HEALTH QUESTIONNAIRE

NAME _____ **Birthday** _____ **Date** _____

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

Occupation _____ **DRUG ALLERGIES** _____

PERSONAL MEDICAL HISTORY

____Acid Reflux	_____Diabetes	____High Cholesterol	____Stroke	____Panic Attacks
____Allergies	_____Diverticulosis	____High Blood Pressure	____Sleep Apnea	____Blood Disorders
____Prostate Disease	_____Alzheimer's	____Hyperthyroidism	____Shingles	____Autoimmune Disorder
____Anemia	_____COPD	____Heart Disease	____Pacemaker	____Heart Valve Disorder
____Anxiety	_____Heart Murmur	____IBS	____Migraines	____Visual Problems
____Emphysema	_____Arthritis	____Depression	____Angina	____Osteoporosis
____Colon Problems	_____Asthma	____Bipolar Disease	____Seizures	____Prostate Disease
____Glaucoma	_____Ulcers	____Autism	____Memory Loss	
____Hearing Loss	_____Hemorrhoids			

_____Hepatitis (type)_____ ____Cancer(type)_____

Please list all Surgeries, Hospitalizations and the dates of when they happened:

_____

_____

_____

_____

_____

_____

_____

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 _____Asthma _____Allergies _____Alcoholism _____Seizures _____Blood Disorders

_____Migraines _____Alzheimer's _____Thyroid _____High Cholesterol _____Arthritis _____Autoimmune Disorder

Personal Habits:

Do you smoke? Y / N If so how many?_____ Former Smoker? Y / N

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

Health Maintenance: Please mark and date the last time you had your last...

Colonoscopy_____ Pap smear_____ Mammogram_____ Bone Density_____

Tetanus Vaccine_____ Pneumonia Vaccine_____ PSA_____

THE PROVIDERS AND STAFF AT CVFC TRY TO MAKE OUR BEST EFFORT AT PROVIDING COMPASSIONATE MEDICAL CARE WITH EXCELLENCE. WE ARE ALWAYS STRIVING TO IMPROVE OUR SERVICES AND THE CARE WE PROVIDE. PLEASE LET US KNOW IF WE CAN SERVE YOU IN ANY WAY. WE GREATLY APPRECIATE YOUR CONFIDENCE IN US BY CHOOSING US FOR YOUR HEALTH CARE NEEDS. MAY GOD RICHLY BLESS YOU AND YOUR FAMILY. THANK YOU!

E-MAIL _____

PATIENT INFORMATION

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

ADDRESS _____ CITY/STATE _____ ZIP _____

1st PHONE # _____ 2nd PHONE # _____ 3rd PHONE # _____

SS# _____ MARITAL STATUS _____ PLACE OF EMPLOYMENT _____

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

PATIENT ETHINCICITY· ☐Hispanic Origin ☐Not of Hispanic Origin ☐Unknown/I do not wish to respond

Language _____ Preferred Notification Method: ☐Postal ☐Phone ☐Web Message

EMERGENCY CONTACT _____ PHONE _____
NOT LIVING WITH YOU

SPOUSE/GUARANTOR INFORMATION

NAME _____ BIRTHDATE _____ SS# _____

EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A CHILD, PLEASE GIVE COMPLETE INFORMATION ON MOTHER & FATHER

MOTHER'S NAME _____ D.O.B. _____ SS# _____ HOME PHONE _____

ADDRESS _____ CITY/STATE _____ ZIP _____

EMPLOYER _____ WORK PHONE _____

FATHER'S NAME _____ D.O.B. _____ SS# _____ HOME PHONE _____

ADDRESS _____ CITY/STATE _____ ZIP _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION (SUBSCRIBER)

"ALL LAB WILL BE SENT TO LAB CORP UNLESS YOU PROVIDE US WITH LAB CARDS SHOWING OTHERWISE"

PRIMARY INSURANCE _____

WHO HOLDS INSURANCE _____ BIRTHDATE _____

RELATIONSHIP TO PATIENT _____ SS# _____

SECONDARY INSURANCE _____

WHO HOLDS INSURANCE _____ BIRTHDATE _____

RELATIONSHIP TO PATIENT _____ SS# _____

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 to 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 copay amount, and that I am financially responsible for all charges whether or not paid by said insurance. I give you and any of your agents, permission to call me on any phone number that I have provided to 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# _____

Address: _____ City: _____ State _____ Zip _____

Day Phone: _____ Evening Phone: _____ Cell# _____

With your permission, Canadian Valley Family Care/or West End Physical Therapy may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, Canadian Valley Family Care/West End PT may tell a family member when your next medical appointment is scheduled, the results of a laboratory test or procedure or provide the person with a copy of shot record, a prescription, sample medications or any basic medical information. By completing the top portion of this form, you are authorizing release of this information to these individuals. However, you are not authorizing Canadian Valley Family Care/West End PT 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/West End PT may use its professional judgment 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 the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name _____ Relationship: _____ Date of Birth: _____
Name _____ Relationship: _____ Date of Birth: _____
Name _____ Relationship: _____ Date of Birth: _____
Name _____ Relationship: _____ Date of Birth: _____

- 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/West End Physical Therapy, 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 dificiency syndrome (AIDS).
- Canadian Valley Family Care/or West End PT and its employees are hereby released from liability as a result of providing the requested confidential information upon receipt of this authorization.

_____ _____

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 8:00 a.m.-4:00 p.m. and Fridays from 8:00 a.m.-Noon. 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. Yukon office fax-806-2207 El Reno Office fax-262-2116.

2. MEDICATIONS WILL NOT BE REFILLED—After noon on Friday—please plan ahead if you will run out over the weekend. After office hours, at night, on weekends or holidays. If you miss scheduled appointments. If you are requesting a narcotic (controlled medication) and have not seen the doctor, PA or Nurse Practitioner in the last three months. On call physicians will not respond to medication requests for pain medications or other controlled medications.

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 PRESCRIPTSIONS WILL NOT BE ISSUED IF YOU USE MORE THAN THE AMOUNT PRESCRIBED FOR THAT MONTH.

Please be advised that we regularly check the State of Oklahoma controlled substance reporting site 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 Healthcenter Parkway
Yukon, OK 73099
Office: 405-806-2200 Fax: 405-806-2207

Patient Disclosure Form

Disclosure of Physician Financial Interests or 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 ownership interests in the following healthcare facilities:

Sleep Solutions, LLC

HPI, LLC and its holdings which include: Community Hospital, Lakepoint 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 time of service.***

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

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 services provided.

DEDUCTIBLE:
If you have a deductible, it is Canadian Valley Family Care's policy that you ***pay the deductible at 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 co-payments for services and procedures*** must be made ***at the time of service. We cannot bill you for these charges.***

SELF PAY:
If you have no health insurance, we will charge you based on our self-pay rates. ***Payment is due at 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 Physicians 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 the following number: (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 care, it is very important for each scheduled patient to attend their visit on time. It is your responsibility to show up on time to your appointments.

PLEASE REVIEW THE FOLLOWING POLICY:

1. If you need to cancel, please call the office and 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, so we can document on your account, to prevent 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. Once you have a "No-Show" Appointment, you will be charged a $20.00 No-Show fee. Which 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 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:_____