information to other caregivers concerning my condition while under medical care.

COMMUNITY EXCHANGE AGREEMENT

Release of medical records to another physician involved in my care or to the insurance company for payment of claims is approved.

ACQUIRE MEDICATION HISTORY AGREEMENT

The Family Health Centers may acquire a medication history from my pharmacy or insurance company.

ACQUIRE MEDICAL RECORDS AGREEMENT:

The Family Health Centers may acquire medical records from any provider I have seen in order to assist in my treatment while under medical care at any of their facilities.

Print Patient Name Date of Birth

Patient Signature (orRepresentative Signature) Date

Print Name of Person Singed Above (if other than patient)

OFFICE USE

MR # _____ DATE FAXED /INITIALS _____

THE FAMILY HEALTH CENTERS
ASHEVILLE | ARDEN | HOMINY VALLEY

Date: _____

Please review this **Financial Policy** and sign in the space provided.

1. Please complete all forms provided and be prepared to present your driver's license and current insurance card at the time of your visit. It is YOUR responsibility to provide us with your most current mailing address, phone number and insurance information.

2. We participate with many insurance plans, including Medicare. Understanding your plan benefits and what services are or are not covered is your responsibility. Contact your insurance company directly for any questions you might have regarding your coverage.

3. Please check our website for our participation list. If your insurance plan is not listed, payment in full is expected at time of service.

4. Co-payments and deductibles are due at time of service. We accept: cash, check, debit and major credit cards, including Care Credit.

5. Please be advised that some services you receive may be designated as non-covered or not necessary by Medicare or other insurers. Payment for these services is also expected at time of service.

6. We submit claims to insurance carriers promptly. Your insurance company may require additional information directly from you to pay your claim. It is your responsibility to provide this as timely as possible. Whether your insurance pays all or part of the claim, it is ultimately your responsibility to pay any balance due after insurance processes your claim.

7. If your insurance coverage changes, please notify us before your next visit so we can make the change in our system.

8. If you do not have health insurance, the Family Health Centers offers a 30% discount on select services ONLY if payment in full is made at the time of the visit.

9. If a balance due on your account is 90 days or older, your account will be moved to a collection process. You will receive a final letter offering an opportunity to pay the debt. If payment is not made, your account may be turned over to a collection agency and you may be dismissed from the practice. If this occurs, you will be given 30 days to find alternative medical care. During that 30-day period your FHC provider will only be able to treat you on an *emergency* basis.

   Our practice is committed to providing high quality care to the patients. Please let us know, if you have any questions or concerns.

I have read, understand and agree to abide by the above financial policy.

_____ _____

Signature of Patient/Responsible Party | Printed Name of Patient

_____ _____

Signature of FHC Employee | MR #