# Family Care
## Walk-in Clinic


15001 South 1st Street
Milan, TN 38358
P: 731-613-2535
F: 731-613-2534

176-C W. University Pkwy
Jackson, TN 38305
P: 731-660-6915
F: 731-668-4557

400 US Hwy 45 W
Humboldt, TN 38343
P: 731-784-7773
F: 731-784-0001


**PATIENT INFORMATION (PLEASE PRINT)**

NAME_____ SOCIAL SECURITY #_____ AGE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

TELEPHONE_____ DATE OF BIRTH_____

STATUS _____SINGLE _____MARRIED _____DIVORCED SEX _____FEMALE _____MALE

RACE _____ HISPANIC or NONHISPANIC PREFERRED LANGUAGE _____

EMPLOYER_____ TELEPHONE_____

EMAIL_____ May we email results to you? Please Circle YES NO

**CONTACT IN CASE OF EMERGENCY**

NAME_____ RELATIONSHIP_____

PHONE_____

**IF THE PATIENT IS A MINOR CHILD**

RESPONSIBLE PARTY_____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE_____SS#_____ DATE OF BIRTH_____

**ZERO-TOLERANCE POLICY**

The management of Family Care Walk-In Clinic believes that our employees have a right to care for others without fear of being attacked or abused. Our entire staff aims to be polite, helpful, and sensitive to all patients and circumstances.

Aggressive, violent, abusive or disrespectful behavior and/or language, whether in person or via telephone, will **NOT** be tolerated and could result in the discharge of one or multiple family members from our practice.

"I CERTIFY THAT THE ABOVE INFORMATION THAT I HAVE PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHERMORE, I WILL ADVISE YOU OF ANY CHANGES THAT MAY OCCUR WITH REGARDS TO MY PERSONAL OR INSURANCE DATA. ADDITIONALLY, I HAVE READ AN UNDERSTAND THE ZERO-TOLERANCE POLICY FOR PATIENT BEHAVIOR. I UNDERSTAND THAT VIOLATION OF THIS POLICY WILL RESULT IN DISCHARGE FROM THIS CLINIC'S CARE."

**SIGNATURE** _____ **DATE** _____

**PARENT OR GUARDIAN** _____ **DATE** _____

# Patient History Form

Patient Name:_____ Date of Birth:_____

Please list any allergies:_____

_____

Preferred Pharmacy:_____ Street Location:_____

Please list all medications you are taking including dosage & frequency:

_____

_____

**Past Medical History: (* SPECIFY TYPE)**

| | | | | | | |
|---|---|---|---|---|---|---|
| *Diabetes | | Asthma | | Stomach Problems | | Other: (Please List) |
| *Heart Disease | | COPD | | *Psychological | | |
| *Kidney Disease | | *Cancer | | *Neurological | | |
| *Thyroid Disorder | | Hypertension | | ADD/ADHD | | |
| *Seizure Disorder | | High Cholesterol | | *STD's | | |

**Pregnancy History:** Births:_____ Miscarriages:_____ Abortions:_____

**Gynecological History:** Date of last Pap:_____
Was it normal: _____Yes_____ No If no, specify:_____
History of abnormal:
_____ Yes Date:_____ No_____

Female Cancers? List
_____
_____

Date of last Mammogram:_____
Was it normal: _____Yes_____ No If no, specify:_____
History of abnormal
_____ Yes Date:_____No_____

**Surgical History and Date: (*SPECIFY TYPE)**

| | | | | | | |
|---|---|---|---|---|---|---|
| Tubal Ligation | | Appendectomy | | Ear Tubes | | Other: (Please List) |
| Hysterectomy (Total/Partial) | | Tonsillectomy | | Vasectomy | | |
| C-Section | | Hernia Repair | | *Heart Surgery | | |
| Colostomy | | Gallbladder | | Repaired Broken Bones | | |

| **Family History: (Check all that apply/ *SPECIFY)** | Mother | Father | Mother's Mother | Mother's Father | Father's Mother | Father's Father |
|---|---|---|---|---|---|---|
| *Diabetes | | | | | | |
| High Blood Pressure | | | | | | |
| *Heart Disease | | | | | | |
| *Cancer | | | | | | |
| *Arthritis | | | | | | |
| High Cholesterol | | | | | | |
| Other (Please list) | | | | | | |

Tobacco Use (incl. smokeless): ___Past___Current___Never
If current, how many packs per day? _____

Ecig/Vape Use: ___Past___Current___Never
If current, how often? _____

Alcohol Use: ___Past___Current___Never
If current, how often? _____

Street Drug Use: ___Past___Current___Never
Specify: _____
If current, how often? _____

Do you have an advanced directive? ___Yes___No
Do you have a living will? ___Yes___No

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# Controlled Substance Agreement

The providers at Family Care Walk-In Clinic understand the need for pain control for patients suffering from chronic pain. Ultimately it is our goal to decrease pain and discomfort for each of our patients in a safe, effective manner. Below, is a contract intended to promote a mutual understanding between the provider and the patient regarding controlled medications for pain and other scheduled medications such as Adderall, Xanax, etc. Patients with prolonged (chronic) symptoms will have an individualized plan to improve symptoms which may include physical therapy, Psychological Assessment, counseling, or a reduction and eventual cessation of narcotic use. The pain management plans are based upon clinical findings, the patient's pain level and ultimately, the discretion of the providers. Generally, the providers at Family Care prescribe controlled substances on a short-term basis for acute problems and will not prescribe these medications for long term use.

*A *narcotic* is a controlled substance intended to decrease pain and may affect mood, behavior, or has the potential for dependence or tolerance.

*The providers of Family Care define *narcotic* abuse as the following:

1. Repeatedly requesting early refills on narcotic medication.
2. Receiving multiple narcotic prescriptions from different providers.
3. Altering written prescriptions.
4. Selling narcotics.
5. Sharing pain medications with others (including family members)
6. Using narcotics other than as prescribed

**** Please read this contract carefully and sign the labeled areas. If you have any questions regarding this contact, please let one of our staff members know.****

- Family Care Walk-In Clinic (FCWIC) cannot replace medications which are lost or stolen unless a police report of the theft has been filed and sent to us. In the case of theft, a legal investigation will take place. If medications are lost or stolen a second time in any twelve (12) month period, they cannot be replaced, no matter the circumstance. Medications or prescriptions lost in the mail cannot be replaced
- It is the policy of FCWIC to occasionally perform random urine drug screens. There may, or may not be a cost to the patient for this however, FCWIC will be unable to prescribe medications if a patient refuses such testing, FCWIC will be unable to prescribe medications to any patient who test positive for any illegal substance, tests positive for narcotics not prescribed to the patient, or any evidence of narcotic prescription diversion.
- It is the responsibility of each patient to keep all appointments. If a patient does not keep his or her appointments, FCWIC will not refill any medications unless the patient returns to the clinic for an appointment. Ultimately, it is at the discretion of the provider to continue to prescribe any medication after repeated appointment cancellations, no-shows or provider conflicts within or outside the office.
- The pain regimen of the patient will only be changed at the providers' discretion. The patient should only receive pain medications from the original prescribing provider. In any event, if the original provider is unavailable to renew the prescription, another provider from FCWIC may renew or deny the prescription. The initial provider's plan for pain management will be followed in most instances at the providers' discretion. Medication type, strength, quantity and frequency of use may differ from the patient's preference if deemed appropriate by the provider. If the patient feels he/she is not receiving adequate pain control, the patient may be referred to a certified pain clinic for evaluation and treatment. Once referred to a pain management facility, all further pain medications will be managed by the pain management specialist to whom they are referred

I understand that if I violate one or more of the terms listed above, the agreement will be null and void. The medication regimen will be stopped and I may be dismissed as a patient from Family Care Walk-In Clinic _____ Patient Initials

The pharmacy that I use to fill my prescriptions is:

Pharmacy _____ Phone _____

By signing this contract, I signify my understanding and agree to adhere to its terms.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____ _____
Patient Signature Date

# Financial Policy, Simple Agreement, and Assignment of Benefits

Thank you for choosing Family Care Walk In Clinic as your provider. Our practice is committed to providing you with quality and affordable health care. Our prices are representative of the usual and customary charges for our areas. Please take a moment to review and sign our policy agreement. Should you need a copy, one will be provided for you upon request.

1. **FINANCIAL POLICY**
    a. Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan with which we are in network, payment in full is expected at each visit. If you are insured by a plan with which we are in the network but do not have an up-to-date insurance card, payment for each visit is required until we are able to verify your coverage. It is the patient's responsibility to be aware of and understand their insurance benefits and coverage.
    b. Copayments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles is considered fraud. Please help us by upholding laws by paying your co-payment at each visit
    c. Non-covered services: Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonably necessary by Medicare or other insurers. You must pay for these services at the time of the visit.
    d. Proof of insurance: All patients must complete out patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
    e. Claims submission: We file your medical claims as courtesy. We will submit your claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Insurance benefits are contracted between you and your insurance company; we are not party to that contract
    f. Coverage changes: If your insurance changes, please notify us before your next visit so we may make the appropriate changes to help you receive maximum benefits. If your insurance does not pay your claim within 45 days, the balance will automatically be billed to you. All accounts must be paid in full within 30 days for the first statement date.
    g. Nonpayment: An account is considered delinquent if the balance is not paid in full within 60 days from your first statement date. If your account becomes delinquent, a 1% per month (12% annually) service charge may be applied to the accounts monthly balance. Any partial payments will need to be negotiated. Please be aware if a balance remains unpaid, we may refer your account to a collection agency is assigned to the delinquent account, a 33% collection and reasonable attorney fees will be added to the account.

2. **ASSIGNMENT OF BENEFITS AND SIMPLE AGREEMENT**

    The patient authorizes Family Care Walk-In Clinic, INC. to deposit any checks received on their account, which happened to be paid in the order of the patient's name. In addition, the patient authorizes Family Care Walk-In Clinic, Inc. to deposit any payments received in their name from any payor who submits payment to the clinic for services they've received by Family Care Walk-In Clinic, Inc. The patient also assigns their rights to payment of benefits from their insurance company, to Family Care Walk-In Clinic, Inc. for services provided by Family Care Walk-In Clinic, Inc.

3. **ACCEPTANCE OF FINANCIAL RESPONSIBILITY**

    I understand I am financially responsible for any and all charges not paid by my insurance. If the account is turned over to a 3rd party, collection agency or an attorney, I understand that a 33% service charge will be added to the balance and I understand I will be responsible to pay all litigation expenses, court cost, and reasonable attorney fees. I also understand to agree to pay a $25 service charge for a returned checks

**I have read and understand the financial policy, simple agreement and assignment of benefits and agree to abide by its guidelines.**

**Print Patient Name:** _____ **Date of Birth:** _____

**Patient/Responsible Party Signature:** _____ **Date:** _____

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# PATIENT CONSENT FOR CLINIC TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT AND HEALTHCARE OPERATIONS

Patient's Name: _____ Date of Birth: _____

Patient's Social Security Number: _____

I understand that my health information is private and confidential, I understand that Family Care Walk-In Clinic, INC. (FCWIC) works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that FCWIC may use and disclose my personal health information to help provide healthcare to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in FCWIC declining to treat me.

FCWIC has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices under which the clinic protects their patient's privacy. I understand that I have the right to read the "notice" before signing this agreement.

FCWIC may update this "Notice of Privacy Practices." If i ask, FCWIC will provide me with the most current "Notice of Privacy Practices."

Under the terms of this consent, I can ask FCWIC to restrict how my Personal Health Information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that FCWIC would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time, if I do cancel the consent, I understand that FCWIC may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.

I may cancel this consent at any time by doing one of the following:

1. Sign and date a form that FCWIC can give me called a "Revocation of consent for use and disclosure of healthcare information"
2. Write, sign, and date a letter to FCWIC. If I write a letter it must say that I want to revoke my consent to authorize the use of a disclosure of the patient's personal health information for treatment, Payment and healthcare operations.

I understand if I cancel consent, FCWIC doesn't have to provide any further healthcare services to me.

My signature below indicates that I have been given the chance to review a current copy of FCWIC's "Notice of Privacy Practices"

_____ _____
(Patient's or legally authorized individuals signature) Date:

_____
(Relationship to the patient)

I, _____, give FCWIC permission to release my Personal Health

Information to, _____.
(Spouse or other authorized person)