FAMILY CLINIC, LLC_

123 Concord Plaza Shopping Center Saint Louis, Missouri 63128
Phone: 314-416-1926 Fax: 314-416-1007

How did you hear about us?

- **Insurance Company**
- **Online**
- **Word of Mouth**
- **Other_____**

PLEASE COMPLETE ALL 3 FORMS! THANK YOU!

PATIENT REGISTRATION FORM

( ) New Patient ( ) Established Patient / been here before.

Reason for being seen: _____

Patient Information:

Last Name: _____ First Name: _____ M.I. _____

Preferred Name : _____ Birth date : _____Age: _____ Sex: _____

Email : _____ Social Security: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Home Address: _____ Marital Status: ( ) single ( ) married

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City _____ State _____ Zip _____ ( ) divorced ( ) widowed ( ) separated

Home Phone: _____ Work Phone: _____ Cell Phone : _____

Responsible Party: ( ) Policy Holder ( ) Self

Insured Last Name : _____ First Name :_____ M. I. _____

Relationship to Patient: _____ Birth Date _____ Social Security: _____

Address:_____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Secondary Insurance: _____

Emergency Contact: _____ Phone: _____Relationship: _____

I hereby consent to any medical treatment, lab procedures, surgical procedures, x-ray, immunizations or services rendered to me or by my legal Minor by the Medical Staff of Family Clinic, LLC. I understand that I am fully responsible for all charges whether or not paid by my insurance company. I authorize Family Clinic, LLC medical information to my insurance to secure payment of benefits. I also authorize the use of my signature shown below on all insurance submissions and as authorization for payment to be sent to Family Clinic, LLC.

_____

Responsible Party Signature Relationship Date

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HEALTH HISTORY

Patient Last Name:_____ **First Name:**_____ **M.I**._____ **Date**_____

Date of Birth: _____

DRUG ALLERGIES:_____ **Reaction**:_____

CURRENT MEDICATION:_____
_____
_____

CIRCLE ANY SURGERY THAT APPLIES, OR LIST UNDER "OTHER."
Heart Bypass, Appendectomy, Hysterectomy, Cholecystectomy (Gall Bladder Removal), Tonsillectomy, Hernia Repair, C-Section.OTHER:_____

WOMEN ONLY Pregnant? ( ) Yes ( ) No Planning Pregnancy ? ( ) Yes ( ) No

PAST MEDICAL HISTORY:

CIRCLE ANYTHING THAT APPLIES, OR LIST UNDER "OTHER."

Acid Reflux	Dizziness	High Cholesterol
Allergies	Diabetes	Meningitis
Anemia	Headache	Osteoporosis
Asthma	Heart Problems	Shortness of Breath
COPD/Bronchitis	Hepatitis	Thyroid Problems
Depression/Anxiety	High Blood Pressure	

OTHER:_____

FAMILY HISTORY:
Please specify which family member has the problem.

	TYPE	FATHER	MOTHER
ASTHMA			
BLEEDING DISORDER			
CANCER			
DIABETES			
GLAUCOMA			
HEART ATTACK/DISEASE			
HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
MENTAL ILLNESS			
OSTEOPOROSIS			
STROKE			
THYROID DISEASE			

SOCIAL HISTORY:

Do you currently smoke or chew tobacco? □Yes □No If no, have you in the past? □Yes □No
How many packs per day? _____
Do you drink alcohol, beer, or wine? □Yes □No If no, have you in the past? □Yes □No
How many drinks per week? _____ Do you currently drink coffee and/or tea? □Yes □No If yes, how many cups per day?_____Do you consume energy drinks? □Yes □No If yes, how any cups per day? _____

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HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this privacy notices. This notice of privacy practices describe how we may use and disclose your protected health information . (PHI) to carry out treatment or health care operations (TPO) and for other purposes that are required by law. It also describes your rights to access and control your protected health information.. Protected health information is information about you including your demographic information, that pertains to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our clinic staff and other offices that are involved in your care and treatment for the purpose of providing health care services to you , to support the operation of the physician's practice , to pay your health care bills and any other use as required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and related services including the management of your health care with a third party .

Payment:: Your protected health information will be used, as needed to obtain payment for health services provided to you.

Healthcare Operations: We may use or disclose, as needed your protected health information, without your unique identity, in order to support the business activities of your physician's practice including but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition we will use sign – in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. And we may use or disclose your protected health information , as necessary to contact you to remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight ,Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Funeral Directors and Organ Donation, Research, Criminal Activity, Military and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorizations or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician's or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

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You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment , payment or health care operations. You may also request that no part of your protected health information will be disclosed to your family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If our physician believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request or receive confidential communications from us by alternative means , or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively, i.e. electronically. **You may have the right to have your physician amend your protected health information**. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information

We reserve the right to change the terms of this notice. You then have the right to object or withdraw as provided in this notice.**Complaints:**
You may complain to us or to the Secretary of Health and Human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.
This notice was published and becomes effective on or before **April 14, 2003.**

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Signature of Participant or Personal Representative Date

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Printed Name of Participant or Personal Representative Relationship