APPOINTMENT AND WALK-IN POLICY

We welcome both **APPOINTMENTS** and **WALK-INS**, however, **APPOINTMENTS** will be taken back and seen at their appointment time, which may cause a **LONGER WAIT TIME** for patients who choose to walk in rather than making an appointment.

THANK YOU FOR ALLOWING US TO PARTICIPATE IN YOUR HEALTH CARE, AND YOUR PATIENCE, AND KINDNESS TOWARDS OUR STAFF!!

HIPAA Consent Form

Patient Information:

Full Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

I, the undersigned, hereby authorize and consent to the use and disclosure of my protected health information (PHI) as described in this form. This authorization is in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

- ### Purpose of Disclosure:

I understand that my PHI may be used or disclosed for the following purposes:

- Treatment: To provide, coordinate, or manage my healthcare and related services.
- Payment: To obtain payment for the healthcare services provided to me.
- Healthcare Operations: To carry out administrative, financial, and operational activities necessary for the practice.

- ### Types of Information to be Disclosed:

I authorize the use and disclosure of the following types of PHI:

- Medical records and test results
- Treatment and medication information
- Billing and insurance information

- ### Recipients of Information:

I authorize the disclosure of my PHI to the following individuals or entities:

- Healthcare providers involved in my treatment
- Insurance companies for payment purposes
- Business associates involved in healthcare operations

- ### Duration of Consent:

This consent shall remain in effect unless revoked by me in writing. I understand that revocation of consent will not affect any actions taken prior to the revocation.

- ### Rights of Revocation:

I understand that I have the right to revoke this consent at any time by providing a written revocation to the healthcare provider. However, I also understand that revocation will not apply to information already disclosed based on my prior consent.

I acknowledge that I have read and understood the contents of this consent form and that I have received a copy for my records.

Signature: _____

Date: _____

Medical Release Form

Patient Name_____ Date of Birth_____/_____/_____

SSN_____ Address_____ City_____

State _____ Zip Code _____ Email _____

INFORMATION REQUESTED FROM

Name_____

Address_____ City_____ State_____ Zip_____

Phone ( )_____ Fax ( )_____Email_____

SEND INFORMATION TO

Name: Eva Family Health Clinic Send By _____Mail _____Fax _____Secure Email

Address: 4208 Eva Road, Suite B City: Eva State: AL Zip Code: 35621

Phone: 256-735-4154 Fax: 256-735-4054 Email: evafamilyhealthclinic@outlook.com

I, _____(name), herby grant permission for you to release confidential health information about me, by releasing a copy of my medical record or a summary or narrative of my protected health information to the physician / person / facility / entity.

_____ _____

Printed Name Date

_____ _____

Signature Date

PEDIATRIC PATIENT INFORMATION

EVA FAMILY HEALTH CLINIC
4208 EVA ROAD, SUITE B
EVA, AL 35621
P: 256-735-4154 F: 256-735-4054

PERSONAL INFORMATION

Child's Full Name :

Name of Parent / Guardian :

Date Of Birth : ____ / ____ / ____ **Gender** : ☐ Male ☐ Female

Address : ____

Phone Number : ____ **E-Mail** : ____

ID Number : ____ **Social Security Number** : ____

Name of School : ____ **Grade** : ____

Please tell us the reason for your visit today:

____

____

____

EMERGENCY CONTACT DETAILS

Contact Name : ____ **Home Number** : ____

Relationship : ____ **Mobile Number** : ____

In the event your child needs to be seen at our clinic and you are unable to be present, please list the names and contact information for the individuals in which you authorize to bring your child in for evaluation and treatment. If you chose to have them removed at any time, please notify us immediately.

Authorized Person's Name : ____ **Authorized Person's Name :** ____

Relation to patient: ____ **Relation to patient:** ____

Contact number: ____ **Contact number:** ____

Signature: ____

Print name: ____ **Date:** ____

MEDICAL HISTORY

CURRENT HEALTH

Please check ALL conditions you currently have :

- ☐ Headaches
- ☐ Anemia
- ☐ Pre-Diabeties
- ☐ Anxiety
- ☐ Depression
- ☐ Fatigue
- ☐ Abnormal skin condition
- ☐ Autism
- ☐ Developmental delays
- ☐ ADHD / ADD
- ☐ Family history of High / low blood pressure
- ☐ Family history of cancer
- ☐ Family history of cholesterol problems
- ☐ Family history of diabetes
- ☐ Family history of heart issues

☐ Allergies _____

BIRTH HISTORY

☐ Hospital Delivery If yes, where: _____

☐ Home Birth If yes, Midwife: _____

Infants gestational age at delivery: _____

Complications during pregnancy: _____

Complications during delivery: _____

Was vitamin K administered at delivery: _____

Birth Weight: _____

Birth Length: _____

Any time spent in NICU: _____

If infant is male, was he circumcised: _____

Anything else you find significant about the child's birth history:

_____

_____

MEDICATION

Please list any medications your child is currently taking and the dosage (Please include herbal remedies and supplements):

_____

_____

_____

CHILD MEDICAL CONSENT

CHILD INFORMATION

Full Name :

Date Of Birth : ____/____/____ **Gender** : ☐ Male ☐ Female

Address : _____

ID Number : _____ **Social Security Number** : _____

PARENT / LEGAL GAURDIAN INFORMATION

Full Name :

Date Of Birth : ____/____/____ **Gender** : ☐ Male ☐ Female

Address : _____

ID Number : _____ **Social Security Number** : _____

Relationship : _____ **Phone Number** : _____

CONSENT AGREEMENT

I, _____, parent / legal guardian of _____, do herby declare that I am the parent or legal guardian of the child herein listed and that there are no court orders preventing the parent / legal guardian authorization. In case of emergency I should be the primary contact.

Date: _____

FAMILY MEMBER LIST (Please list everyone living in the home with the child)

Mother: _____ **Phone:** _____ **Occupation:** _____

Father: _____ **Phone:** _____ **Occupation:** _____

Address: _____

Step-Mother: _____ **Phone:** _____ **Occupation:** _____

Step-Father: _____ **Phone:** _____ **Occupation:** _____

Address: _____

Siblings and others living in the home

Sibling: _____ **Sibling:** _____

Sibling: _____ **Sibling:** _____

Sibling: _____ **Sibling:** _____

Sibling: _____ **Other:** _____

Sibling: _____ **Other:** _____

Safety and Exposures

Is the child exposed to any second hand smoke? _____

Does child live in a home built prior to 1978? _____

Is there a smoke detector in the child's home? _____

Is there a carbon monoxide detector in the child's home? _____

If there are handguns in the child's home, are they locked up? _____

Are there any environmental or safety concerns you have for your child that you would like us to know about?

_____

VACCINE AND WELL VISIT POLICY

At Eva Family Health Clinic we are proud to say that we are fully respectful and supportive of all parental choices regarding vaccine administration, including the choice to decline all vaccines, space out vaccines or stay current with the CDC recommendations.

Regardless of your choice to vaccinate, we do ask that you remain compliant with your child's routine well visit schedule to allow us to continue to monitor your child's health and to stay established as their PCP in the event of an emergency.

I am signing below agreeing to the following:

- I fully understand that Eva Family Health Clinic is both respectful and supportive of my parental choices regarding vaccine choices for my child.
- I will discuss my child's vaccine plan in private with my healthcare provider and make the best decision for my family.
- I have been given a copy of the CDC recommended vaccination schedule and given the opportunity to accept vaccinations for my child at this facility.
- I have been given the proper education and counseling regarding vaccinations and am able to make an informed decision.
- I understand that although I chose not to follow the CDC recommended vaccination schedule, I am required to bring my child to all recommended well-visits. I understand that well-visits are not about vaccinations, but about making sure my child is developing in a healthy manner in ways in which I am unable to see and hear.
- Well-visit schedule: 3-5 days, 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 2.5 years, 3 years – then once yearly.
- I understand that **not being compliant for well-visits can dismiss my child from the care of this practice**, which can leave them without a primary care provider in the event they become sick or need referrals to any specialist.
- I have discussed any concerns I have related to this form with my healthcare provider.

_____ _____

Patient Name Printed Date

_____ _____

Guardian Name Printed Guardian Signature