Our Family Doctor

Dr. Jeffrey B. Taylor and Misty Hornsby-Odom, NP

Patient Demographic Information

Name: (Last)________________ (First)________________ (Middle)____________

SS# ____-____-____ DOB: ____/____/____ Sex: Male Female

Race: ___________ Language: ____________ E-Mail:________________

Marital Status: Single Married Divorced Widowed

Home Address: ______________________________ Apt #: __________

City: ____________________ State: ____________ Zip: ______________

Home #: ________________________ Cell #: ____________________

Work #: ________________________ Other #: ____________________

Pharmacy Name: ________________ Pharmacy Phone: ______________

Guardian (minor patients): ____

Primary Insurance

Policyholder Name: ____________________________ DOB: ____/____/____

Insurance: ___________________________________ SS# ____-____-____

Policy #: _____________________ Group #: _______________________

Relationship to Policyholder: Self / Spouse / Child / Other

Employer Name: ___________________ Address: ____________________

City: ____________________ State: ___________ Zip: ______________

Secondary Insurance

Policyholder Name: ____________________________ DOB: ____/____/____

Insurance: ___________________________________ SS# ____-____-____

Policy #: _____________________ Group #: _______________________

Relationship to Policyholder: Self / Spouse / Child / Other

Employer Name: ___________________ Address: ____________________

City: ____________________ State: ___________ Zip: ______________

Emergency Contact (NOT living with you)

Name: __________________ Phone: ______________ Relationship:__________

I authorize the release of any previous results or images in the event Our Family Doctor (OFD) is in need of them to help with the diagnosis of my treatment today. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. OFD will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

Patient or Guardian Signature: ______________________ Date: ____________

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New Patient History

Name: ______________________________ **DOB:** ______________

Reason for today's visit: ______________________________

Previous Primary Care Doctor: ______________________________

Medication Allergies: ______________________________

Pharmacy Information:

Name: ______________________ Pharmacy Phone: ______________

Pharmacy Address: ______________________________

Medical History: (Example: High Blood Pressure, Diabetes, High Cholesterol)

______________ ______________ ______________

______________ ______________ ______________

Immunization History: (Month/Year)

Tetanus: ___/____ Pneumonia: ___/____ Flu: ___/____

Family History: (Please Circle)

Heart Disease Heart Attack Diabetes Stroke Depression Cancer

Other: ____________________ Type of Cancer: ____________________

Social History:

Alcohol Use: No / Yes Daily / Occasional / Rare

Tobacco Use: No / Yes Packs Per Day: _____ How many years? _____

Current Medications: (Please Name ALL Prescription and OTC medications)

	Name of Medication (Prilosec)	Dosage (20mg)	Frequency (Once Daily)
1.			
2.			
3.			
4.			
5.			

Previous Surgeries: (Example: Tonsillectomy - Year 1980)

______________ ______________ ______________

Health Maintenance: (Month/Year)

Pap Smear: ___/____ Mammogram: ___/____

Dexa Bone Scan: ___/____ Colonoscopy: ___/____

Signature: ______________________________ Date: ______________

ourfamilydoctor

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted by the following manner (check all that apply):

Telephone: Home____________________
□ OK to leave message with detailed information
□ Family member(s) with whom we can leave messages:
Name:____________________________
Relation to Patient:____________________
Name:____________________________
Relation to Patient:____________________
□ Leave message with callback number only

Work____________________________
□ OK to leave message with detailed information
□ Leave message with callback number only
□ OK to fax to specified number:
Fax:____________________________
Special instructions:____________________
____
____

____________________	____________________	__________
Patient Signature	Please Print Name	Date

Please note: Authorization is valid for 12 months from date of signature

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosure made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

PATIENT REGISTRATION FORM
DISCLOSURES & CONSENT

Patient Name:________________________________ **Date of Birth**____________
First Name M.I Last Name

ASSIGNEMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Our Family Doctor, P.A. for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that will be responsible for any co-pay or balance due that Our Family Doctor, P.A. is unable to collect from my insurance carrier for whatever reason.

MEDICARE INSURANCE BENEFITS:
I certify that the insurance given by me in applying for payment under these programs is correct. I authorize the release of any of my dependents records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Our Family Doctor, on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy of Our Family Doctor patient information privacy policy. I hereby authorize Our Family Doctor to release any of my or my dependents medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR E-MAIL
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Our Family Doctor representative or my physician to mail, Call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Our Family Doctor to that effect in writing.

LAB/X-RAY/ DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my physician at Our Family Doctor or his or her designee.

PATIENT SIGNATURE:______________________________ **DATE:**________________

GUARANTOR SIGNATURE:____________________________ **DATE:**________________
(If different from patient)

GUARANTOR NAME (Please Print)____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name:___________________________ **Date Of Birth**_____________ **Date Of Visit:**___________

I understand and agree that I will be financially responsible for any and all charges for services not paid by my Insurance for my visit. This includes and Medical service or visit. Preventative exam or physical, lab testing, X-ray, EKG, and any other screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician of clinic to know if my Insurance will pay for my Medical service or visit, Preventative exam or physical, lab testing, X-ray, EKG, or any other screening service or Diagnostic testing ordered by the physician or the physician staff.

I understand and agree it is my responsibility to know if my Insurance has any Deductible, Co-payment, Co-insurance, Out-Of-Network amount, Usual and Customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted In-Network provider recognized by my Insurance Company or plan. If the physician or provider I am seeing is not recognized by Insurance Company or plan, it may result in claims being denied or higher Out-Of-Pocket expense to me. I understand this and agree to be financially responsible and make full payments.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance Company or plan. If I have requested a PCP change that is not processed by my Insurance Company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature:________________________________**Date:**____________________

(Please Sign Here Patient or Responsible Party)

Responsible Party Name:____

(Please Print Name of responsible Party if different from Patient)

Our Family Doctor

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Please update your e-mail address with the office personnel. We will send you an invitation to join FollowMyHealth.

This will allow you to take a more active role in your health care by using FollowMyHealth™ - an online, innovative tool that provides anywhere, anytime access to your personal health records, and enables you to take a proactive role in managing your care.

FollowMyHealth is used by hundreds of healthcare organizations and thousands of physicians across the country as the power behind their hospital or clinic's specific patient portal.

With FollowMyHealth, you can:

- Review your medical records online in a safe, secure environment
- Communicate privately with physicians via secure messaging
- View test and lab results, read medical notes from your doctor
- Update your health information (allergies, medications, conditions)
- Request Rx refills
- Schedule or change appointments
- Fill out and submit forms prior to appointments...and more!

And it's available online 24 hours a day, 7 days a week via any computer, tablet, or smart phone!

Patient Name: ______________________________ DOB: ______________________

E-mail Address: ____

Last 4 numbers of SS#: _____________________