HEALTH QUESTIONNAIRE

NAME _____ **DOB** _____ **DOB** _____

Male / Female Married / Single / Divorced / Widowed / Adopted / Foster

Occupation _____ **DRUG ALLERGIES** _____

PERSONAL MEDICAL HISTORY

___ Acid Reflux	___ Diabetes	___ High Cholesterol	___ Insomnia	___ Panic Attacks
___ Allergies	___ Diverticulosis	___ High Blood Pressure	___ Stroke	___ Blood Disorder
___ Prostate Disease	___ Alzheimer's	___ Hypothyroidism	___ Sleep Apnea	___ Autoimmune Disorder
___ Anemia	___ COPD	___ Heart Disease	___ Shingles	___ Heart Valve Disorder
___ Anxiety	___ Heart Murmur	___ IBS	___ Pacemaker	___ Visual Problems
___ Emphysema	___ Arthritis	___ Depression	___ Migraines	___ Osteoporosis
___ Colon Problems	___ Asthma	___ Bipolar Disorder	___ Angina	___ Chronic Pain Syndrome
___ Glaucoma	___ Ulcers	___ Autism	___ Seizures	___ Hearing Loss
___ Hemorrhoids	___ Hepatitis (type) ___	___ ADD / ADHD	___ Memory Loss	___ Fibromyalgia
			___ Cancer (type) _____	

Please list all surgeries and hospitalizations as well as the dates they occured:

Specialist's Name	Specialty

Any metal in your body? Y / N

Please list all medications you take and dosage:

Please mark any disease that runs in your family:

F-Father **M**-Mother **S**-Siblings **PGF**-Paternal Grandfather **PGM**-Paternal Grandmother **MGF**-Maternal Grandfather **MGM**-Maternal Grandmother

____ Diabetes	____ High Blood Pressure	____ Heart Disease	____ Stroke	____ Mental Illness	____ Cancer
____ Osteoporosis	____ High Cholesterol	____ Allergies	____ Asthma	____ Alcoholism	____ Seizures
____ Migraines	____ Autoimmune Disorder	____ Alzheimer's	____ Arthritis	____ Blood Disorder	____ Thyroid

Personal Habits:

Do you smoke / Use vape device Y / N If so, how much? _____ Former smoker? Y / N

Do you use any form of tobacco? Y /N If so, what type? _____

Do you drink alcohol? Y /N How often? _____ Do you drink caffeine? Y / N

Do you exercise regularly? Y / N Do you use recreational drugs? Y / N Do you have a THC card? Y / N

Health Maintenance: Please provide the date you last had the following:

Colonoscopy _____ Pap Smear _____ Mammogram _____ Bone Density _____

Tetanus Vaccine _____ Pneumonia Vaccine _____ PSA _____

PATIENT INFORMATION

PATIENT NAME _____ DOB _____ SEX _____
LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS _____ CITY/STATE _____ ZIP _____

HOME PHONE # _____ CELL PHONE # _____ E-MAIL _____

SS # _____ MARITAL STATUS _____ PLACE OF EMPLOYMENT _____

RACE: ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Black ☐ Caucasian ☐ Other ☐ Unknown/I do not wish to respond

ETHNICITY: ☐ Hispanic Origin ☐ Not of Hispanic Origin ☐ Unknown/I do not wish to respond

LANGUAGE _____ PREFERRED NOTIFICATION METHOD: ☐ Postal ☐ Phone ☐ Web Message

EMERGENCY CONTACT NAME _____ PHONE # _____

RELATIONSHIP TO YOU _____ (Please provide an emergency contact who does not live with you.)

SPOUSE/GUARANTOR INFORMATION

NAME _____ DOB _____ SS # _____

EMPLOYER _____ PHONE # _____

IF PATIENT IS A MINOR, PLEASE GIVE COMPLETE INFORMATION ON PARENT(S) OR LEGAL GUARDIAN(S)

PARENT/GUARDIAN NAME _____ DOB _____ SS # _____

ADDRESS _____ CITY/STATE _____ ZIP _____

EMPLOYER _____ PHONE # _____

PARENT/GUARDIAN NAME _____ DOB _____ SS # _____

ADDRESS _____ CITY/STATE _____ ZIP _____

EMPLOYER _____ PHONE # _____

INSURANCE INFORMATION (POLICY HOLDER)

ALL LAB WILL BE SENT TO LAB CORP UNLESS YOU PROVIDE OUR STAFF WITH A LAB CARD SHOWING OTHERWISE

PRIMARY INSURANCE _____ POLICY HOLDER'S NAME _____

DOB _____ SS # _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____ POLICY HOLDER'S NAME _____

DOB _____ SS # _____ RELATIONSHIP TO PATIENT _____

PATIENT CONSENT FOR TREATMENT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf, and I assign the benefits payable to which I am entitled, including Medicare, private insurance, and other health plans, to this practice. I understand it is my responsibility to pay any deductible and/or co-pay amount at the time of service and that I am responsible for all charges whether or not paid by insurance. I give you and any of your agents permission to call me on any phone number that I have provided you, including all cell phone numbers, for the purpose of collecting my debt. I authorize Canadian Valley Family Care to electronically access my eligibility and medication history from my insurance company. **My signature below acknowledges that I have been given the chance to review a copy of the Canadian Valley Family Care Notice of Privacy Practices.**

SIGNATURE _____ DATE _____

24-HOUR NOTICE MUST BE GIVEN FOR CANCELLATIONS.
THANK YOU FOR CHOOSING OUR CLINIC FOR YOUR HEALTHCARE NEEDS.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

SS #: _____ Phone Number: _____

Address: _____ City/State: _____ Zip: _____

With your permission, Canadian Valley Family Care may release your protected health information to a family member or another person involved in your care or in paying for your health care. For example, Canadian Valley Family Care may tell a family member when your next medical appointment is scheduled, a prescription, sample medications, billing statements, or any basic medical information. By completing this form, you are authorizing release of this information to these individuals. However, you are not authorizing Canadian Valley Family Care to provide extensive information about your medical history or copies of information from your medical record. If you wish to have this information disclosed, you must complete a separate authorization form. Please be aware that Canadian Valley Family Care may use professional judgment both in determining the amount of information it may disclose to any person besides yourself and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care or in the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friends, or guardians. Please list below:

Name_____ Relationship: _____ DOB: _____
Name_____ Relationship: _____ DOB: _____
Name_____ Relationship: _____ DOB: _____
Name_____ Relationship: _____ DOB: _____

-By signing this form, I am acknowledging that I have received a copy of Canadian Valley Family Care's Notice of Privacy Practices as required by HIPAA

-I understand that if I change my mind about any of the information on this form, I must contact Canadian Valley Family Care in writing, to revoke this form in its entirety or to complete a new form.

-The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS).

-Canadian Valley Family Care and its employees are hereby released from liability as a result of providing the requested confidential information upon receipt of this authorization.

- I understand CVFC participates with an electronic network to exchange my protected health information with other providers unless I choose not to participate.
(See office staff if you want to opt out.)

_____ _____

Signature of Patient/Parent/Legal Guardian/Authorized Person Date

CANADIAN VALLEY FAMILY CARE

PRESCRIPTION POLICY

IT IS OUR GOAL TO RESPOND TO MEDICATION QUESTIONS AND REFILL REQUESTS IN A TIMELY MANNER

1. HOW TO REQUEST A REFILL – Refill requests may be made Monday through Thursday from 8:00 a.m. to 4:00 p.m. and Friday from 8:00 a.m. to 12:00 p.m. You must call **24 hours in advance** for a refill. **Refill requests received on Friday will be addressed on Monday.** You may also request a refill through your pharmacy. Ask them to send us the refill request electronically or by fax. The fax number is 405-806-2207.

2. MEDICATIONS WILL NOT BE REFILLED:
    - After noon on Fridays – Please plan ahead if you will run out of your medication(s) over the weekend.
    - After hours, nights, or holidays
    - When you have missed scheduled appointments for refills
    - If you are requesting a narcotic (controlled medication) and have not seen your physician, physician's assistant, or nurse practitioner as required by Oklahoma statute.
    - On call physicians will not respond to requests for pain medications or other controlled substances.

NARCOTICS POLICY

PLEASE NOTE: Patients are responsible for their controlled substance medications (narcotics). New prescriptions will not be issued for lost, stolen, or misplaced medications until 30 days from the previous date of issue. New prescriptions will not be issued if a patient uses more than the amount prescribed for that month.

BE ADVISED: We regularly check the State of Oklahoma controlled substance reporting website to monitor controlled substance prescriptions. Any patient found to be receiving duplicate controlled substance prescriptions from another source is subject to dismissal from this practice.

I acknowledge that I have received a copy of and agree to adhere to the above stated policy.

_____ _____

Patient Signature Date

CANADIAN VALLEY FAMILY CARE
1491 HEALTH CENTER PARKWAY
YUKON, OK 73099
OFFICE: 405-806-2200 FAX: 405-806-2207

Patient Disclosure Form

Disclosure of Physician Financial Interests of Ownership in Healthcare Facility

Under federal law, physicians may not refer patients to any ambulatory or surgical care facility, or other treatment and rehabilitation service in which the licensee or a member of the licensee's immediate family has any financial relationship, unless the licensee at the time of making the referral discloses in writing such an interest to the patient.

This disclosure is notification that Curtis Brown, M.D., James Brown, D.O., and Aaron Wilbanks, D.O. have a small minority interest in the following healthcare facilities:

Sleep Solutions, LLC

HPI, LLC and its holdings which include:
Community Hospital, LakePointe Imaging Center, and Northwest Surgical Hospital

By signing below, I certify that I have received this information, and I understand and acknowledge all the disclosures described in the document.

_____ _____

Signature Date

NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____

At Canadian Valley Family Care, we are dedicated to helping patients understand and manage their medical expenses.

INSURED PATIENTS:
You must provide a copy of your insurance card. We ***cannot*** look up this information for you. Failure to do so will result in a ***self-pay*** visit and ***full payment will be due at the time of service.***

You are responsible for reviewing your insurance company's guidelines for fees, deductible amounts, and copayments.

It is ***your responsibility*** to provide us with any changes to your insurance. Failure to do so will result in charges being billed to you for the services provided.

DEDUCTIBLES:
If you have a deductible, it is Canadian Valley Family Care's policy that you ***pay the allowable amount at the time of service*** until the deductible has been met. ***Charges will be estimated*** based on what your insurance allows. ***We cannot bill you for these charges.***

COPAYMENTS:
Your insurance company requires that ***all copayments for services and procedures*** must be made ***at the time of service. We cannot bill you for these charges.***

SELF PAY:
If you do not have health insurance, we will charge you based on our self-pay rates. ***Payment is due at the time of service. We cannot bill you for these charges.***

I acknowledge that I have read and agree to adhere to the above-stated policy.

_____ _____

Name Date

NO SHOW/MISSED APPOINTMENT POLICY

The providers at Canadian Valley Family Care understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible. You can cancel appointments by calling our office at 405-806-2200.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality of care, it is very important for each scheduled patient to attend their visit on time. It is your responsibility to show up on time for your appointments.

PLEASE REVIEW THE FOLLOWING POLICY

1. If you need to cancel, please call the office to let our staff know as soon as you are able.
2. If you are going to be late, please call the office and notify the staff. We will document this in your account to prevent the visit from being marked as a "no show".
3. If you do not present to the office for your appointment, this will be documented as a "no show" appointment.
4. You will be charged a $20 fee for each "no show" visit you accrue, and this fee must be paid before you will be able to schedule another appointment.

I have read and understand Canadian Valley Family Care's No Show/Missed Visit Appointment Policy and understand my responsibility to plan appointments accordingly and notify Canadian Valley Family Care appropriately if I have difficulty keeping my scheduled appointments.

Patient Name	Date of Birth	Date

Patient Signature or Parent/Guardian if minor	Relationship to Patient

LAB NOTICE

We send all lab specimens to Lab Corp.

If your insurance has a lab card requirement that requires it to go to Quest or DLO, it is your responsibility to notify our lab personnel so we can document it in your chart.

Signature: _____

Date: _____