My Family Healthcare, LLC Requested Provider: _____ Approved By/Date: _____

Patient Name: _____ _____
Last First MI Name you prefer to be addressed by

Sex: ☐ Male ☐ Female Birthdate: _____ Social Sec. #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow Race: _____ Ethnicity: _____

Primary Language: _____ Preferred Contact Method: (Phone / Mail / Secure Email)

Address: _____
Mailing Address City State Zip

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Email Address: _____

Preferred Pharmacy: _____

Emergency Contact: _____ Ph. Number: _____ Relationship: _____

Responsible Party/Guarantor

Patient's relation to guarantor: _____

Guarantor's Full Name: _____ Birthdate: _____

Address: _____ Phone Number: _____

Insurance Information

Insurance Company: _____

Member ID: _____ Group Number: _____ Phone Number: _____

Name of Policy Holder: _____ Birthdate: _____ SSN: _____

Employment Status

Employment Status: (Employed / Unemployed / Self Employed / Retired / Student)

Employer: _____ Phone Number: _____

Do you have advanced directives? DNR: Circle One Yes No Power of Attorney? Circle One Medical / Legal

Who may we thank for referring you to our office? _____

If you have a provider currently, reason for the change? _____

Please Note: Please have your insurance cards and photo ID available for our records. We will file your visit with your insurance and your co-payment, deductible, or co-insurance is expected at the time you arrive for your appointment. If you are unable to pay your co-payment, deductible, or co-insurance at the time you arrive for your appointment, you may be asked to reschedule your appointment. If you are scheduled with a My Family Healthcare, LLC provider that is not listed as your PCP, you will be asked to reschedule until your PCP can be verified as changed. Your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your insurance company. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, and information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature: _____ **Date:** _____

PATIENT INFORMATION SHEET

NAME:_____ DOB:_____ DATE:_____

ALLERGIES:_____

SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:_____

Alcohol: Currently Past Never Drinks/day:_____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications	OTC and vitamins

PERSONAL MEDICAL HISTORY: (Please circle/fill in all that apply)

ADHD	COPD	High Cholesterol	Peptic Ulcer
Alcoholism	Dementia	HIV	Psoriasis
Allergies, Seasonal	Depression	Hepatitis	Pulmonary Embolism (PE)
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Rheumatoid Arthritis
Anxiety	Diverticulitis	Kidney Stones	Sciatica
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Kidney Disease	Seizure Disorder
Arthritis	Eczema	Lupus	Sleep Apnea
Asthma	Emphysema	Liver Disease	Stroke
Bipolar	Gallstones	Macular Degeneration	Thyroid Disorder
Bladder problems/Incontinence	GERD (Acid Reflux)	Migraines	Ulcerative Colitis
Bleeding problems	Glaucoma	Nosebleeds	
Cancer:_____	Heart Disease	Neuropathy	
Carpal Tunnel	Heart Attack (MI)	Osteopenia/Osteoporosis	
Headaches	Hiatal Hernia	Parkinson's Disease	
Crohn's Disease	High Blood Pressure	Peripheral Vascular Disease	

Last Menstrual Period	Yes/No Date:____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dxa (Bone Density)	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:

FATHER: Living: Age_____ Deceased: Age_____

Alcoholism	Blood Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Skin Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Lymph Cancer	Thyroid disorder	
Anemia	Asthma	Breast Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Prostate Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:_____

MOTHER: Living: Age_____ Deceased: Age:_____

Alcoholism	Breast Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Blood Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Skin Cancer	Thyroid disorder	
Anemia	Asthma	Lymph Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Ovarian Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:_____

Siblings:_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

_____

_____

Patient signature:_____ Date:_____

Provider reviewed:_____ Date:_____

My Family Healthcare, LLC

1708 Delivery Lane Durant, OK 74701
Phone (580) 924-5622 Fax (580) 745-5060

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, My Family Healthcare originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means for a third-party payer to verify that services were billed as actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that My Family Healthcare reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that My Family Healthcare is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Patient Name: _____

DOB: _____

By Oklahoma law we are required to notify you **that the information authorized for release may include records which may indicate the presence of a communicable 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)**

In addition to the releases outlined above, information may be released to the following individuals/organizations for the indicated purpose:

Name_____ Relationship_____

Name _____ Relationship_____

I request the following restrictions to the use and/or disclosure of my health information: _____

You ____ may _____ may not leave (appointment reminders, medical information) on my message service or machine.

You ____ may _____ may not fax information to me. My fax number is:_____

You ____ may _____ may not contact me by E-mail. My E-mail address is:
_____@_____

_____ _____

Signature of Patient or Legal Representative Date Notice Effective

_____ accepts _____ denies

_____ accepts conditionally the restrictions imposed on release of information as stated above (approved by Privacy Officer).

_____ _____

My Family Healthcare Representative Date

My Family Healthcare

Medical Marijuana Policy

Due to the number of medical marijuana cards being issued in recent months, the providers at My Family Healthcare have implemented a policy for medical marijuana card holders.

Your provider's top priority is to provide you with the best medical care possible for both acute and chronic conditions. In order to do that, it is imperative that they know all medications that you are currently taking and that includes medical marijuana. There are medications they may prescribe that are contraindicated while using medical marijuana and the usage of marijuana is contraindicated for people with certain medical conditions. The provider's want to give you the safest care possible and knowing if you use marijuana is essential to do so. Therefore, we are asking that you kindly inform us within 30 days of receiving your medical card. If you are a current card holder, please inform your nurse and provider today. Thank you for your cooperation.

Social Media Policy

The providers' and staff at My Family Healthcare take the protection of your health information very seriously. Unfortunately, it has become commonplace for social media and email accounts to be hacked. Due to this ever-increasing risk, as well as following the guidelines of the HIPPA Privacy Policy, we have implemented a social media policy.

If you are needing to speak to a nurse or provider regarding any health-related issues or questions, we ask that you not contact them through social media. That applies to messages through sites such as Facebook, Facebook Messenger, Instagram, or personal email. This is for your personal protection as well as ours. You may contact us by calling the office at (580) 924-5622 and scheduling an appointment or leaving a message for us to call you back or you may contact us through the patient portal. If you do not have a portal account and would like to set one up, please ask one of our office staff to help get you started.

By signing this, you acknowledge that you have received notice of our policies and that you agree to comply.

On behalf of Dr. Michael A. Lee, Dr. Brian S. Lee, Brooke Decker-Walters, APRN-CNP, and Jennifer Nelson, APRN-CNP we appreciate your understanding.

_____ _____

Signature Date

Medical Home Agreement

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ***ongoing, quality*** and ***safe*** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your ***PCP,*** to meet ***all*** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report ***any*** changes related to your health, treatments, medications, etc.
   This includes use of ***all medications*** - prescription, over-the-counter, herbal and street drugs.
   This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us ***before*** going to the Emergency Room, unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.

_____ _____

Patient or Guardian Signature Date

_____ _____

Provider Signature Date

Updated 1/13/2015